

A qualitative exploration of older adults' and care providers' perceptions of health and psychosocial factors shaping drinking in later life.

Bethany Kate Bareham

Doctor of Philosophy

Institute of Health and Society, Newcastle University

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## Abstract

**Background:** Numerous factors may influence how older people use alcohol. Risks of harm from drinking increase with age, as alcohol affects common health conditions and medications. Drinking can play a positive role in older people's social lives, and has been associated with some health benefits. Care providers can support older people to make informed decisions surrounding their drinking. However, their work may be affected by their own views about alcohol.

**Aim:** To explore the views of older adults and primary care providers regarding health and psychosocial factors shaping drinking practices in later life, and how these practices are influenced.

**Methods:** A systematic review of qualitative literature examined older adults' and care providers' views of drinking in later life, influencing factors and patterns of consumption. In-depth interviews and focus groups were conducted with older adults and primary care providers. Data were analysed thematically, applying principles of constant comparison to conceptualise how health and psychosocial factors shape drinking. Relevant social theory, including Bury's biographical disruption and Bourdieu's theory of practice, aided interpretation.

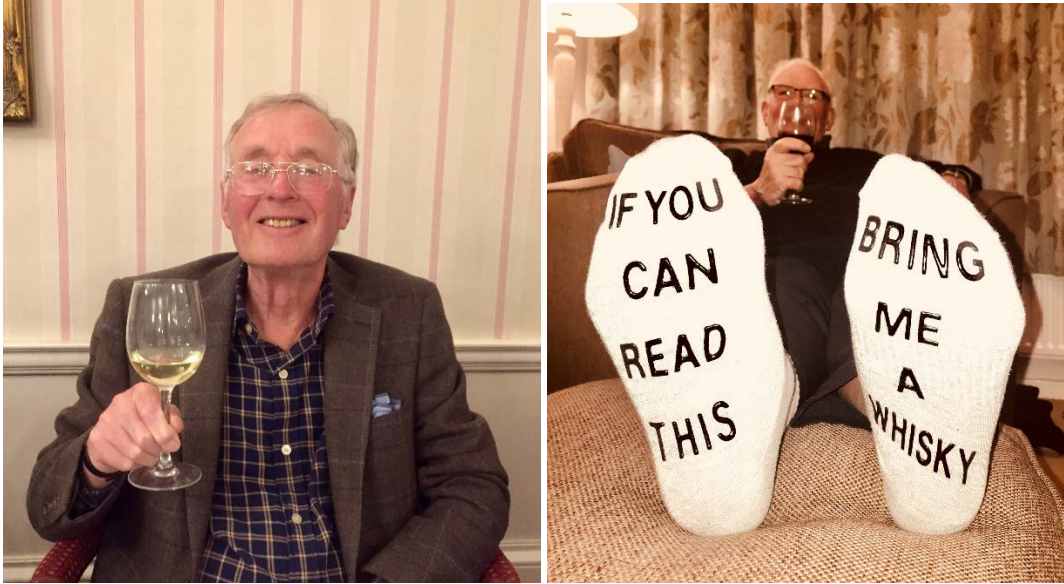
**Results:** Drinking routines developed across the life course, shaped by cultural expectations and norms, and in response to late-life transitions. Drinking played ritualised roles in older people's social and leisure lives. Older people did not identify with risks of drinking, unless they had explicit reason to believe their intake was damaging. Care providers' preconceptions surrounding the meaning of alcohol in older people's lives shaped their approach to discussion.

**Discussion:** Positive roles of alcohol and processes involved in perceiving risk meant associated risks were overlooked by older adults and care providers. Social, routine and moralistic justifications for risky alcohol use must be challenged to address risky drinking amongst older people. Care providers can support older people to recognise risks and develop healthy routines, but require appropriate resources and knowledge.



## Dedication

To Grandad and Grandad. I love you both dearly. Your curiosity and unquestioning enthusiasm for my work made this endeavour all the more enjoyable. You also made wonderful poster boys.





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## Outputs and Awards Associated With This Work

### Outputs Associated With This Work

#### *Published manuscript*

1. Bareham, B., et al. (2019). "Drinking in later life: A systematic review and thematic synthesis of qualitative studies exploring older people's perceptions and experiences." Age and Ageing **48**(1): 134-146.

**\*Material from this manuscript is included in Chapters 3, 4 and 7. A copy of this article is provided in Appendix A.**

**\*\*This publication formed the basis of an editorial, which highlighted the importance of this paper's contributions to the field of research in alcohol and ageing:**

Fudge, N. (2019). "Enhancing our understanding of drinking in later life: qualitative data refreshes parts that other data cannot reach." Age and Ageing **48**(1): 3-5.

#### *Submitted manuscript*

1. Bareham, B. K., et al. (2019). "Care providers' perspectives of older people's drinking: A systematic review and thematic synthesis of qualitative studies " Completing revisions for publication in Age and Ageing.

**\*Material from this manuscript is included in Chapters 3, 4 and 7.**

#### *Published abstracts*

1. Bareham, B., et al. (2018). "THE LATE-LIFE AND THE LIFE-LONG: EXPLORING PERSPECTIVES OF FACTORS SHAPING OLDER ADULTS' ALCOHOL USE." Innovation in Aging **2**(Suppl 1): 309-310.
2. Bareham, B. K., et al. (2017). "A QUALITATIVE SYSTEMATIC REVIEW EXPLORING ROLES, RISKS, AND SOCIAL PATTERNS OF DRINKING IN LATER LIFE." Innovation in Aging **1**(Suppl 1): 435-436.

#### *Oral presentations*

1. Stewart, J, Bareham, B, Kaner, E, Hanratty, B. (2018). Supporting healthier alcohol use amongst older people within community care settings: Insights from a qualitative

exploration of older people's and care providers' perspectives. SAPC North 2018, Kendal (poster pitch).

2. Bareham, B, Kaner, E, Hanratty, B. (2018). Supporting healthier alcohol use amongst older people within community care settings: Insights from a qualitative exploration of older people's and care providers' perspectives. SAPC 27th annual scientific meeting, London (oral presentation within ageing and frailty stream).
3. Bareham B, Kaner E, Hanratty B. (2017). A systematic review and qualitative synthesis of health and social care workers' views and experiences regarding older adults' drinking. SAPC North 2017, Kendal (oral presentation).
4. Bareham B, Kaner E, Hanratty B. (2017). 'We are not 'drinkers': Older adults' considerations and priorities surrounding drinking in later life. MedSoc annual conference, York (oral presentation).
5. Bareham B, Kaner E, Spencer L, Hanratty B. (2017). A systematic review and comparison of qualitative syntheses of older adults' and associated health and social care workers' perceptions and experiences of drinking in later life. SAPC 46th annual scientific meeting, Warwick (oral presentation within diabetes and lifestyle stream).
6. Bareham B, Kaner E, Spencer L, Hanratty B. (2017). Roles and practicalities of drinking in later life: A systematic review and synthesis of qualitative studies exploring older adults' perceptions. BSA Drinking Bodies conference, Manchester (oral presentation).

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2. Bareham B, Kaner E, Hanratty B. (2017). A qualitative exploration of older adults' and associated health and social care workers' perceptions of the positive and negative consequences of drinking in later life, and how these are considered and prioritised in practice. SPCR 2017 Showcase, Oxford (poster presentation).
3. Bareham B, Kaner E, Spencer L, Hanratty B. (2017). A Qualitative Systematic Review and Synthesis Exploring Roles, Risks and Social Patterns of Drinking in Later Life. IAGG World Congress, San Francisco (late break poster presentation).

4. Bareham B, Kaner E, Spencer L, Hanratty B. (2016). Qualitative systematic review of perceptions of drinking in later life. School for Primary Care Research 10 year anniversary showcase, London. (poster presentation).

### *Engagement activities*

1. Newcastle University Faculty of Medical Sciences INSIGHTS Public Lecture: 'Wine-ing Down in Retirement'.
2. SPCR (blog): Braving the Stage to Engage: The Bright Club Experience.
3. Bright Club at The Stand, Newcastle (comedy set): Counting Your Units.
4. Drink Wise Age Well Glasgow (oral presentation): Thinking About Drinking – exploring older people's and their health and social care workers' considerations and priorities regarding drinking in later life.
5. Newcastle University Institute for Ageing (blog): 'Time we 'rosé' to the challenge': combatting ageism in alcohol policy and practice at the House of Lords.
6. Newcastle University Institute for Ageing Q&A (blog): Meet the researcher.
7. Clinical Research Network ageing and dementia research matters (oral presentation): Thinking About Drinking.
8. Carlisle rotary (oral presentation): 20 minutes of w(h)ining.
9. Clinical Research Network (oral presentation): A multi-method exploration of perceptions of risks and benefits of alcohol consumption in older adults.

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## Definitions of Alcohol-Related Terminology As Applied Within This Thesis

Alcohol use is a complex concept. It encompasses an array of different behaviours, each described using different terms within literature cited within this thesis, and more broadly across society. Employed definitions of terms relating to these behaviours are used inconsistently. The following terms were utilised within this thesis, as defined unless otherwise specified:

**Alcohol use/drinking:** Any consumption of alcohol.

**Drinking practice:** An individual's typical procedure for alcohol use within their life.

**Non-drinker/abstainer:** An individual who does not currently engage in alcohol use within their life. Some older adults described themselves as non-drinkers although still used alcohol. Such lay use of this term is indicated through use of inverted commas: 'non-drinker'

**Alcohol use guidelines:** The UK Chief Medical Officer's guidelines for low risk drinking, as published in August 2016:

*"You are safest not to drink regularly more than 14 units per week, to keep health risks from drinking alcohol to a low level. If you do drink as much as 14 units per week, it is best to spread this evenly over 3 days or more."* (pg. 2, (1))

**Risky drinking:** Alcohol use that puts the individual at risk of physical, psychological or social harm.

**Alcohol misuse:** As risky drinking; a pejorative and not a technical term. The term is often applied within research to mean any consumption above low risk levels.

**Excessive drinking:** Consuming alcohol in excess of current alcohol use guidelines.

**Moderate drinking:** Predominantly consuming within current alcohol use guidelines. Lay definitions of this term were also employed by participants, referring to their socialised view of acceptable alcohol use. This did not necessarily reflect consumption within current alcohol use guidelines. Lay use of this term is indicated through use of inverted commas: 'moderate'.

**Reactive drinking:** Alcohol use as a coping mechanism in response to life stressors.

**Binge drinking:** High intensity drinking during a single drinking session (2); often associated with intoxication or drunkenness. Consuming more than six units of alcohol in a single session was considered to qualify as binge drinking, reflecting the most recent guidance by the National Health Service (3). Lay definitions of this term were also employed by participants, referring to drinking to the point of drunkenness. Lay use of this term is indicated through use of inverted commas: 'binge'.

**Dependent drinking:** The condition of alcohol dependence; characterised by an inner drive to consume alcohol, continued drinking in spite of harmful consequences, and a withdrawal state when stopping drinking (4)

**Alcohol Use Disorder:** Alcohol use at levels that results in, or increase the individual's risk of, physical or psychological consequences. Alcohol dependence is encompassed within this label (5).

**Alcoholic:** Employed here as a lay term utilised by study participants. This reflected their social view of problematic alcohol use; which often encompassed the concept of dependent drinking, but also encompassed social consequences attached to drinking such as unfulfilled responsibilities. This term was attached to stigma; implying negative qualities possessed by individuals with this condition.

**Problematic drinking:** Alcohol use resulting in health or social consequences for the individual or those around them. This term was also used to refer to the group of drinkers that participants perceived had a problem with their drinking – indicated through use of inverted commas: 'problematic'. Participants' definitions of problematic drinkers often echoed lay use of the concept 'alcoholism'.

**Standard drink unit:** 10ml, or 8g of pure alcohol, as defined within the UK (1). This equates to around half a pint of beer (4% alcohol by volume, or ABV), 75ml wine (13% ABV) or 25ml spirits (40% ABV).

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# Chapter 1. Introduction

## 1.1. Overview

This introductory chapter describes the background to this research study. The study population is defined and justified. The aims, objectives and research questions are specified. This chapter concludes with an overview of the content of subsequent chapters within this thesis.

## 1.2. Background and Area of Study

### *1.2.1. Drinking represents a health risk, particularly in later life*

Alcohol consumption is a leading modifiable risk factor for illness and death (6), and is causally-linked to over 200 disease-conditions, including liver disease, cardiovascular disease cancer, osteoporosis, hypertension, stroke and diabetes (7). Many of these disease conditions are most common in later life. High levels of consumption can also affect coordination and judgement, which can result in accidents and injury (1). Evidence for the effect of different levels of alcohol use for health outcomes is variable between different diseases. Firstly, there is a dose-response relationship between alcohol intake and a number of conditions; particularly cancer, where risk increases linearly with the amount of alcohol consumed (8). There is some risk of harm attached to any level of drinking, including non-dependent drinking which forms the focus of this thesis (9). Secondly, the relationship between the amount of alcohol regularly consumed and the incidence of other diseases, such as cardiovascular disease, cognitive decline, Alzheimer's disease, diabetes and frailty, has been described as J-shaped. This reflects an association between lower doses of alcohol and reduced risk of disease compared to heavier drinking or total abstinence (10, 11). This was previously thought to indicate that moderate drinking has protective effects for health. However, these bi-form relationships between alcohol intake and disease risk are now thought to be due to confounding characteristics of non-drinking groups (12). Abstainers may have ceased drinking due to pre-existing health complaints. This group also includes many members of society with greater risks of health complications, such as minority religious and ethnic groups (13, 14). Most recent alcohol use guidelines from the UK Chief Medical Officers advise that there is no 'safe' level of alcohol use, and that health benefits should not be regarded as a reason to consume alcohol (1). Current recommended limits of no more than 14 units per week spread evenly over three or more days reflect 'lower risk' intake, so that 1% of people consuming within these limits will experience harm resulting

from their alcohol use (1). The effects of alcohol on psychomotor skills, visual perception, information processing and attention have also prompted legal restrictions on alcohol use when driving in many higher-income countries (8)

Older adults are more susceptible to harm from drinking. Age-related sensitivities to the effects of alcohol mean that quantities considered to be low-risk for the general population pose a risk to older people (15). Older people have a lower physiological tolerance to alcohol, reaching a higher blood alcohol concentration compared to younger people given equivalent alcohol intake (16, 17). This is due to changes in body composition, reduced efficiency of the liver and higher sensitivity of the central nervous system associated with ageing. They experience the disinhibitive effects of alcohol, and associated risks, at lower doses. Older adults are more likely than younger people to have one or more chronic medical condition that may be exacerbated by drinking. They are also more likely to use medications to treat conditions common in later life that may interact harmfully with alcohol (18). Consequently, older adults are at a higher risk of developing diseases caused by alcohol use, as well as therapeutic failure or overdose associated with medication interactions and worsening of existing health states. Insomnia, mood disorders, sedation, dizziness, reduced coordination and associated falls or injuries are connected to drinking in later life, due to increased neurotoxicity (19, 20). Older people take longer to recover from alcohol-related injuries, and poorer outcomes are associated with alcohol-related disease with age as the ageing body is less resilient to harms (21, 22). Individual differences in health status and medication-use also mean that definitions of risky levels of drinking need to be specific to the individual. Within the older age group, there are no clear trends between experience of harm from drinking and the level of alcohol consumed (23). Current guidelines within the UK highlight that older adults and people taking medications should take more care with their alcohol use. However, there is no specified level for low-risk drinking amongst older adults (1).

There are risks attached to typical patterns of alcohol use in many older populations (24). This is particularly true in high income countries, where up to 45% of older drinkers are categorised as at-risk through their alcohol intake (24). The drinking practices characteristic of these at-risk older drinkers do not reflect the dramatic excesses typically associated with 'risky' drinkers such as younger binge drinkers. People tend to consume less alcohol with age (25). Experience of alcohol use, and learned personal tolerance across the life course also



means older adults may be less likely to experience harm through the disinhibitive effects of drinking (26). Most older adults drinking in excess of recommendations do so through frequent drinking; consuming alcohol on five or more occasions per week. This can result in exceeding recommended weekly limits for overall intake (24). Drinking alongside health conditions or medication use that had a high likelihood of being negatively affected by alcohol is also a common practice amongst the older age group. In a sample of 3308 older Americans, over a fifth were at risk of alcohol-related harm for this reason (27). Risky patterns of alcohol use are more common amongst particular groups of older people. These groups include men (28-30); the more socio-economically advantaged, who possess the resources to facilitate their alcohol use (although resources may also protect this group from harms associated with drinking) (29), and the younger old (aged 75 years and younger), with more liberal views regarding drinking (31). Particular ethnicities such as Europeans (particularly Irish), Chinese and Maoris are also more likely to consume alcohol harmfully, due to cultural norms for higher levels of alcohol use (24, 29, 30). Driving after drinking alcohol is a common practice amongst some populations of older adults. A recent study in New Zealand reported that almost one third of older drinkers had driven within two hours of consuming three or more alcoholic beverages (32). In a similar survey in the UK, 18% of older adults reported driving within an hour of consuming alcohol (23). Population ageing brings the maturation of the large 'baby boomer' cohort, born in two decades following the Second World War. This group has a higher alcohol intake overall, and greater tendency to binge drink, compared to previous cohorts of older adults. As a result, the number of older adults engaging in risky drinking practices continues to rise (33, 34), particularly within high income countries (35).

Older adults' non-dependent alcohol consumption is a pressing public health concern (36). This section of the population has not responded to recent public health campaigns to address risky drinking, maintaining their drinking practices where younger age groups have reduced their intake and associated risks (37-40). Older adults are facing increasing rates of harm through their alcohol use. Within the UK, the highest numbers of alcohol-specific deaths and alcohol-related hospital admissions are amongst the older age group (41, 42). The majority of older people experiencing harm from their drinking do not drink at levels that would be classified as an alcohol use disorder (43). Few alcohol-related preventive policies and strategies have looked to address alcohol misuse specifically within the older

population, instead tending to focus on younger binge drinkers or general approaches to prevention (44). In response to the evidence indicating that older adults are an at-risk group because of their drinking, there have been calls to develop tailored intervention programmes to prevent, identify and address alcohol misuse amongst the older age group (33).

### *1.2.2. Health and psychosocial factors motivating older people's alcohol use*

The current discourse within literature on older people's drinking presents a negative image, focussing on the health risks attached to their alcohol use. Few studies examine the beneficial roles of alcohol in older people's lives that serve to motivate their drinking (45). Alcohol use affects older adults' quality of life in many ways, aside from the effect of alcohol upon health state. Drinking can play a positive role in aspects of older people's lives, such as socialisation, relaxation and coping. Socialisation is the most common reason for drinking reported by older adults within survey data (23, 46, 47). Drinking plays important roles in social opportunities in later life (46), where other opportunities may be diminished through retirement and transitions relating to the ageing process (23). Drinking may enhance involvement in socialisation, having a positive effect on older people's quality of life (48). Many studies report on the reactive use of alcohol, where it forms a coping mechanism to respond to late-life stressors (23, 46, 49-51). Riskier levels of alcohol use have been associated with experiences of bereavement, retirement, divorce, financial hardship, loss of sense of purpose, social isolation and loneliness in later life (23, 46, 50, 51). Survey data indicate that such higher-level and reactive use represents a source of escape from these stressors (23). The contributions alcohol may make to older people's lives influence the way they choose to drink. Within the UK, current alcohol use guidelines advise that people must make their own assessment of the risks and potential benefits of alcohol consumption in terms of their personal priorities (1). The Royal College of Physicians' calls for targeted strategies to address alcohol misuse amongst the older population highlight that developed approaches must balance prevention of alcohol misuse carefully against positive roles played by alcohol in older people's lives (33).

Other factors influence the way older people use alcohol. Although current evidence suggests that drinking is not associated with any positive health outcomes (12), studies examining health benefits associated with drinking have been highlighted within the media (52). Data from the Geriatric Multidisciplinary Strategy for Good Care of the Elderly study

have suggested that older people use alcohol for its protective effects for health (53). Further, there is a poor awareness about the specific health risks attached to drinking in later life amongst policy makers, practitioners and the public (33). Most older adults experiencing harm from their drinking do not recognise the role played by alcohol (15). Older adults are also less likely to be aware of alcohol-use guidelines compared to younger age groups group (23, 54). The older population may not possess the knowledge needed to make informed decisions about their drinking. Environmental and circumstantial factors may also affect older people's drinking practices. US survey data suggests that older people tend to align their practices with norms of alcohol use (55, 56). Increased time and disposable income associated with late-life transitions may serve to facilitate drinking (50). A lifetime of routinised drinking may also mean that older people's drinking practices are well-established (57).

Many factors may therefore influence how older people use alcohol. Any new interventions must be responsive to these factors, to ensure that they are effective in supporting older people to make healthy decisions about their alcohol use. Older people's perspectives can provide a deeper understanding of such factors to advise developing strategies. However, their views have received little exploration to date (52). Within this study, the body of available qualitative evidence reporting older people's perspectives of their alcohol use is examined. Older people's perceptions are then explored in-depth within further fieldwork and qualitative analysis to identify and understand the factors that shape their drinking.

### ***1.2.3. Primary care: a context to support older people to make healthy decisions about their alcohol use***

Primary and community care settings (referred to hereafter as primary care settings) represent a key context where risky drinking amongst older adults can be identified and addressed (58). Face-to-face interactions present an opportunity to explore and incorporate older people's individual perspectives into support for healthy choices (59). Contact levels with primary care are higher than for other health providers (60). The older age group are majority attenders in primary care, and those with riskier patterns of alcohol use are likely to attend more frequently (61, 62). Primary and community care providers (referred to hereafter as primary care providers), such as general practitioners, practice nurses, health care assistants, dentists, pharmacists and social care workers, are also recognised by older adults as a source of support for addressing their alcohol use (23).

Screening and brief intervention for alcohol use are integrated within care provision, particularly in primary care (49, 63). Patients are screened using tools such as the Alcohol Use Disorders Identification Test (AUDIT), which provides an indication of consumption level, pattern and risk due to alcohol. Where potentially risky drinking is identified but results are not suggestive of alcohol dependence, a brief intervention may be supplied (64). This consists of between one and five short sessions, and can include personalised assessment and feedback, motivational counselling, goal setting and monitoring (49). Where potential dependence is indicated, the patient may be referred for specialist addictions treatment. Primary care providers also play a role in diagnosing and managing medical conditions, referrals for specialist input, and prescribing appropriate medications that may be effected by drinking. They must be aware of the possibility that their care recipients' lifestyle may have implications for their health state and treatment (23). However, evidence suggests that health and social care providers are less likely to discuss alcohol use with older care recipients than younger individuals (44). A number of barriers have been suggested within the literature, which may explain this. These include lack of awareness of specific risks associated with drinking in later life (43); misattribution of signs of harm from drinking to age-related conditions (54); perceptions that older care recipients' typical drinking practices do not represent a health risk (54); reluctance to raise the topic due to stigma associated with problematic drinking and perceived sensitivity (59); perceptions that older people would not respond to intervention due to the entrenched nature of their alcohol use (44); and therapeutic nihilism associated with perceptions that excessive drinking in later life is understandable given associated stressors (65). As a consequence, health and social care providers may not identify or intervene with older adults whose health is at risk from drinking (23). In a recent survey of older adults within the UK, most of those at risk from their alcohol intake reported that their care providers had never expressed concern about their drinking practices (23). Despite the established nature of some older people's drinking practices (57), older people are just as likely to benefit from alcohol-related discussions in care settings as other age groups, and may in fact be more responsive than younger people (66).

Health and social care providers have a practical understanding of how they can support older people to adopt health-related behaviours that are not harmful. They are aware of factors that may shape older people's lifestyle choices, and how these factors might be

addressed within their care practice. Care providers' perspectives represent an important source of knowledge to inform the development of strategies to address alcohol misuse within the older age group. This thesis will also examine existing evidence on health and social care providers' perceptions of older people's alcohol use and associated practice. Primary care providers' perspectives are drawn upon in developing a conceptualisation of factors shaping older people's drinking with practical implications for primary care practice.

### **1.3. Study Population**

#### ***1.3.1. Non-dependent drinkers***

This thesis considers the factors shaping alcohol use of older individuals without a diagnosis of alcohol dependence. By focussing on non-dependent drinkers, the findings will be relevant to the majority of older drinkers who experience harm from their alcohol use (15). Risk of harm from alcohol amongst older drinkers does not correlate with intake in later life, and non-dependent drinkers represent 97% of older adults using alcohol within the UK (23). My work will not, therefore, consider addiction as a driver for drinking practices. Instead, it will focus on older people with a non-dependent relationship with alcohol. This means that low-risk, moderate drinking is the goal of strategies to reduce harm amongst this group, rather than complete abstinence.

#### ***1.3.2. The older age group***

Two defining age ranges are employed to operationalise 'the older age group' within this thesis. The systematic review and syntheses of qualitative studies exploring drinking in later life aimed to be inclusive of all studies examining perceptions of older adults' drinking. The starting point of 'later life' was defined as 50 years, as this is the lowest age employed by studies within the available literature base (67). However, a major justification for identifying the factors that shape older people's drinking was to advise developing interventions for addressing alcohol-related harm amongst the older age group. An age range of 65 years+ was employed in the fieldwork phase of this study, as the evidence suggesting that drinking represents an increased risk in later life focuses upon this specific age group.

### **1.4. Aims, Objectives and Research Questions**

The aim of this study is to conceptualise the factors shaping older people's drinking, and how these factors are influenced; particularly within primary care settings in the United Kingdom. The following research objectives were specified:

1. To conduct a systematic review and synthesis of qualitative research examining the views and experiences of older adults and health and social care providers concerning non-dependent alcohol use in later life, and health and social care providers' approach to alcohol-related practice with the older age group.
2. To examine older adults' and primary care providers' views of factors shaping drinking in later life and how they are influenced, particularly in primary care settings, through qualitative analysis of interviews and focus group data generated on the topic.
3. To consider these findings in combination. The views of older adults will be compared with those of health and social care providers, and focussed data and analysis conducted by myself locally will be compared with research from across the world, examined within the systematic review. The findings of this work will be discussed in the context of relevant social theory and wider literature on older people's drinking to establish the contribution of this work to our understanding of and approach to older people's alcohol use.

These objectives were addressed through work to answer the following research questions:

- What do older adults and health and social care providers view to be the positive consequences of drinking as an older person?
- What do older adults and health and social care providers view to be the negative consequences of drinking as an older person?
- What factors influence how an older person uses alcohol?
- Which of these factors are most important in determining older people's drinking practices?
- What influences these determining factors?
- What do health and social care providers consider when addressing risky drinking amongst older adults within their practice?
- How can factors that shape older people's drinking be addressed within primary care settings and more broadly?

## 1.5. Overview of Thesis

The content of the remaining chapters within this thesis are outlined below:

Chapter 2: The philosophical positioning of this research is detailed. Contextual background for this work is reported. Theoretical perspectives applied within this thesis are introduced. A reflexive account of my work for this study and thesis is then provided.

Chapter 3: The methodological approach and employed methods are outlined for the systematic review and syntheses of qualitative literature.

Chapter 4: The results of the systematic review and syntheses are reported. The flow of papers within the review process is detailed, and the characteristics of included studies are summarised. The thematic syntheses of a) older adult and b) care provider bodies of literature are then presented. Factors shaping perceptions and use of alcohol in later life as suggested by this body of evidence are then highlighted; as well as areas requiring further research.

Chapter 5: The methodological approaches to data collection and analysis of the fieldwork phase of this study are discussed. The methods employed are specified.

Chapter 6: The findings of the thematic analysis of qualitative data from the fieldwork phase. Each theme is detailed, and their connections are explained to present my conceptualisation of factors shaping older people's drinking and how these are influenced.

Chapter 7: Each element of the thesis is integrated to discuss how the systematic review, qualitative fieldwork and analysis and interpretive theory assimilate to determine the contribution of this body of work to our current understanding of older adults' alcohol use. The study findings are discussed in the context of the existing literature base, and recommendations for primary care, health and social policy and future research are presented. Strengths and limitations of this research are described. This chapter ends with concluding thoughts from the process of this research study.

## Chapter 2. Thesis Methodology and Positioning

### 2.1. Overview

Within this chapter, I present the philosophical orientation underpinning my work, and then provide contextual background for the studies reported within this thesis. Social theories that aided my interpretation of the fieldwork study are introduced, highlighting the relevance of these perspectives to the topic of study. Finally, my positionality as the researcher conducting this body of qualitative work is discussed, stating considerations for understanding the work presented.

### 2.2. Philosophical Orientation of This Research

This research was conducted from a critical realist orientation. In taking this position, it is assumed that there is a real world existing independently of our perceptions, theories and constructions (ontological realism), but our understanding of this world is constructed from our individual perspective (epistemological constructivism). It follows that reality is accessed via our own interpretations, and it is not possible to attain a single, 'correct' understanding of the world (68). Critical realist research is primarily concerned with accounting for human activity, rather than merely documenting it, through understanding the causal mechanisms underpinning events as they are experienced (69, 70). Within this research, underpinning mechanisms form the focus of analysis, producing a conceptualisation of factors shaping older adults' drinking practices and how these are influenced. Mental concepts, such as beliefs, values and decisions relating to alcohol use, were considered here to be a component of reality within a causal nexus leading to action, in accordance with the critical realist perspective (71). These concepts are seen to be causally relevant in explaining human activity, and form the material of study in this research (72).

Social and physical contexts define how causal mechanisms manifest to determine human behaviour and our associated perceptions (69, 72). Different elements of underlying mechanisms may or may not have an observable impact on the world in the particular context within which they are examined (69). Critical realist research therefore aims to identify tendencies, rather than laws, in explaining patterns in social events (69), and produced knowledge is viewed as incomplete and fallible. In understanding the operation of causal mechanisms, it is crucial to also examine the social and cultural contexts within which they operate (71). Older people's drinking practices are known to vary based on factors such



as their cultural and socio-economic context (24, 29) (as introduced in [Section 1.2.1](#)). The qualitative approach taken within this research facilitates understanding of these mechanisms in context (69). In conceptualising causal mechanisms for human activity and their operation, it is helpful to examine phenomena within different contexts (73). This work therefore begins by examining the underpinning reasons for older people's drinking across contexts – through the views of older adults and their care providers within societies across the world. The specific phenomenon of focus is then examined in-depth in a local setting to develop a conceptualisation of causal mechanisms underpinning older people's drinking practices, and how they might be influenced. As the understanding of underlying mechanisms was fine-tuned within the localised fieldwork phase of this study, findings and implications of this research will be most applicable to comparable cultural and care settings (74).

Reality is viewed to be theory-laden. Applying social theory facilitates a deeper analysis, serving to progress understanding of potential causal mechanisms that underpin human behaviour and related perceptions (69). It is important to be open to the use of different theories that may facilitate understanding of the specific phenomenon and its constituent elements (75). Here, I identified candidate theories that might aid interpretation during the systematic review and early fieldwork phases of this work, led by emergent findings. These candidate theories were considered for their applicability and usefulness as an interpretive tool to aid analysis of fieldwork data. The theoretical models and concepts selected to aid analysis are explained in the following section.

The philosophical position of this research has implications for what generated knowledge represents. In conducting this study from a constructivist epistemological stance, it is assumed that discussions (such as within an interview or focus group) contribute to how an individual constructs their perspective. The findings of this research therefore represent a co-construction, grounded in an interaction between the perspectives of the study participants and myself as a researcher; and the contributions of my supervisors and other academics, my Patient and Public Advisory Group, relevant literature and social theory to interpretations of data. However, the underpinning assumption is that perspectives reflect an external reality where social problems exist. This suggests that findings will be applicable to developing recommendations for policy and practice to address these social problems (69). Factors identified to shape older people's drinking, and my conceptualisation of how

these determine older people's drinking practices, represent valuable targets for developing health and social care policy and practice. In consulting primary care providers as I progressed my conceptualisation, findings are particularly applicable to practice in primary care settings.

The critical realist approach has further implications for the conduct of this research. Rather than testing pre-determined hypotheses, as is traditional in scientific studies, this research pursues discovery and emergent knowledge. Particular strategies associated with critical realist research were employed to promote a more complete understanding of the culture, setting and phenomenon of study (76). Purposive sampling ensured a range of relevant perspectives were consulted in conceptualising the mechanisms underpinning phenomena, examining different contextual factors that may affect how mechanisms manifest. Recording and transcribing interviews and focus groups and taking field notes ensured an accurate record of data upon which to base analysis. Reflexivity supported me, as a researcher, to explore my own position and values in relation to this research topic given my role in data generation and analysis. As an individual embedded within a society that influences my own personal perspective, I cannot be considered objective or value-free. Reflexivity enabled me to acknowledge and account for my influence on findings (77). My reflexive thoughts are discussed below in [Section 2.6](#). Through examining negative cases and alternative explanations, I worked to progress my conceptualisation of underpinning mechanisms so that different manifestations of phenomena were accounted for. Applying multiple qualitative methods within this work allowed for a dialectic between different perspectives (78). Findings from my own focussed fieldwork are considered in view of related findings from research based in different contexts, and the views of older adults and their care providers are compared and contrasted. The findings of this thesis are then discussed in the context of relevant social and psychological theory and wider relevant literature. Through triangulating these different understandings, my understanding of causal mechanisms underpinning the phenomenon was deepened (76).

### **2.3. Study Context**

The first component of this thesis is a synthesis of qualitative studies exploring older adults' and care providers' perspectives of drinking in later life within higher income countries. Alcohol misuse represents a particular issue within higher income countries, where relatively greater income supports the purchase of alcohol (24, 79). Alcohol use is the norm within

these cultures, with up to 87% of older people in these countries consuming alcohol (24). Normative drinking practices amongst older adults vary between different higher income countries (24). Relevant contextual intricacies are therefore highlighted within the findings of the synthesis. Resources and scope for prevention of alcohol-related harm are comparable across higher income countries (80), and all look to address alcohol use within their public health strategies (79).

Primary qualitative data were collected within the North of England to further the conceptualisation of factors shaping older people's drinking. Within the UK, 'frequent' drinking practices, where alcohol is consumed on two or more occasions per week, represent the norm amongst the older age group (24). Typical drinking practices amongst older adults within the UK often exceed low-risk alcohol use guidelines. In 2016, survey data highlighted that nearly a third of older men and a fifth of older women consumed in excess of former guidelines (23). Health and social care services within England are currently practicing within a crisis of limited resources and rising demands for care provision (81). Data for this study were collected in the context of recent changes to alcohol-use guidelines, where men's recommended alcohol use guidelines were reduced from 21 units to align with the 14 units recommended for women (1).

The North East and North Cumbria were the setting for the fieldwork study. This region has a higher than average older population (82). A culture of heavier alcohol use means that regional rates of alcohol-related harm are high relative to the rest of England, as indicated by figures for alcohol-related hospital admissions and deaths (42). These regions include a mixture of industrialised urban and rural environments, and although levels of deprivation vary widely within the area, they are relatively high in comparison to other areas within the UK (83).

#### **2.4. Social Theories Applied to Aid Data Interpretation and Conceptualisation**

The social theories introduced here were employed as an interpretative tool to aid analysis of fieldwork data. My understanding of the topic, developed through conducting the review study and fieldwork data collection and early analysis, guided exploration and identification of applicable theory to aid interpretations. Concepts and ideas identified within these findings were discussed with other academics and examined within relevant literature in order to explore which social theories may aid understanding. Four theories and constructs

were helpful in furthering understanding of fieldwork data. These theoretical perspectives did not drive the design or conduct of this study, nor did they make any major contribution to analysis of review findings. Review material and analysis was considered an opportunity to understand the existing literature base, and contextual factors that may affect older adults' drinking practices. Bury's Biographical Disruption (84) and Bourdieu's Theory of Practice particularly aided the development of a conceptualisation of factors shaping older people's drinking based on fieldwork data (presented in [Chapter 6](#)). Other social constructs, such as 'othering' and 'rituals', are drawn upon in describing this conceptualisation within themes. Work on 'rituals' advised articulation of the construct within review findings (presented in [Chapter 4](#)). Each of these theoretical perspectives are introduced below.

#### ***2.4.1. Biographical Disruption***

Bury's theory of biographical disruption describes how a person's developed biography and self-identity are disrupted in the face of transitory events, with chronic illness as the classic example. Daily routines and lifestyle choices both reflect and contribute to an individual's sense of self (84). To maintain a stable sense of self, continuity in one's lifestyle is essential (85). This is particularly important in later life, where continuity represents a societal marker of successful ageing (85). In the face of life transitions, people therefore attempt to maintain their lifestyle. Disruptions to an individual's identity reflect the disturbance of routines and lifestyle within their day to day life, as the individual is unable to maintain these due to significant changes in their circumstances (84). In the face of life transition, a person's lifestyle is therefore often altered (86). Bury's theory of biographical disruption was applied to examine how late-life transitions act as factors leading to change in older people's drinking practices.

Biographical disruption as applied within this analysis focusses on the disruption to routine practices associated with transitory events in the individual's life, in contrast to classic applications where the theory aids understanding of the effect of this lifestyle change upon the individual's self-identity (84, 86). Drinking practices represent a day-to-day routine and lifestyle choice, as highlighted within the qualitative synthesis presented within this thesis. Transitions commonly experienced when growing older, such as retirement, children leaving home, bereavement and illness, may disrupt a person's daily life – altering the individual's social roles, daily routines and social network (87). The thematic synthesis (presented in [Section 4.3.1](#)) suggested such transitions affected older people's drinking routines. Stability

in one's self-identity is viewed within this analysis as a motivator of maintained drinking routines. Biographical disruption was applied as a lens to examine the effect of late-life transitions upon alcohol use within Nicholson and colleagues' (88) analysis (a qualitative exploration of older adults' view of late-life alcohol use published following completion of the review presented within this thesis), where transitory events in later life led to both increases and decreases in individual's alcohol intake, linking to changes in their social networks and also in their daily routines (88). In applying the construct of biographical disruption to examine the effect of late-life transitions on older people's drinking practices, the analysis was sensitised to factors that may distinguish late-life drinking practices from drinking practices earlier in life.

#### *2.4.2. Bourdieu's Theory of Practice*

Bourdieu's Theory of Practice and developments of this theory by other academics were applied within the analysis of fieldwork findings to aid interpretation of the social factors that motivated older people's alcohol use. The theory suggests that societally-embedded, inexplicit, but universally accepted social standards defining what behaviour is appropriate and desirable serve both to motivate and constrain the decisions underpinning our behaviour, such as alcohol use (89). The social world is composed of social spaces, discussed by Bourdieu in terms of 'fields' (90). Examples include fields of work, leisure and sport, and appropriate drinking practices differ between each of these.

Social fields are structured by the relative positions of those interacting within them. Here, people act in accordance with these standards, or 'social rules', competing to position themselves relative to others through the signals of value conveyed in their actions and choices (90). The way a person uses alcohol affects their social position differently within different social spaces, as the social rules governing behaviour are specific to the given social field. For example, alcohol use is not seen to be appropriate in the fields of work or particular facets of family life, as was demonstrated within the systematic review findings ([Section 4.3.1](#)). Here, drinking would be damaging to their social position through interfering with the individual's ability to satisfy their responsibilities within the social space (91). However, the way an individual uses alcohol within fields of leisure signals particular values, contributing to their social position (91). For example, in Brierley-Jones and colleagues' qualitative exploration of middle class adults' alcohol use, regular home drinking conveyed respectability and sophistication, which were valued attributes (91).

The relevant rules governing behaviour within a given field differ based upon the individual's resources and status that enable them to act in a particular way (capital) (92). These resources come in a number of forms: social capital (networks, affiliations, family and cultural heritage); cultural capital (tastes, cultural preferences, and knowledge of what actions are valuable within a given field); economic capital (financial and material assets); and symbolic capital (anything else of value within a social space) (90). Different forms of capital are valuable in establishing one's social position through particular actions within a given social space. For example, drinking was socially accepted as a valued social activity in Lunnay and colleagues' qualitative exploration of social and cultural practices shaping young women's drinking, which the authors noted represented a source of symbolic capital so that alcohol use offered social gains (93). In Scott and colleagues' qualitative exploration of socio-ecological influences on young people's drinking practices, social connections, a form of social capital, were required in enabling young people to attend parties, where alcohol was consumed (94). People occupying the highest social positions, supported by the greatest capital (particularly cultural capital, as the most valuable resource in social exchanges) are dominant. They define the actions that convey distinction and elevated social position, and the capital required to perform these actions (95).

The social rules that are relevant to the individual in influencing their behavioural choices, and the forms of capital that support their actions, are also determined by their social identity. Social positioning within a given field is structured by elements of social identity, such as social class, gender and ethnicity – representing different social axes of power (96, 97). People's behaviour therefore differs based on their social identity, reflecting differing social expectations relative to their social position (96). People act true to their social position, as defined by their actions and capital to support these actions. Behaviour out of line with one's position does not carry legitimacy and would not positively implicate their social position (98).

Social rules are internalised through our interactions within the social space and relevant norms and expectations for behaviour, to form an understanding of how to act (*habitus*), and reproduce the rules (89, 99). Because our behavioural choices are situated within and disposed by wider social structures (100), we perceive our behaviour to be logical, without being consciously reasoned (101). In the context of lifestyle choices, such as our drinking practices, we reproduce these social rules and expectations in the form of our 'tastes',

where we act to distinguish ourselves relative to others in our social spaces, through our seemingly voluntary choices and preferences, to convey particular values (102). Within Brierley-Jones and colleagues' analysis, drinking wine represented a signal of 'good' taste and distinguished drinking practices (91). In Scott and colleagues' analysis, drunkenness assigned negative attributes such as shame and losing out, leading many younger drinkers to approach their drinking with restraint. Young men were also motivated to consume particular drinks due to their connotations of masculinity, which represented another valued attribute (94).

Social constructs from Bourdieu's Theory of Practice can help understand the intricacies of social factors affecting alcohol use (103). Bourdieu's Theory of Practice was utilised within this analysis to help understand the social mechanisms underpinning these patterns of practice.

#### *2.4.3. Othering*

'Othering' represents a psychological and social process, employed by an individual to dissociate themselves from negative qualities, such as the sense of 'immorality' attached to alcohol misuse. Our self-perception is constructed through self-attributed qualities. The concept of othering describes how the qualities that compose the self are defined through contrast with opposing qualities of other people or groups (104). Thus, a positive self-identity can be constructed through opposition to the negative qualities of stigmatised others. This construct is complimentary to Bourdieu's Theory of Practice in distinguishing the individual from 'lesser others', through affording themselves valued attributes and thus establishing their own social position relative to others.

How we use alcohol in comparison to others therefore signals particular qualities. Negative attributes such as social inappropriateness and irresponsibility are associated with those who misuse alcohol, due to the effects of intoxication in disinhibiting behaviour and health risks attached to drinking. Positioning oneself as a socially appropriate and healthy drinker associates the individual with positive attributes, such as responsibility, restraint and associated morality (104, 105). This position, and associated positive attributes and self-identity, are achieved through the relative positioning of one's own alcohol use to a contrasting 'other', stigmatised through the negative implications of their behaviour.

Scientifically, we know that risks are attached to alcohol use at any level (1). However, through othering, those identifying as 'healthy drinkers' oppose themselves to the promiscuously indulgent 'other', distancing themselves from associated risk and deviance (104). The risks attached to drinking are confined to the 'other', conceived to embody the negative attributes associated with risky behaviour who are viewed to be qualitatively different from the constructed self (104, 106, 107).

The process of othering was evident within the findings of the systematic review, and similarly in many studies of alcohol use (105, 108-110), where the immorality of alcohol-related risks and harms was viewed as belonging to other heavier, more problematic drinkers, such as younger binge drinkers and 'alcoholics'. During analysis of fieldwork data, it became evident that 'othering' was employed by participants, serving to eliminate the threat of health risks attached to their drinking as a factor influencing how they used alcohol.

#### *2.4.4. Rituals*

'Rituals' are defined as actions that are repeated because they carry symbolic meaning (111) – that is, a quality is attached to the conduct of the activity (112). There are a number of symbolic meanings evidenced for different uses of alcohol, and these are introduced below.

The symbolic properties of alcohol in providing disinhibition and relaxation mean alcohol is used ritualistically as a marker to shift mood and roles within the day, playing a key function in the temporal organisation of day-to-day life (113). In carrying these attributes, alcohol creates a frame that defines leisure time, distinguishing it from periods of other activities. Drinking symbolically marks the release of the actor from their societal roles and behaviour confined to social regulations. Drinking places behaviour in a different frame, where actions carry different meanings. For example, disinhibition associated with drinking mitigates immorality attached to behaviour that might usually be considered inappropriate.

The role of alcohol in social positioning represents another example of the symbolism attached to alcohol use, introduced above in relation to Bourdieu's theory of practice. In providing little nutritional value, alcohol takes consumption behaviour beyond necessity to symbolism, serving to convey resource, and in doing so positioning the individual socially relative to others (113).



Drinking also represents an interpersonal ritual, forging a sense of stability and identity in relationships (114). Drinking symbolises celebration and solidarity in social settings, which are key to providing support in the face of life events, signalling commitment to the individual and the relationship (105, 115). Reciprocated engagement in social drinking rituals symbolises equality and solidarity within relationships, conveying investment in that relationship (116). Shared drinking rituals represent common values in social interactions, conveying a commonality that binds those partaking in the ritual (117). Rituals are therefore central to stability in relationships (112)

The ritualization of older people's drinking was evident in the systematic review, where alcohol played a meaningful role in older adults' interactions with friends and family members. Drinking was engrained within many social occasions as a consequence. Drinking was also used to distinguish leisure time, providing structure to the day where it may have been lost in retirement. Rituals attached to alcohol in symbolising investment in relationships, leisure time, mood setting and social positioning are examined as a motivator for drinking in the analysis of fieldwork data.

## **2.5. Situating This Research Within Theories of Ageing**

As a study examining alcohol use in the context of old age and ageing, theories of ageing can enhance understanding of this body of work. Life course theory and theories of the third age particularly related to the findings reported within this thesis, and are introduced below. These theories did not inform analysis of either the review or fieldwork data; but are returned to in contextualising the findings of my study in [Chapter 7](#).

### ***2.5.1. Life course theory***

Life course theory helps understand health-related behaviour in terms of how it is shaped by historical social contexts, individual life dynamics, and intersections between these (118). A number of principles are encompassed within this perspective that can aid understanding of late life drinking practices. As with Bourdieu's Theory of Practice, [discussed earlier](#), this perspective emphasises the influence of social contexts upon behaviour, creating barriers to, norms for and meaning attached to behaviour (119). Life course theory highlights the temporal nature of these influences upon behaviour, drawing attention to changing social contexts over time, and how the social context at any given time affects people's behaviour differently depending on their life stage (120). A life course perspective facilitates a

longitudinal view of health-related behaviour. The choices people make earlier in life, within constraints associated with their social environment, define the social contexts and associated external influences upon the individual's behaviour later in life. As such, health-related behaviour can be considered in terms of life course trajectories; as patterns of behaviour result from this sequence of settings, events and experiences across a person's life (121). Stability and change in health-related behaviour can be understood in the context of a life course continuum (118).

Life course patterns for health-related behaviour are particularly evident in longitudinal studies of food choices and smoking; characterised by continuity in these behaviours. Such behaviour later in life is strongly predicted by earlier choices; and characteristics of individuals' childhood social context are highly predictive of their choices in adulthood (120). Alcohol use trajectories, in contrast, tend to be unstable. This is thought to be explained by the strong influence of life transitions upon drinking practices (121). Life transitions are major changes in an individual's social roles or life stage. Each life stage is associated with particular norms and expectations for appropriate behaviour, or 'age norms' (122), specific to the individual's social identity (as discussed in [Section 2.4.2](#)) and to their social context at that point in time (123) that shape behaviour. Different social roles are associated with particular obligations, which may be incompatible with alcohol use (as discussed in [Section 2.4.2](#)) (122). Life transitions that cause a change in a person's behaviour are 'turning points' in the behavioural trajectory, as the individual's outlook and circumstances that shape their behaviour change significantly (124). Alcohol use rises and falls in conjunction with constraints, pressures and opportunities associated with different life stages and roles (121). Across the life course, tidal changes in responsibilities, norms and opportunities, such as those experienced when leaving formal education, when married, and through retirement, are attached to changes in how people use alcohol (121, 125, 126). Examples of transitions that may affect alcohol use trajectories in later life were introduced in [Section 2.4.1](#).

Life course theory aids understanding of patterns of behaviour amongst birth cohorts. Through shared experience of the same social context at the same point in their life course, trends, or 'cohort effects', are evident in their behavioural trajectories (127). Trends for excessive drinking in the recent baby boomer cohort are a strong example of this (33, 34) (introduced in [Section 1.2.1](#)). Alcohol use is thought to be integral to the social activities this group engage in; patterns for which were developed in a context where alcohol advertising

was becoming increasingly widespread, and drinking was viewed as an 'accoutrement of post-war prosperity' (p. 604, (128)). Resultant trends for risky alcohol use have carried into later life with this generation (34); a pattern likely also influenced by the common belief amongst this group in recent years that alcohol use is associated with health benefits (129).

### *2.5.2. Theories of the third and fourth age*

Theories of the third and fourth age distinguish older populations by those who are younger and healthy, versus older and ill (87). Rather than being defined by chronological points in a person's life, the third and fourth age reflect life stages characterised by new freedoms in later life, and then loss of these freedoms (87). The third age is 'an era of personal fulfilment' (130); the period where the individual is released from responsibilities through retirement and children leaving home, creating opportunity and freedom (131). The fourth age represents the stage where decline and decrepitude associated with later stages of ageing necessarily conclude the potential and possibility that typify the third age. Within this stage, older adults once again lose freedom, through inability to freely engage in activity due to declines in physical and/or mental ability (130). Late life alcohol use has not previously been considered in terms of theories of the third and fourth age. However, each of these life stages is attached to particular expectations and experiences that may affect older adults' perspectives and practices regarding alcohol. Older adults in the third age typically have increased leisure time (132); where alcohol is commonly used (91). Through recognising the potential for imminent decline, older adults in the third age have been described to focus upon monitoring and maintaining their body and health (87). As such, they may be motivated by health considerations in decisions about alcohol use. In contrast, reduced ability to engage in leisure activities in the fourth age likely has implications for older adults' alcohol use. Recognising the potential imminence of death may affect motivations to engaging in protective behaviours, such as limited alcohol use. Older adults in the fourth age have been described to be focussed upon adapting to health difficulties (87); rather than upon preventing decline. Increased health care utilisation amongst older adults in the fourth age, due to increasing health needs (130), may also effect interactions with care providers; and therefore their potential influence upon older adults' perspectives of alcohol. As such, theories of the third and fourth age are useful in understanding distinctions in perspectives regarding alcohol use across my study population.

## 2.6. Reflexive Account of the Researcher

It is acknowledged that my own positionality influences the research process and outcome (133). In providing a reflexive account below, I explore my position and reflect upon how it may have influenced the generated data, findings and interpretations.

### 2.6.1. *My relationship with and understanding of alcohol use*

Alcohol use is normalised within my culture, and I therefore began this study with pre-existing assumptions about the topic. Throughout this work, I was part of the British drinking culture, and personally in touch with the potential positive roles of alcohol in social life. This understanding of alcohol use contributed to the balanced perspective upon which the research questions guiding this work were based. It led me to take a critical view of the health focus of studies included within the review, and commit to exploring the positive roles of alcohol further within the fieldwork study.

Personally, I possess an affinity to explicit rules, and find the clarity provided by guidelines appealing. Throughout my adult life, I have sought to act in accordance with guidance for a healthy lifestyle. Across this work, I had a tendency to use alcohol use guidelines as a benchmark. During the earlier phases of this work, I employed these guidelines as a 'black and white', around which I could gauge risk. This conflicts with their intended use as just one consideration in the context of relevant risks and benefits of drinking that may contribute to individual decisions for alcohol use. This tendency was recognised and explored during discussion within supervisory meetings. I challenged myself to think critically about the meaning and use of these guidelines as I progressed this work. However, this attitude shaped my approach to the project and engagement with participants. Particularly, alcohol-use guidelines were a theme I incorporated within my initial topic guides for fieldwork, and returned to in my line of questioning; as is evident within excerpts provided to support finding for the fieldwork study ([Chapter 6](#)). Discussing alcohol use in terms of guidelines generated rich data, prompting discussion of their meaning to older adults, and their use and challenges associated with their application with primary care providers. This process meant that I was engaging with discourses that challenged my own perspective, broadening my understanding. However, this tendency to think in terms of alcohol use guidelines influenced the data that I generated, and how I considered and interpreted findings. Although I have consciously worked to take a critical perspective on alcohol use guidelines and their meaning, my use of guidelines as a frame of reference is retained within the

narrative presented within this thesis. When I started this work, my understanding of alcohol-related harm was mostly linked to experiences of my own, family members' and customers' (from work in hospitality) intoxication. However, my studies in health psychology and natural risk aversion meant that considerations underpinning my behaviour were grounded in potential health risks. My view of alcohol use became more critical during the first year of this PhD. I became versed in guidelines and risk messages through engaging with relevant literature, and my own alcohol use was temporarily curtailed due to illness. During planning and initial data collection and analysis for this study, I was consciously wary of the risks attached to drinking alcohol, both on a personal basis and for my study population. It was evident within my early writing that I had begun to problematize alcohol use. My thematic synthesis of existing literature (presented in [Chapter 4](#)) re-emphasised in my mind the positive roles of alcohol within my study population. However, when I started interviewing, I expected that participants would explain their drinking or alcohol-related clinical practices by discussing potential risks and benefits of drinking in later life and what they prioritised. My understanding was challenged during early data collection, as I was surprised to find that potential health risks were not always cited as reasons for using or recommending a particular level of alcohol use. Initially this made me feel frustrated, as I was concerned that I was not inciting relevant responses from participants. I also began to feel uncomfortable, worried that older adults and their care providers were not aware of the risks of drinking as an older adult. I considered supplying materials to promote awareness of these risks.

As data collection progressed, I came to understand that risk of harm through drinking is often not a priority in determining a person's behaviour. Present health status and social factors were often viewed to be more important. I became aware that my own background in health psychology meant that my initial understanding of risk behaviour was based upon individual considerations. Engaging with relevant social theory helped me to explore the alternative explanations for participants' alcohol use and related clinical practice. The weight of external factors beyond conscious decision-making in shaping practices also became clear. I was able to examine the influence of these factors further within interviews and focus groups and analysis of data.

### *2.6.2. A young adult researching later life*

I conducted this study when I was in my mid-twenties. Age differences between myself and my study population made me an outsider in the conduct of this work. This gave me a critical perspective on drinking as an older person, and I approached data collection with great curiosity. Engaging in data collection as an outsider could have represented a barrier to establishing rapport with participants (133). In practice, my older participants and I drew on our roles in grandparent-grandchild relations to build rapport. Most relationships with my participants were positive, and I found that I transferred the respect and affection I have for my grandparents, towards them. Perhaps because of this, power issues sometimes manifested during data collection, where at times I struggled to retain command of the direction of discussion. The tendency for participants to speak to their own agenda, however, is a common occurrence in qualitative data collection (134). This is particularly the case amongst individuals who do not often have the opportunity to be heard, such as participants within this study who were socially isolated. Rich and relevant data were nonetheless generated, and in speaking to their own agenda, participants were able to contribute insights of importance that may not have been incited by the topic guide or my own probing.

Participants often drew on my youth in our interactions. Many explicitly associated my age with pre-conceptions about younger 'binge' drinkers, assuming that I, or my acquaintances, engage with potentially risky behaviours. This appeared to aid participants' disclosure of their own potentially risky drinking practices, and was sometimes employed in positioning their own drinking (discussed as 'othering' in findings presented in [Chapter 6](#)).

### *2.6.3. My social status*

My socio-economically advantaged position and high level of education are conveyed in the way I present myself: in how I dress, speak, and interact. This had implications for my exchanges with participants. It became clear that participants with a more deprived socio-economic position responded in terms of my values (socio-economic advantage is often associated with a concern for health and a tendency to behave 'healthily' (135)) and at times reflected these in the way they presented their own alcohol-related views and behaviour. I attempted to tone down my image through the way I presented myself, in accent and appearance, when meeting these individuals in an effort to prevent this. I drew on my status

to build rapport on the basis of commonality with care providers and socio-economically advantaged participants.

#### *2.6.4. Interviewing members of my professional networks*

Because I had professional relationships with some of the care providers, I felt pressure to present myself as knowledgeable and adept as a researcher during data collection for the fieldwork study. I often felt compelled to contribute my own understanding to discussions in conveying this image. I was concerned that this approach might constrain participants' contributions to align with my own views. Issues arose in terms of my own professional image during data collection with younger care providers. Some members of this group knew me in a social capacity. The resultant casual relationship between myself and these participants meant I found it difficult to direct discussion. However, I was struck by how forthright this group were with their views relative to other participants. They offered value-laden personal opinions, experiences and preconceptions that underpinned their approach to alcohol-related practice. This seemed to be facilitated by our casual relationship, and provided a rich insight into the perspectives of care providers.

#### *2.6.5. Generating data as a developing researcher*

This work was my second qualitative project, and I was working to develop my skills as a qualitative interviewer throughout fieldwork data collection. The nature of my interactions and resultant data evolved across the course of the study, as I worked in and reflected upon different approaches to interviewing and facilitating, and as my understanding of the topic progressed. Disconnect between my initial understanding of the topic with older adults' perspectives, as discussed above, meant my early approach at times was antagonistic. Although this led to uncomfortable interactions, data collected were rich, as I explored participants' views through discussion so that I could better understand them. However, I was concerned about the ethical implications of this discomfort in discussion, and worked to mirror participants' views in my understanding as data collection progressed. This served to retain rapport and encourage elaboration.

These approaches had implications for the course of discussion and therefore for collected data. Particularly, through challenging interactions with participants during the process of early data collection, I became aware that participants were keen to distance themselves from problematic drinking labels, through employing labels associated with acceptable

alcohol use (explained in findings presented in [Chapter 6](#)). In an attempt to maintain rapport, I accepted and sometimes reinforced these labels during discussion; rather than challenging them as I had done initially. However, I ensured that I considered participants' use of and reasons for employing these labels within my analysis.

## 2.7. Chapter Summary

The philosophical orientation, contextual background and applied social theories were detailed within this chapter. This work was conducted from a critical realistic orientation. Underpinning mechanisms explaining older people's drinking practices, and care providers' perspectives of and approach to late-life alcohol use, were understood through this work. This orientation determined methodological decisions. The findings of this thesis are grounded within contextual intricacies of this work. Within this thesis, perspectives of late-life alcohol use are examined across studies from higher income countries, and in-depth within the North of England. Social theories were drawn upon as an interpretive tool to develop understanding of fieldwork data. Biographical disruption theory (84) highlighted the effects of typical late-life transitions as factors influencing older adults' drinking practices. Bourdieu's theory of practice (136) aided understanding of the socially-situated nature of these drinking practices, pre-conscious processes involved in decision making and importance of roles of these drinking practices in formulating and projecting identity. 'Othering' highlighted social mechanisms involved in positioning individual risk and self-image. Rituals aided understanding of the importance of some roles of alcohol in socialisation and leisure time. My positionality as a researcher has a number of implications for the work presented within this thesis. My initial and developed perspective of alcohol use influenced the questions I asked of participants and of data, and how findings are discussed. Age differences between myself and participants determined my pre-existing understanding of the topic. These age differences, and my social status, affected interactions with participants, and therefore data upon which fieldwork findings are based. My approach to data generation as a developing researcher also influenced the body of data produced. These issues were explored within the reflexive account provided within this chapter.



## Chapter 3. Review and Thematic Synthesis of Qualitative Studies: Methodology and Methods

### 3.1. Overview

The following chapter presents the methods of the systematic review and syntheses of older adults' and care providers' views and experiences of drinking in later life. The aims and objectives are first stated. The stance taken within this review is then outlined, with a discussion of methodological critiques, strengths and limitations of conducting a systematic review of qualitative literature. The methods of identifying relevant articles, of data extraction and quality appraisal, and of data analysis are then described.

### 3.2. Aims and Objectives

The aim was to conduct a systematic review and synthesise available qualitative literature exploring a) older adults' and b) care providers' views and experiences of drinking in later life, and factors that may shape these. The specific objectives were:

1. To identify and appraise available qualitative research articles on older people's and/or care providers' views and experiences of drinking in later life using a systematic search strategy.
2. To conduct a thematic synthesis of data presented in relevant articles to explain:
  - i. Older people's reasons for drinking alcohol
  - ii. Factors that may shape older people's drinking practices
  - iii. Care provider's views of older people's drinking
  - iv. Factors that may shape care provider's views of and approach to older people's drinking

### 3.3. Methodology

#### 3.3.1. *Rationale for performing a systematic review*

Systematic reviews seek to convey the current understanding of a given topic based on all available relevant evidence (137). Through specified and systematic methods, relevant studies are identified, evaluated and summarised (137). Systematic reviews are popularly applied in health research, and can enable practitioners to keep up-to-date by providing a transparent evaluation of the body of evidence (137). Systematic reviews can indicate conclusions of a body of work, and also highlight areas where knowledge may be lacking to direct future research (137).

Systematic reviews are classically applied to evaluate evidence for effectiveness of particular interventions within relevant quantitative studies (137). However, qualitative insights are increasingly drawn upon in health care, enhancing how we understand issues in clinical practice and guiding future approaches. (138). The systematic approach and transparency underpinning systematic reviewing can be drawn upon to review qualitative literature. Methods inspired by those employed in traditional systematic reviews guide data identification, extraction, appraisal and synthesis, ensuring a rigorous and extensive evaluation of the available body of work (139). These methods can support the development of explanations of a given phenomenon through exploring the collective meaning of the body of research on a topic (138, 140).

The appropriateness of reviewing qualitative evidence is debated by academics. Findings of qualitative work are bound contextually to the place, time and interactions within which data were collected (141). Drawing generalisations across a body of evidence through the review process can risk overseeing the contextual intricacies of data (138). However, there is much to be gained through incorporating views across a broad range of contexts (142). These contextual intricacies can be utilised by examining diversities within the body of literature to enhance understanding of the topic (143).

Here, the literature available on older adults' and care providers' views and experiences of older people's drinking is drawn upon to examine relevant perspectives surrounding the reasons for older people's drinking and care providers' approach to alcohol-related practice with older care recipients. Contextual factors shaping these views are examined in the process of qualitative evidence synthesis.

### ***3.3.2. Rationale for the approach taken to analysing data presented within included studies***

Qualitative research encompasses many approaches, developed from a variety of theoretical perspectives. Methods for synthesis each carry strengths and limitations in combining a given body of literature, and each research question will be individually suited to particular approaches (141).

Methods of qualitative synthesis can be categorised into aggregative and interpretative approaches (144). Aggregative approaches summarise data, theories of causality are identified, and findings report claims of generalisability (145). This approach can include

applications of thematic analysis (originally developed for use with primary qualitative data (146)), where included studies are summarised and refined into key themes. However, methods provide little structure for developing these themes and understandings beyond those conveyed within the body of literature (145). Conversely, interpretative approaches facilitate the development of conceptual understanding and theory that explain and integrate concepts identified within studies (144). Interpretative approaches require rich review data (where complexities within the phenomena are evident in reporting), and are therefore not possible to apply to every body of literature (145). The methods of meta-ethnography and thematic synthesis are forms of interpretative synthesis (145, 147). Meta-ethnography maps key themes and concepts across studies, identifying and resolving contradictions in data to further interpretation (145). Thematic syntheses draw from different methodological approaches, typically developing descriptive themes identified in early analysis of the review studies into analytical themes through further interpretation (145, 147).

Here, a thematic synthesis was conducted to rework and refashion the different ways in which themes were described within included studies, creating higher-order (interpretative) thematic categories. This approach drew on the transparent and rigorous processes for summary described in Braun and Clarke's thematic analysis (146) and interpretative constructs and underpinning attention to context from meta-ethnography (144). The product was explanatory themes, providing a summary of understandings from included studies whilst examining their content in view of each study's contextual intricacies. The role of different contextual factors in shaping older people's drinking practices and care providers associated practices were examined, taking the analysis beyond a simple summary of existing evidence.

### ***3.3.3. Rationale for the approach to identification of relevant studies***

Applying systematic search strategies to qualitative literature can be problematic. Article titles and abstracts, upon which many search strategies are dependent, are unreliable in their inclusion of keywords relevant to identifying qualitative studies (148). Databases upon which developed search strategies are applied are also inconsistent in their indexing of qualitative studies (139). Search filters specific to qualitative articles have been developed by organisations such as the CRD and the Hedges project to combat this issue, where a combination of terms maximises identification of qualitative texts (149, 150). The search

strategy applied within this review draws upon these filters. Further terms were identified for inclusion through examining relevant studies' title and abstracts for concepts indicating qualitative analysis to enhance the sensitivity of the search. Key words and database-specific indexing terms were combined within the search strategy to maximise sensitivity to relevant articles (151). Potentially relevant articles identified within the search were examined up to the point of full text if there was any question as to whether qualitative methods had been applied in analysis.

The topic late-life alcohol use is relevant to a number of academic disciplines, including health research, anthropology and sociology. Each of these disciplines have corresponding databases, collating potentially relevant articles. Appropriate databases were selected for searching from these disciplines to ensure this review drew from all relevant fields.

Journals relevant to the review topic were identified and searched by hand, in order to find additional articles that may not have been identified through search terms. As publication biases mean qualitative studies are sometimes not published (152), grey literature sources were searched for further relevant articles.

#### ***3.3.4. Rationale for the approach taken for the quality appraisal of included studies***

Quality assessment is a fundamental component of systematic review methodology. The methodological rigour of the body of evidence and risk of biases are assessed, establishing the reliability of the review's conclusions (137). The value of appraising quality of qualitative articles is a topic of controversy. Some suggest that assessing qualitative research against specific criteria disregards the flexibility required to produce an interpretative analysis in qualitative studies (153). Guidelines affirm that some structured quality appraisal should be involved in the process of systematic review of qualitative studies (137). Quality appraisal can direct attention to the intricacies of the article, promoting reflection on the appropriateness of the approach taken and any issues with reporting transparency (152). Specific tools developed for use with qualitative research are flexible, allowing for different approaches to data collection and analysis. These tools assess quality through reflection on a number of domains that are important in rigorous and insightful qualitative research. These include the appropriateness of the research design, data collection and analysis for the aims of the study, thick descriptions of findings (detailing relevant context and exploring meaning

within data, and interpreting reasoning underpinning the findings (154)), details of the research context, reflexivity and the application of theoretical frameworks to enhance interpretation (155).

Controversy also exists regarding the product of quality appraisal. Some tools guide numerical scoring based upon quality appraisal of each article. This approach is criticised for giving weight to issues in reporting or data collection in judgements of quality, potentially negating the strength of insights presented through the analysis within the review reporting (153, 156). There is also debate as to whether the outcome of quality appraisal should determine inclusion, or exclusion, within the review. The quality of a review is partly dependent on the quality of included studies. However, exclusion based on appraisal risks discounting papers for surface issues, such as omissions in reporting often linked to journal restrictions (152), rather than fatal problems with the conduct of the study (145).

Critical appraisal was applied here, guiding evaluation of the appropriateness of approach and meaning of interpretations reported in included studies. The product is a narrative summary of findings from the appraisal process. Quality evaluations were considered during data analysis, preventing undue influence of potentially unreliable findings on the synthesis and conclusions of the review (157). Articles deemed to be of poorer quality often present thinner descriptions of the phenomena (157). Poorer quality studies may therefore contribute little to the synthesis, but offer relevant descriptive data (158), and were not excluded from analysis.

Saini and Shlonsky's Qualitative Research Quality Checklist (152) was applied to guide quality appraisal, providing an overview of key qualities and issues within articles. The tool evaluates rigour and appropriateness of the methods and the level of detail and interpretation in the results presented within studies for inclusion (specific questions and guidance are provided in [Appendix B](#)). Narrative summaries of quality appraisal were produced based on comments made in response to each of the checklist items. This tool combines criteria from popular critical appraisal tools (141, 159), and offers detailed guidance for assessing study quality. Unlike many major quality appraisal tools, the checklist has been verified for application across qualitative studies (152).

### *3.3.5. Registration of review protocol*

The protocol for this review study was registered at inception on PROSPERO (international prospective register of systematic reviews). Protocol registration is intended to prevent duplicated work, and reduce bias in reporting by enabling readers to compare the completed review with the planned approach (160). The registered protocol reports the developed research questions, inclusion criteria, search strategy and methods of analysis (161) (provided in [Appendix C](#)).

## **3.4. Method**

### *3.4.1. Review question and inclusion criteria*

To define the material of interest, review questions were developed applying the PICO mnemonic, as recommended for application in reviews of qualitative literature (162, 163). The mnemonic states that inclusion and exclusion criteria should define the population, phenomena of interest and context of study. In addition, I have stated the types of study for inclusion, ensuring the synthesis incorporates only appropriate sources of data (i.e. qualitative research).

#### *Population*

Studies with participants who are older adults (aged 50+) and/or health or social care providers working with older people were included. The views of these groups must be distinguishable from other populations within reporting.

#### *Phenomena of interest*

Studies reporting views and experiences of alcohol consumption in later life (50+) were included. Studies were excluded if views and experiences of alcohol use in later life could not be distinguished from those of alcohol use at any age. Studies that focused on perceptions and experiences of alcohol dependence or those who had received treatment for problematic drinking were excluded (in view of the focus of this research, justified within [Section 1.3.1](#)). Studies were also excluded if views and experiences of alcohol use could not be distinguished from those of other or general forms of substance use.

#### *Context*

Studies with a focus on the views and experiences of alcohol consumption in later life within higher income countries were included. Studies that focus on the views and experiences within middle or lower income countries were excluded.

### *Types of studies*

This review considered studies that focus on qualitative data including, but not limited to, designs such as grounded theory, phenomenology and ethnography. Studies with exclusively quantitative methods of data analysis were excluded (including survey studies). Reviews were also excluded. Studies were not excluded on the basis of language to ensure all evidence from relevant countries was incorporated into the synthesis.

### *3.4.2. Scoping, searching and selecting the literature*

#### *Scoping*

To determine whether this systematic review was feasible given the available literature base, a period of scoping was performed. Keywords relating to the topic of interest were entered into relevant databases to identify appropriate material. To ensure the review drew from all relevant areas within the available body of literature (139), the research question, objectives, inclusion and exclusion criteria were defined to reflect the results of the scoping exercise. Through scoping, it was established that an adequate body of relevant articles existed with which to conduct the review and meaningful synthesis.

#### *Search Outline*

The search strategy for this systematic review principally relied on the use of electronic databases. Further relevant studies were identified through exhaustively searching references and citations of studies identified for inclusion and through searching key terms using Google Scholar and grey literature sources (National Institute for Clinical Excellence evidence search, Open Grey and Dissertation Abstracts International). Journals relevant to this topic area were also identified and hand searched. Full texts of papers identified as potentially relevant through title and abstract were accessed through Newcastle University Library or direct contact with authors.

#### *Electronic Database Searches*

Information scientists at Newcastle University Institute of Health and Society were consulted in selecting relevant electronic databases for searching. The selection ensured that searches would maximally include relevant journals from health and social sciences. The searched databases are listed and described in Table 3-1.

Table 3-1 A list of the electronic databases utilised within this qualitative systematic review, with a description of their content.

<b>Database</b>	<b>Description of Contents</b>
Medline	Medicine, nursing, pharmacy, dentistry, veterinary medicine and health care from 1946 to present.
PsychInfo	Psychology and related fields from 1806 to present
Scopus (health sciences; social sciences and humanities)	Health sciences, social sciences and humanities from 1960 to present
Cumulative Index to Nursing and Allied Health Literature (CINAHL)	Nursing and allied health from 1984 to present
Applied Social Sciences Index and Abstracts (ASSIA)	Health, social services, psychology, economics, politics, race, relations and education from 1987 to present

A formal search strategy was developed combining keywords and database-specific headings (where applicable) corresponding to the concepts of ‘older adults’, ‘alcohol consumption’, ‘views and experiences’ and ‘qualitative methods’. The population of study was not specified in the applied search strategy to avoid compromising sensitivity through attempting to apply an exhaustive list of care providers. The search strategy was amended with the help of an information scientist at Newcastle University to ensure maximum sensitivity and specificity to relevant articles. During this process, the searches were tested for their recognition of studies that had been identified during the scoping phase as appropriate for inclusion (where registered on the database). Identified studies were also examined by title, abstract, keywords and database-specific headings to help identify further search terms that were relevant to this systematic review. The searches were undertaken during March 2016. The search terms applied in Medline are presented in Table 3-2. The full searches applied to each database are provided in [Appendix D](#).



Table 3-2 The search terms applied to the Medline electronic database by concept.

Concept:	Keywords applied to Title and Abstract:	MeSH Headings:
Older Adults	"older adult*" OR "older age*" OR "old age*" OR "old person*" OR "old people*" OR "older person*" OR "older people*" OR retire* OR retiring OR ageing OR aging OR elder OR elderly OR "nursing home*" OR geriatric OR geriatrics OR senior OR veteran* OR "older individual*" OR "later life" OR "older drinker*" OR "older client*"	RETIREMENT; ADULT; AGED; MIDDLE AGED; AGE FACTORS; AGING
Alcohol Consumption	(alcohol* adj3 (drink*)) OR abstinence OR abstainer OR abstainers OR "tee-total" OR "alcoholic*" OR alcohol OR sobriety	*DRINKING BEHAVIOR; ALCOHOLISM; ALCOHOL INTOXICATION; ALCOHOL-RELATED DISORDERS; *ALCOHOLIC BEVERAGES
Perceptions and Experiences	Perception* OR perceive OR perceived OR perceiving OR perspective OR perspectives OR experience OR experiences OR view OR views OR risk OR risks OR risky OR benefit OR benefits OR biograph* OR autobiograph* OR attitude* OR values OR "life story" OR	SOCIAL PERCEPTION; DECISION MAKING; JUDGMENT; HEALTH SURVEYS; SOCIAL STIGMA; STEREOTYPING; BEHAVIOR; SOCIAL BEHAVIOR; ATTITUDE; ATTITUDE OF HEALTH PERSONELL; ATTITUDE TO HEALTH

"life stories" OR behaviour  
 OR behavior OR identit\* OR  
 attitude\* OR belief\* OR "life  
 course" OR "course of life"  
 OR habit\* OR choice\* OR  
 meaning\* OR lifestyle\* OR  
 story OR stories OR  
 account\* OR "life histor\*\*"  
 OR reasons OR reasoning OR  
 expectation\*

Qualitative Methods

qualitative OR theme OR  
 "discourse analysis" OR  
 interview\* OR "constant  
 comparative" OR thematic  
 OR narration OR  
 "exploratory research" OR  
 "focus group\*" OR "content  
 analysis" OR transcript\* OR  
 "social construction\*" OR  
 "grounded theory" or  
 phenomenolog\*

INTERVIEW; FOCUS GROUP  
 \*QUALITATIVE RESEARCH;  
 \*BIOGRAPHY

Note: Keywords and MeSH headings were combined for each concept using the Boolean operator 'OR'. Search terms for the four concepts were combined using the Boolean operator 'AND'

### *Selecting the Literature*

Papers identified through searching were screened against inclusion and exclusion criteria by two independent reviewers. A research assistant with experience in qualitative work and the topic of alcohol use assisted me in this process. Articles were screened by title and abstract for initial exclusion. Non-English titles/abstracts were translated online to assess eligibility. Remaining papers were screened at full text to establish their appropriateness for inclusion within the review and synthesis. Articles written in other languages carried through to this stage of screening were translated by individuals bilingual in the language and English. Any

discrepancies in articles identified for inclusion were discussed and resolved between the two reviewers.

### ***3.4.3. Data analysis***

#### ***Data Extraction***

Data extraction forms and spreadsheets were developed to extract details of each included study. Descriptive and demographic information was extracted for each study, as well as study aims and methods for data collection and analysis. Findings presented in included studies were extracted as data for synthesis (full details for extraction are listed in [Appendix E](#)).

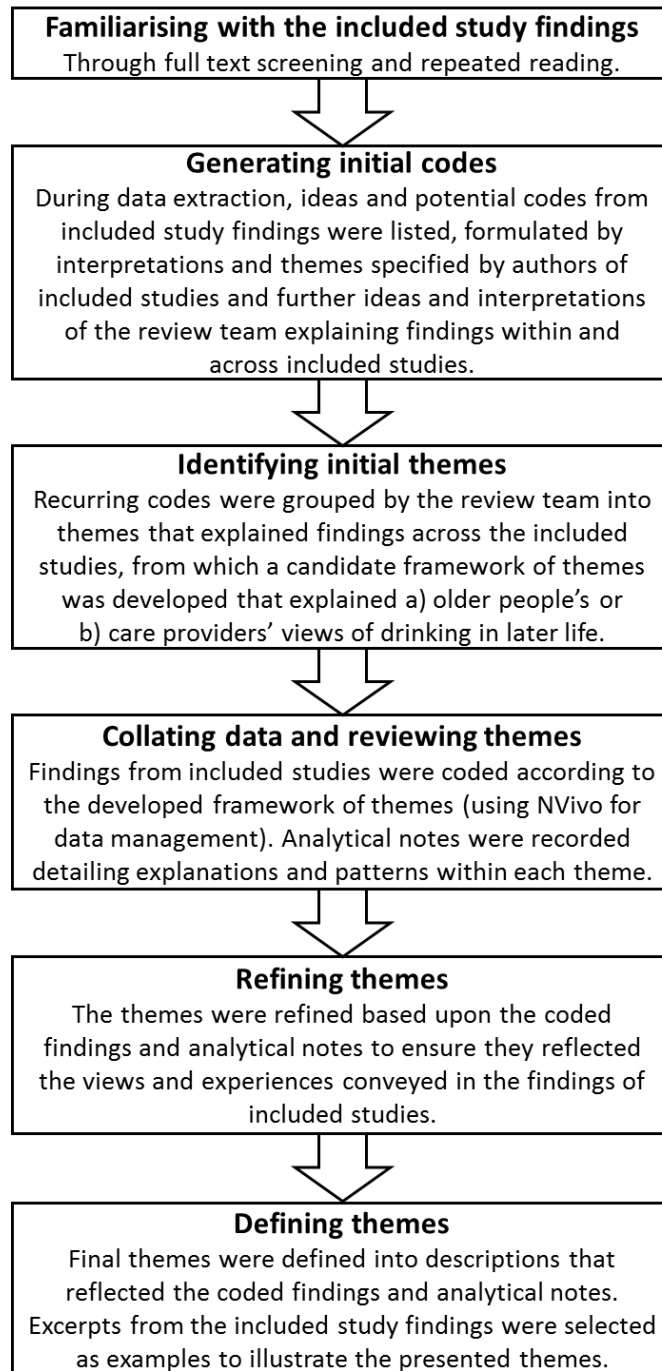
#### ***Quality appraisal***

Quality appraisal was completed by two independent reviewers, guided by Saini and Shlonsky's Qualitative Research Quality Checklist (152). Narrative summaries of quality appraisal were produced based on reviewers' responses to each of the checklist items.

#### ***Thematic Synthesis***

The stages of analysis employed, drawing on Braun and Clarke's Thematic Analysis (146) and Noblit and Hare's Meta-Ethnography (144), are portrayed in Figure 3-1 and described below.

Figure 3-1 Phases of thematic synthesis employed within this analysis



I familiarised myself with findings of each included study during full text screening and immersion through repeated reading. During this phase, I listed ideas and potential codes from primary study findings. The compiled codes were comparable to second- and third-order constructs described in meta-ethnography. Second-order constructs are interpretations and themes derived from primary data, specified by the authors of included studies. Third-order constructs are ideas and interpretations identified by the reviewer that further explain findings within and across the primary studies [46].

Recurring codes, explaining findings across the studies, were developed into a candidate framework of themes that explained the views of older people and care providers surrounding their drinking. During these earlier processes of analysis, it became clear that the bodies of literature corresponding to the two populations of study (older people and care providers) conveyed disparate content. It was decided that analyses would progress separately from this point, each with unique coding frameworks, to produce two separate syntheses and respective themes.

NVivo (version 11 (164)) was used for data management, which involved storing included study findings, and coding these according to the respective developed frameworks. Analytical notes were recorded during this process, detailing explanations and patterns within each theme. Emerging findings were examined for any particular patterns linking to older adult or care provider characteristics. Across the process of analysis, possible interpretations and developing themes were discussed with the review team (supervisors Barbara Hanratty and Eileen Kaner, and research assistant Liam Spencer).

The developed thematic frameworks were then further refined to ensure each reflected the views and experiences conveyed across the included studies for that population, and defined to form the theme descriptions. Excerpts from the included studies were identified to support and exemplify the presented review findings. Understanding of the constructs discussed in review findings were developed drawing on theoretical literature. Particularly, Gusfield's sociological work on drinking rituals (113) informed interpretations of data conveying the ritualised drinking authors described of older adults (theoretical perspective was introduced in [Section 2.4.4](#)).

### **3.5. Chapter Summary**

This chapter detailed the methodology and methods for the systematic review and thematic syntheses of qualitative studies. This work aimed to explore existing evidence of older adults' and care providers' views and experiences of drinking in later life, and factors that may shape these. The aim determined the specific objectives that guided methodological decisions and analysis. The review and syntheses examined relevant perspectives within available studies, and the influence of contextual factors upon these perspectives. Data analysis was conducted through thematic synthesis, drawing upon methods of thematic analysis and meta-ethnography to produce an interpretative understanding. The material of

interest was defined using the PICO mnemonic, which guided the approach to searching. A systematic search strategy ensured identification of all relevant literature. Saini and Shlonsky's Qualitative Research Quality Checklist (152) guided quality appraisal of included studies.

## Chapter 4. Review and Thematic Synthesis of Qualitative Studies: Results

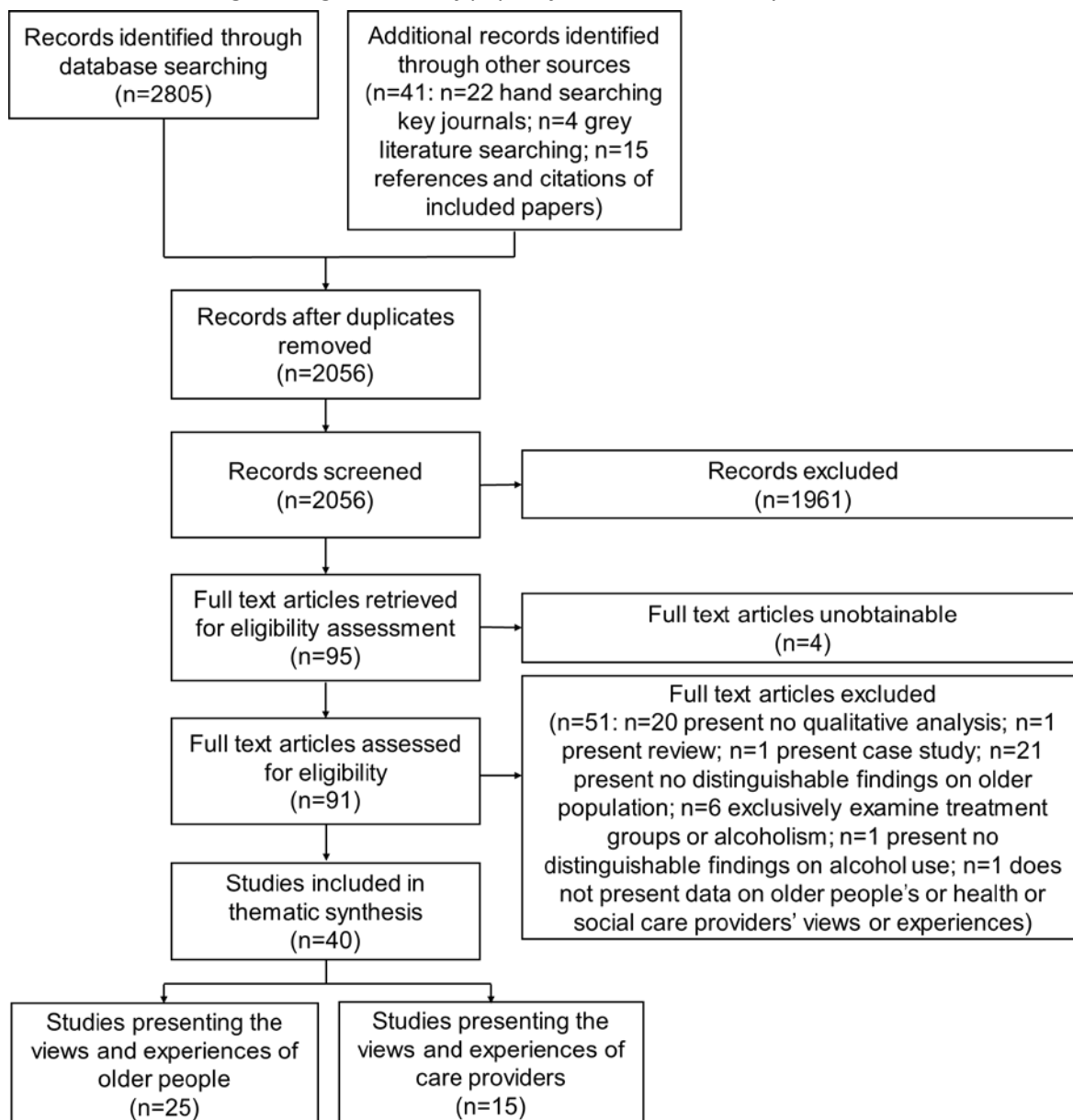
### 4.1. Overview

This chapter presents the findings of the systematic review and syntheses of older adults' and care providers' views and experiences of drinking in later life. Studies identified for inclusion within the systematic review are summarised, and the results of the thematic syntheses are presented. Factors identified to shape drinking and alcohol-related care practices within these syntheses are then highlighted, along with gaps in the existing knowledge base requiring further exploration.

### 4.2. Summary of Included Studies

In total, 40 articles were identified as meeting inclusion criteria, and therefore formed data for the thematic syntheses. The flow of papers through the selection process is presented in the PRISMA flow diagram (Figure 4-1). Full citations of studies excluded following screening of the full text are noted in [Appendix F](#), with detailed reasons for exclusion. Four articles that were identified for assessment against inclusion criteria at full text were unobtainable. Unsuccessful attempts were made to access these texts via connections within Newcastle University Library and by contacting authors.

Figure 4-1 PRISMA flow diagram, depicting the flow and number of studies identified and then excluded at each stage during selection of papers for this review and syntheses



#### 4.2.1. Summary of studies contributing to synthesis of older adults' perspectives

Twenty-five papers, reporting 21 unique studies were included (see Figure 4-1). Two studies were reported in multiple articles ((165, 166) and (167-169)), however each addressed unique research questions through analysis, presenting distinct findings. Brief descriptive summaries of included studies are reported in Table 4-1. More extensive details of each included study are provided in [Appendix G](#), Table Apx-G-2. Studies included data collected from as early as 1989. Included studies explored a range of different aspects of older adults' drinking practices. Different studies looked to describe older people's drinking, and examine how they presented their drinking, their views of acceptable alcohol use, beliefs about the



consequences of drinking, gendered factors affecting how older people use alcohol, factors affecting their alcohol intake, and changes in alcohol use in later life.

The synthesis of findings involved over 1500 older adults, aged 50 to 90 years upwards (see Table Apx-G-1 in [Appendix G](#) for summary of study details). Most studies included men and women. One study had all female participants (166). Authors variably reported other characteristics including socio-economic status (four studies) (170-173), ethnicity (seven studies) (170, 174-179), health status (four studies) (170, 172, 173, 180), work status (four studies) (170, 173, 175, 181), living context (seven studies) (173, 174, 178, 180, 182-184), marital status (eight studies) (173, 174, 176-179, 185, 186), religion (one study) (176) and sexuality (one study) (178) (detailed in Table Apx-G-1 [Appendix G](#) where reported).

All studies included participants with a range of drinking behaviours, including abstainers (10 studies) (165, 167-169, 171-173, 183, 187, 188), occasional drinkers (six studies) (166-169, 172, 187), moderate drinkers (20 studies) (165-169, 171-174, 176-180, 182, 183, 185, 187, 188) and heavy drinkers (10 studies) (167-170, 172, 175, 179, 180, 186, 187). Five studies included some people who may have been dependent on alcohol, but these were a minority of participants (167-170, 186).

Studies were from 16 countries. Six studies were conducted in the United Kingdom (167-169, 171, 172, 178), four each in the United States of America (170, 174, 177, 186) Finland (165, 173, 183, 189) and Sweden (165, 166, 179, 181), two each in Canada (175, 176) and Australia (179, 182). Single studies included participants from New Zealand (180), Russia (187), Norway (185) and Slovenia (188). Three studies were conducted across several European countries (165, 184, 185). Three studies specifically focussed on settled migrant groups (170, 175, 176). All of the countries in which studies were conducted had a temperance movement within their history, aside from a handful of countries studied in Vaz de Almeida and colleagues' article exploring alcohol use amongst European older adults (184). Within these studies, restricted alcohol use was idealised by governing bodies and amongst the population, and developing public health policies have focussed on alcohol for many years (190).

Where reported, most samples were recruited either purposively (six studies) (167-169, 171, 172, 182) or opportunistically (10 studies) (170, 173, 176-179, 181, 186, 187). Ten studies

also employed snowball sampling (167-170, 172, 173, 176, 177, 179, 181). Data were collected through in-depth/semi-structured interviews, focus groups, written autobiographical responses and ethnographic observation. A range of theories and approaches were applied to qualitative analyses, including grounded theory, discourse analysis, conversation analysis and thematic analysis.

*Table 4-1 Brief descriptive summaries of included studies reporting older adults' perspectives with key limitations identified in quality appraisal*

Article and country	Aims	Sample	Data collection methods and analysis	Author-identified key themes	Key limitations and comment on richness from quality appraisal
Abrahamson, 2009 (165) (a) Sweden and Finland Abrahamson et al, 2012 (166) (b), Sweden	a) To investigate how old people - who during their lives have experienced the displacement of drinking's moral border from soberness to moderate drinking - are presenting themselves, and their values, and attitudes towards alcohol. b) To examine changes in women's relationship to alcohol during the 1960s.	a) <i>n</i> = 32, Age = 78-94, Drinking status = sober or moderate b) <i>n</i> = 25, Age = 61-94 years, Drinking status = light or moderate.	Written responses to autobiographical questions, a) Qualitative thematic analysis b) Narrative construction and rhetoric motives	a) Sober repertoire; Moderation repertoire b) Scene and co-agents; Scene and counter-agents; Choice of the protagonist; Alcohol as agency	a) Lack of transparency in reporting of study design and methods; lack of exploration of study limitations and biases; thick description with reference to trends and contextual details. b) Inconsistent transparency in reporting; thick description in places with some contextual details and trends presented.
Aitken, 2015 (180), New Zealand	To understand the meanings of alcohol use for older people who use alcohol and to understand older people's reasons for drinking and identify the discourses they draw on to construct their alcohol use.	<i>n</i> = 18, Age = 53-74 years, Drinking status = responsible and potentially hazardous drinkers.	Semi-structured interviews, Discourse analysis	A 'social life' discourse; A 'drinking to relax' discourse; The 'health issue' discourse; A 'problem' discourse	Lack of transparency in reporting; thick description in places with some contextual details presented and many exemplary quotes
Billinger et al, 2012 (181), Sweden	Examines how older adults reason their relationship with alcohol and how they see the boundaries between what is acceptable and unacceptable drinking	<i>n</i> = 20, Age = 61-70 years, Drinking status: not reported.	Focus groups, Hermeneutic interpretation analysis	How the participants described the role of alcohol in their childhood; How participants described their first experience with alcohol; The participants' definition of their current alcohol consumption; The boundary between acceptable and unacceptable alcohol use; Other people's means of dealing with alcohol	No exploration of author biases presented; thick description rich with contextual detail, characteristics and trends.
Bobrova et al 2010 (187), Russia	Investigated gender differences in drinking patterns and the reasons behind them among men and women in the Russian city of Novosibirsk	<i>n</i> = 44, Age = 48-63 years, Drinking status = abstainers, occasional drinkers, frequent drinkers and heavy drinkers.	Semi-structured interviews, Framework approach and inductive and thematic analysis	Traditional drinking patterns; Individual drinking patterns; Perceived reasons behind the gender differences in drinking	Lack of transparency in reporting; thinner description with some details presented of sample and context linked to study findings.
Burruss et al 2014 (174), United States of America	Exploring alcohol use among a subpopulation of older adults in congregate living, specifically a continuing care retirement community	<i>n</i> = 11, Age = 68-90 years, Drinking status = regular drinkers.	In-depth interviews, Thematic analysis	Drinking as habit/routine; Peers as catalysts for increased consumption; Alcohol use and congregate living	Lack of transparency in reporting; thick description of study findings supported with contextual detail.
Dare et al 2014 (182), Australia	To explore 1) What role does alcohol play in older people's lives? 2) What factors facilitate or constrain alcohol use in different residential settings? 3) How does setting influence older people's alcohol use?	<i>n</i> = 44, Age = 65-74 years, Drinking status = frequent drinkers, mostly low risk.	In-depth interviews, Thematic analysis	Alcohol and social engagement; Alcohol and relaxation; Alcohol, work and leisure; Social engagement; Social norms; Self-imposed regulations; Driving; Convenient and regular access to social activities; Driving and setting	Inconsistent transparency in reporting; thick description of study findings exploring differences between contexts.

Article and country	Aims	Sample	Data collection methods and analysis	Author-identified key themes	Key limitations and comment on richness from quality appraisal
del Pino et al, 2013 (170), United States of America	To understand unhealthy alcohol use behaviours in socially disadvantaged, middle-aged and older Latino day labourers.	<i>n</i> = 14, Age = 50-64 years, Drinking status = occasional and frequent binge drinkers.	Semi-structured interviews, Grounded theory	Perceived consequences of unhealthy alcohol use on physical and mental health; The impact of unhealthy alcohol use on family relationships; The family as a key factor in efforts to change behaviour	Lack of transparency in reporting; thick description in places within context of individual characteristics, but no trends presented.
Edgar et al, 2016 (171), United Kingdom	1) Investigate how the process of retiring and ageing shapes alcohol use and its role in the lives of retired people 2) Explore the meaning and uses of alcohol in retirement 3) Explore the lives of older people more broadly, including social networks, interests and family life 4) Capture the intersections of gender, age and socio-economic status in shaping the experience of retirement and how it relates to alcohol use. This was achieved by including men and women, three specific age groups, and those from areas categorised as 'more deprived' and 'less deprived', according to the Scottish Index of Multiple Deprivation (SIMD) 5) Consider service and policy implications flowing from an enhanced understanding of alcohol use in later years.	<i>n</i> = 40, Age = 55-81 years, Drinking status = current or non-drinkers.	Semi-structured interviews, Thematic analysis	Routes into retirement; drinking routines; "keeping busy": work and leisure in retirement; adapting to changing social networks; processes offering protection: adapting drinking routines	Inconsistent transparency in reporting; thick description of findings presented, supported by contextual detail with trends conveyed.
Gell et al, 2013 (172), United Kingdom	To explore: 1) What purpose(s) does drinking serve for older adults? 2) What kind of knowledge do older adults have of the relationship between health and alcohol consumption? 3) Why do older adults change (or maintain) their alcohol consumption over time? 4) What mechanisms lead to a change or maintenance of alcohol consumption behaviour in older adults after change in health?	<i>n</i> = 19, Age = 59-80 years, Drinking status = abstainers, low-level drinkers, mid-level drinkers or high-level drinkers.	Semi-structured interviews, Thematic and framework analysis	Current alcohol consumption among interview participants; Changes in alcohol consumption among interview participants; Psychological capability; Reflective motivation; Automatic motivation; Physical opportunity; Social opportunity	Thick description of findings; quotes at times appeared to be used out of original context to support the points made.
Haarni and Hautamaki, 2010 (173), Finland	To analyse the relationship third-age people have with alcohol: how does long life experience affect drinking habits and what are those habits actually like in the everyday life of older adults?	<i>n</i> = 31, Age = 60-75 years, Drinking status = current- or ex-consumers of alcohol.	Biographical and semi-structured interviews, Content and biographical analysis	Different kinds of drinking career; The ideal of moderation; Ageing, generation and period of time	Study limitations were not considered in reporting; thick description of study findings with contextual detail provided; quotes at times appeared to be used out of original context to support the points made.

Article and country	Aims	Sample	Data collection methods and analysis	Author-identified key themes	Key limitations and comment on richness from quality appraisal
Johannessen et al, 2015 (185), Norway	To investigate older peoples' experiences with and reflections on the use and misuse of alcohol and psychotropic drugs among older people	<i>n</i> = 16, Age = 65-92 years, Drinking status = experience with drinking but no known history of misuse.	Narrative interviews, Phenomenological-hermeneutic analysis	To be a part of a culture in change; To explain use and misuse	Potential biases of research team were not explored; thin description of study findings with no discussion of sample characteristics or trends in data.
Joseph, 2012 (175), Canada	To examine the alcohol-infused leisure practices of a group of older Afro-Caribbean men in Canada and the ways alcohol consumption at cricket grounds plays an integral role in the reproduction of club members' gender as well as their homeland cultures, age, class and national identities	<i>n</i> = not reported due to study design, Age = 44-74 years, Drinking status = leisurely drinkers.	Observations and interviews, Inductive analysis	Drunkenness as a mask of physical degeneration; Drunkenness as temporal escape from femininity and family; Alcohol brands as class and (trans)nationality markers	Insufficient reporting of study limitations; thick description of study findings presented with rich contextual detail.
Kim, 2009 (176), Canada	To explore the drinking behaviour of elderly Korean immigrants	<i>n</i> = 19, Age = 62-83 years, Drinking status = mostly (63%) drank more than once a week.	Semi-structured focus groups, Thematic analysis	Reasons for drinking among men versus women; Health and alcohol; Signs of problem drinking; drinking in immigrant life; Reasons for a change in drinking behaviour; Religion	Potential biases of research team were not explored; thick description of study findings with trends explored and rich contextual detail provided.
Reczek et al, 2016 (186), United States of America	To provide insight into the processes that underlie the alcohol trajectories of mid- to later-life men's and women's heavy alcohol use identified in the quantitative results	<i>n</i> = 88, Age = 40-89 years, Drinking status = self-reported heavy alcohol users.	In-depth interviews, Inductive analysis	The gendered context of (re)marriage; The gendered context of divorce	Inconsistent transparency in reporting; potential biases of research team were not explored; thick description of study findings presented with rich contextual detail and exploration of trends.
Sharp, 2011 (177), United States of America	To understand the communication between community-based older adults and their physicians regarding their alcohol use	<i>n</i> = 11, Age = 79 years (mean), Drinking status = frequent drinkers.	Semi-structured interviews, Interpretive phenomenological analysis	Factors that hinder alcohol conversations; Characteristics that promote positive patient-doctor relationships	Unclear whether the sample was appropriate for the purpose of the study as most participants had never discussed alcohol use with their physician; thin description of study findings with no supporting excerpts or exploration of trends.
Stanojevic-Jerkovic et al, 2011 (188), Slovenia	To describe drinking patterns in the elderly, to identify the most common risk factors and protective factors for hazardous or harmful drinking, older people's empowerment for resisting social pressure to drink and their knowledge about low risk drinking limits	<i>n</i> = 20, Age = 63-89 years, Drinking status = current drinkers, abstainers or occasional drinkers.	Focus groups, Thematic analysis	Factors that stimulate drinking; Factors hindering drinking; Factors that for some people encourage drinking, for others hinder it; Behaviour in a drinking company; Seeking for help; Familiarity with the recommendations for low-risk drinking; Further findings	Potential biases of research team were not explored; thick description of study findings with rich contextual detail and some exploration of trends.
Tolvanen, 1998 (189), Finland	To examine the ways in which older people in Finland talk about their use of alcohol. It also aims to shed light on the meaning of alcohol use in the context of social ageing	<i>n</i> = 40, Age = 60-89 years, Drinking status: not reported.	Structured interviews, Discourse and conversation analysis	Alcohol use as discussed by older people; Who is the 'one' who drinks?	Insufficient transparency in reporting; questionable suitability of data for qualitative analysis; thick description of findings with contextual trends presented.
Tolvanen and Jylha, 2005 (183), Finland	To explore how alcohol use was constructed in life story interviews with people aged 90 or over	<i>n</i> = 181, Age = 90+ years, Drinking status	Semi-structured/life story interviews, Discourse analysis	I and others: The use of alcohol as a moral issue; Men's and women's drinking; Alcohol as a man's destiny and a threat to the	Inconsistent transparency in reporting; limitations and potential biases of research team were not explored;

Article and country	Aims	Sample	Data collection methods and analysis	Author-identified key themes	Key limitations and comment on richness from quality appraisal
Vaz De Almeida et al, 2005, (184), Europe (Denmark, Germany, Italy, Poland, Portugal, Spain, Sweden and the United Kingdom)	To explore social and cultural aspects of alcohol consumption in a sample of older people living in their own homes, in eight different European countries	= abstainers and current drinkers.  <i>n</i> =644, Age = 65-74 years, Drinking status = non-dependent.	Semi-structured interviews, Grounded theory	happiness of homes; Alcohol use as part of social interaction; Alcohol use as a health issue  Alcohol consumption narratives of older people; Gender differences in the narratives; Specific cultural differences between the eight countries	thick description of findings in places with trends presented; limited discussion of findings in relation to participant characteristics. Inconsistent transparency in reporting; reported methods of analysis did not appear compatible with data collected; thinner description of data with some exploration of trends but descriptive themes; quotes lacked depth where presented.
Ward et al, 2011 (178), England	To generate a wider evidence base by exploring the circumstances in which older people drink, the meaning that drinking alcohol has for them and its impact, acknowledging that this can be a pleasurable and positive experience, as well as something that can have adverse health, financial, personal and interpersonal impacts	<i>n</i> = 21, Age = mid 50s to late 80s (years), Drinking status = regular drinkers who may or may not have a problem with their level of alcohol consumption.	Semi-structured interviews and focus groups, Thematic analysis	Drinking practices and styles; What affects drinking styles; Seeking help	Inconsistent transparency in reporting; insufficient exploration of limitations and biases; thick description of findings with some trends presented.
Watling and Armstrong, 2015 (179), Australia and Sweden	To identify attitudes that might influence drink driving tendency among this group of women and further show how these attitudes vary across countries	<i>n</i> = 30, Age = 52 years (mean), Drinking status = low-risk or risky drinkers.	Semi-structured interviews, Thematic analysis	Findings were not organised under theme headings	Potential biases of research team were not explored; thinner description of findings with inconsistent provision of contextual data.
Wilson et al, 2013 (169) (a), Haighton et al, 2016 (168) (b), Haighton et al, 2016 (167) (c), United Kingdom	a) To elucidate the views of older individuals aged over 50 years about alcohol consumption, health and well-being, to inform future targeted prevention in this group b) To gain an in-depth understanding of experiences of, and attitudes towards, support for alcohol-related health issues in people aged 50 and over c) Explored concurrent alcohol and medication use, as well as the use of alcohol for medicinal purposes, in a sample of individuals in mid to later life	<i>n</i> = 51, Age = 51-95, Drinking status = abstainers, occasional drinkers, moderate drinkers, heavy drinkers, recovering dependent drinkers and dependent drinkers.	In-depth interviews and semi-structured focus groups, Grounded theory and discursive analysis	a) Alcohol identities; Health and changing drinking behaviour; gendered patterns of drinking b) Drinking in mid to later life; Deciding to change; Experiences of primary care; Experience of detoxification and rehabilitation; Experience of counselling and therapy c) Drinking and using medication regardless of consequences; Health professionals being unaware of alcohol use; Reducing or stopping alcohol consumption because of medication; using alcohol to self-medicate; differences related to gender and age	a) Potential biases of research team were not explored; thick description on findings with trends presented and rich contextual detail. b) Inconsistent transparency in reporting; thick description of findings with trends presented and rich contextual detail. c) Inconsistent transparency in reporting; thick description of data with rich contextual detail.

#### *4.2.2. Summary of studies contributing to synthesis of care providers' perspectives*

Fifteen papers met eligibility criteria (see Figure 4-1), reporting 14 unique studies ((191, 192) were analyses of the same data sets). Brief descriptive summaries of included studies are reported in Table 4-2. Different studies explored care providers' understanding of older care recipients' use and misuse of alcohol, care providers' perceived roles and approach to older care recipients' alcohol use within their practice, and factors affecting their work.

The synthesis of findings involved data collected from over 290 care providers. Their job roles included family physician/general practitioner (193, 194), general practice nurse (193), district nurse (195, 196), substance abuse specialist nurse (197), mental health specialist nurse (197), elderly care specialist nurse (197, 198), medical surgical nurse (199), nurse practitioner (193), social worker (200), domiciliary carer (191, 192, 196-198, 201, 202), residential home carer (196, 197, 201, 202), domiciliary care manager (191, 192, 195-197, 202, 203), health care assistant (195-197, 204), physiotherapist (205), occupational therapist (205), behavioural health provider (193), and administrative support (193). Ten of these studies explored the perspectives of multiple health and social care workers of different job roles (191-193, 195-198, 201, 202, 205). The health and social care providers worked with older people in home care settings (191, 192, 195-198, 200-205), residential home care settings (195-198, 201-203), general practice (193, 194) and on a medical surgical ward (199). Where stated, age ranged from 18-70 years, gender was mostly female (mean average 88% of sample), and reported ethnicity was majority white. Years in practice ranged from 0-36 (reported where available in [Appendix G](#), Apx-G-2). The age group discussed by health and social care workers was detailed in 11 studies. Most discussed people aged 65 years and over (194, 196, 197, 199-205), with one study discussing those aged 50 and over (193). All studies referred to a range of drinking statuses, including drinking at any level (191-194, 197, 198, 201, 202, 205) and misuse of alcohol (192-195, 197, 199-201, 203-205). Three studies also included some discussion of dependent drinkers (193, 199, 203). Studies were conducted in the United Kingdom (191, 192, 200, 202), the United States of America (193, 199), Sweden (195-198, 201, 203, 204) and Norway (194, 205). Where reported, samples were recruited either purposively (196, 201, 203, 205) or opportunistically (192-195, 198, 204). Data were collected through in-depth/semi-structured interviews and focus groups. A range of theories and approaches were applied to qualitative analysis. These included

thematic analysis, constant comparison, grounded theory, qualitative content analysis, phenomenological-hermeneutical analysis and analytical systematic text condensation.



*Table 4-2 Brief descriptive summaries of included studies reporting care providers' perspectives with key limitations identified in quality appraisal*

Article and country	Aims	Sample	Data collection methods and analysis	Author-identified key themes	Key limitations and comment on richness from quality appraisal
Andersson & Bommelin, 2013 (203), Sweden	To examine domiciliary care managers' understanding of older people's hazardous use of alcohol, in the context of aid assessment.	$n = 5$ , occupation = domiciliary care managers.	Semi-structured interviews, analytical systematic text condensation	Perilous use or misuse; Neglected social needs; Assistance based on the elders' own request or initiative	Small sample size, which is not reasoned in terms of data saturation; thin description of findings, lacking contextual detail; reporting of findings was predominantly descriptive.
Andersson & Johansson, 2013 (201), Sweden	To describe how municipal elderly care providers perceive, manage and treat older people with alcohol use and abuse.	$n = 6$ , occupation = elderly residential care providers and domiciliary care providers.	Semi-structured interviews, thematic analysis	Alcohol policy; An individual's own choice; Medicine and alcohol; The staff's view of the importance of alcohol to the elderly; The care recipients' background; Relatives and over reporting; The future	Inconsistent transparency in reporting; small sample size, which is not reasoned in terms of data saturation; unclear to what extent findings were grounded in the experiences of participants; rich description of findings with thick contextual detail.
Broyles et al, 2012 (199), United States of America	To identify the potential barriers and facilitators associated with nurse-delivered alcohol screening, brief intervention and referral to treatment for hospitalised patients.	$n = 33$ , occupation = medical-surgical nurses.	Semi-structured focus groups, constant comparison	Anticipated barriers; Suggested facilitators	Researcher biases not discussed in reporting; thinner description of findings - limited contextual detail provided to support understanding of reported findings.
Claiborne et al, 2010 (193), United States of America	To identify the primary care practice patterns relevant to patients' alcohol problems; to identify barriers and incentives for use of particular Veteran's acute care guidelines for screening and referral for evaluation and treatment of these problems.	$n = 31$ , occupation = medical physicians, medical nurse practitioners, registered nurses or nurse practitioners, behavioural health providers, administrative staff and support staff.	Structured one-to-one interviews, constant comparison	AUDIT-C screening process; Identifying alcohol problems; Referral for further evaluation and treatment; Follow-up with patients; Perception of behavioural health provider	Inconsistent transparency in reporting; researcher biases not discussed in reporting; thin description of study findings – some contextual details supplied, but just one supporting quote and findings quantified in places.
Darwish & Fyrpihl, 2015 (195), Sweden	To investigate how care workers handle and interpret alcohol problems in elderly service users.	$n = 9$ , occupation = care managers, nurses and auxiliary nurses.	Semi-structured interviews, thematic analysis	The interpretation of an alcohol problem; The ethical dilemma; Flaws within the field; Strategies and policies	Sample size is not justified in terms of data saturation; researcher biases not discussed in reporting; quotes provided do not consistently support authors' narrative; findings appear to be imposed by the theoretical framework with little support from

Article and country	Aims	Sample	Data collection methods and analysis	Author-identified key themes	Key limitations and comment on richness from quality appraisal
					participants' perspectives; thinner description of findings, with few contextual details presented.
Gunnarsson, 2010 (197), Sweden	To conduct an exploratory study of the perspectives of domiciliary care providers working with the elderly with substance abuse problems.	<i>n</i> = 11, occupation = domiciliary care providers.	One-to-one interviews, thematic analysis	Assessment of needs and substance abuse; The domiciliary carer's every day	Inconsistent transparency in reporting; researcher biases not discussed in reporting; thick descriptions of study findings.
Gunnarsson & Karlsson, 2013 (196), Sweden	To explore domiciliary care assistants' perceptions of drinking in later life (not explicitly reported).	<i>n</i> = 34, occupation = domiciliary care manager, domiciliary care nurses, auxiliary nurses and nursing assistants.	Focus groups and one interview, thematic analysis	The care takers' opinion of the work with elderly and alcohol problems: How the care takers act; Care planners' view of elderly and alcohol; The care staff's talking about their work with the elderly with alcohol problems	Inconsistent transparency in reporting; researcher biases not discussed in reporting; thick descriptions of study findings.
Herring & Thom, a) 1997 (191); b) 1998 (192), United Kingdom (England)	a) To explore policy and practice regarding the purchase of alcohol for older clients of domiciliary carers in three local authorities in the Greater London area. b) To assess the current and potential role of domiciliary carers in the identification and response to problems associated with alcohol use and misuse in older people.	<i>n</i> = not reported, occupation = domiciliary carers and their managers.	Semi-structured interviews, focus groups and written responses to postal questionnaires. a) qualitative analysis b) grounded theory approach	a) Netherfield; Longbourn; Pemberley b) Alcohol policy; Domiciliary carers' perceptions of alcohol misuse; Domiciliary carers' ideas about why older people may misuse alcohol; Spotting alcohol misuse: what do domiciliary carers think are the signs?; Response to alcohol misuse; 'Like a daughter'; The relationship between domiciliary carers and their clients	a) Reporting was not transparent; researcher biases not discussed in reporting; little detail provided on the study sample; some contextual details presented in reporting trends, providing a thicker description of findings. b) Reporting was not transparent; researcher biases not discussed in reporting; thin description of finding. Researcher biases not discussed in reporting; thin description of findings.
Johannessen et al, 2015 (205), Norway	To investigate health personnel's perceptions and experiences of alcohol and psychotropic drug use among older people and to what extent this is an issue when services are planned for and implemented	<i>n</i> = 16, occupation = district nurses, occupational therapists and physiotherapists.	Semi-structured interviews, qualitative content analysis	State of practice; A desire to improve services	Researcher biases not discussed in reporting; thin description of findings.
Johannessen et al, 2015 (206), Norway	To investigate general practitioners' experiences and reflections on use and misuse of alcohol and psychotropic drugs among older people, and to what extent this is an issue in treatment.	<i>n</i> = 11, occupation = general practitioners.	One-to-one interviews, phenomenological-hermeneutical method	The GP's opinion of older people's alcohol and psychotropic use; The GP's practice	Researcher biases not discussed in reporting; thin description of findings.

Article and country	Aims	Sample	Data collection methods and analysis	Author-identified key themes	Key limitations and comment on richness from quality appraisal
Millard & McAuley, 2008 (202), United Kingdom (Scotland)	To explore: 1) how clients' alcohol problems were identified 2) was it the domiciliary care providers work role to raise a possible alcohol problem with a client 3) whether domiciliary care providers had sought help for a client with alcohol problems, and if there were any barriers 4) were there any gaps in services for older people with alcohol problems, and if so, how might they be filled?	$n = 90$ , occupation = domiciliary care staff and domiciliary care managers	Focus groups, method of analysis not reported	None reported. To summarise findings: Trusting relationship between domiciliary care workers and clients; Domiciliary care workers' perceptions regarding the client's alcohol consumption; Barriers to involvement in day care or residential settings secondary to the client's alcohol usage; The impact of Scottish culture	Reporting was not transparent; researcher biases not discussed in reporting; thin description of findings.
Serbic & Sundbring, 2015 (198), Sweden	To investigate how residents' alcohol consumption is treated and handled by nursing staff.	$n = 6$ , occupation = trained nurses working in elderly care and elderly care workers.	Semi-structured interviews, thematic analysis	A picture of consumption; Self-determination and quality of life; Cumbersome situations; Different experiences	The sample size is not justified in terms of data saturation; researcher biases not discussed in reporting; thick description of findings.
Severin & Keller, 2016 (204), Sweden	To explore the domiciliary care staff's experiences of working with older patients who have alcohol problems.	$n = 6$ , occupation = domiciliary care nursing assistants.	Semi-structured interviews, inductive thematic analysis	Self-determination as an obstacle – dilemmas at work; Adaptation and flexibility as a means of management strategy; Support that is lacking in the work – support in the current situation	Inconsistent transparency in reporting; quotes provided were not always supportive of the authors' narrative; thick description of findings.
Shaw & Palattiyil, 2008 (200), United Kingdom (Scotland)	To explore social work practitioners' awareness of alcohol misuse in older people, and their attitudes towards the current support services.	$n = 18$ , occupation = social work practitioners.	Semi-structured interviews, thematic analysis	Extent of the problem; Difficulties identifying the problem; Reasons for alcohol problems among older people; Unmet need among older people with alcohol problems; More effective service provision	Inconsistent transparency in reporting; researcher biases not discussed in reporting; thin description of findings.

### **4.2.3. Quality of studies**

Key issues regarding the quality of each individual article are presented in Table 4-1 for studies examining older adults' perspectives, and Table 4-2 for care providers' perspectives. Comprehensive accounts of each appraisal are provided in [Appendix G](#). Studies included within both syntheses generally lacked explicit detail of the methods employed, and/or any justification of underlying decisions. This limited what could be understood about the credibility of these studies through quality appraisal. Reported methods were predominantly appropriate to addressing stated aims. However, there were a number of issues with study quality across both bodies of literature. Few studies discussed data saturation or related ideas when reporting the sample size. For these studies, the adequacy of collected data for conducting a meaningful analysis was unclear. Reflexive methods or considerations were rarely reported. It was therefore unclear how researchers' perspective on the topic of study may have influenced reported findings. Any employed methods of triangulation were rarely reported. As such, it was unclear how comprehensive developed accounts were of the topic of study. However, articles contributing to the synthesis of older adults' perspectives more frequently furthered their interpretation through application of social theory.

Both bodies of literature provided sufficient detail upon which to conduct a meaningful synthesis. A greater abundance of articles reporting older adults' perspectives provided thicker descriptions. This enabled a deeper understanding of contextual intricacies in findings than was possible for the synthesis of literature on care providers' perspectives. Across both bodies of literature, some studies provided thicker descriptions of findings than others, contributing more to the developed understanding (the thickness of descriptions for each article is highlighted in Table 4-1 for studies of older adults' perspectives, and Table 4-2 for studies of care providers' perspectives). Studies published in foreign language journals were often of poorer quality than those reported in English language journals. However, studies published in the English language were conducted across a range of countries.

### **4.3. Synthesis Findings**

Participant quotes and excerpts from findings identified within included studies are provided to support reported review findings. Relevant participant characteristics are stated where available.

### 4.3.1. Synthesis of older adults' perspectives

#### *Routines and rituals*

Across their life-course, older adults reported developing specific routines related to their drinking as leisure practices. Descriptions of their drinking were bound to certain contexts (165-169, 171-178, 180-189), such as with meals or in company. Some drinking seemed to hold additional symbolic meaning and was more 'ritualistic' as opposed to just regular or repeated (routinised) activity. Thus whilst drinking was engrained within many social occasions (165-167, 169, 171-176, 178, 180-184, 187-189), it could also become a meaningful part of spending time with friends and family members (165, 169, 171-174, 177, 178, 180, 181, 184, 186, 189). Drinking routines helped older people 'stay in touch' in their relationships (165, 166, 168, 169, 171-176, 178, 180-183, 187, 189):

*"Bonnie and I still enjoy a scotch in the evening... and the way we start off, we have a little bit of scotch. And actually that goes way back. That was when we were both working, we'd come home and have scotch. So it's a pattern that we're used to. And we usually then just sit and chat and talk about what's happening the next day." female (174)*

For some, the social role of alcohol increased due to the effect of transitions such as retirement or bereavement in later life, which could lead to an increased frequency of drinking occasions (168, 171, 178, 181, 182). Some heavier drinkers felt it would be difficult to spend time with friends or family without alcohol (168, 172, 176), although situations were also described where a change in drinking habits could adversely affect their social opportunities:

*"The same group, every Friday without fail. There was eight of us and well, there's seven go now because I don't go up [since I stopped drinking] and they've said to me, "oh, come up, we miss the, sort of, banter and all that sort of thing..." but, yeah, as I say, I miss the company more than I miss the drink." (171)*

Drinking was symbolically involved in creating a sense of relaxation during spare time (168, 169, 172-174, 178, 180-182, 184, 187) which was generally viewed as more plentiful following retirement:

*“You know the end of the day – in the evening on the weekend I think it’s time to relax and I find that glass of wine is part of that ritual of starting to enjoy the evening.” Female, (180)*

This increase in spare time sometimes led to an increase in the number of contexts and activities where alcohol was consumed (168, 171, 178, 181, 182):

*“I think possibly it’s tempting to drink more when you retire... I go out more for lunch and go out more with friends because I’ve got time to do it, so possibly linked to that yes [I drink more]” (171)*

Drinking could act to maintain structure in older people’s lives, which may have been lost in retirement, symbolising distinct leisure time and creating a clear daily routine (171, 182, 187). For a small number, the loss of external structure associated with retirement and children leaving home could lead to heavier drinking (171).

Routines and rituals in older adults’ drinking practices were shaped by social norms and expectations (165, 166, 168-176, 178-182, 184-189). For example, the central role of alcohol was highlighted in retirement communities, where social occasions were based in drinking settings (174, 182). Most older adults reported that they had reduced their previous overall intake of alcohol with age (166, 172, 173, 180, 184). However, risky or unhealthy patterns of drinking were described as normal for older adults in some cultures, such Mexican, Caribbean, Nordic and Russian cultures, particularly amongst men (170, 175, 184, 187). Women more often described increasing their drinking in later life from previously lower levels (168, 171, 173, 184). Whilst gender differences in norms and expectation of drinking were present, some described more equal expectations, suggesting these differences were reducing:

*F2: I think a lot of the men go out a lot more. The older men do still drink. Because that’s their only entertainment really, isn’t it? I would say middle aged men –*

*F5: I don’t think it’s just men. I think ladies can drink just as much as men.*

*F2: I’m talking about going out for a drink though, you know. Do you think the older ladies do?*

*F5: Oh yeah, I would say so.*

Swedish, Norwegian and Finnish participants described how their lower levels of drinking were shaped by historic temperance movements (165, 173, 183, 185, 189), particularly amongst women, who were expected to drink less than men. Cultural norms also altered the drinking habits of migrants, where older adults report integrating the new culture with that of their home country (175, 176). This served either to restrict previously risky drinking habits, or encourage riskier practices in groups whose home country consumed less alcohol.

### ***Self-image as a responsible drinker***

Most older adults saw themselves as controlled, responsible and considered in their drinking behaviour (165-167, 169, 171-174, 176-181, 183, 189):

*“Drunk? No, I haven’t really been for a while. I have to say that for the past ten years I’ve managed so that I’ve never been in that bad a way, that I’ve always known what I’ve been doing. Haven’t been out of my senses, like, when you get to bed, you ask which country, what time and where are we. It’s all been so well. I mean, as I’ve gotten older I’ve also gotten wiser and know when to stop. Learnt how to know how to stay in control.” (173)*

This self-image reflected their perception of societal expectations for drinking as an older adult:

*“As a pensioner one drinks a bit more often but less at each occasion. You don’t have any pressures, it’s not as rushed to go to bed. You have more opportunity to eat nice food but it isn’t about getting drunk anymore.” Male, (181)*

Their experience with drinking across the life course was perceived to make them wiser about drinking (165, 166, 169, 171-173, 180, 181, 185, 188). Older people presented an idealised view of moderate, low-risk styles of drinking (165-167, 169, 171-174, 176-178, 180-187, 189). Idealisation of abstinence or low-level drinking was more likely amongst the oldest individuals, particularly in Sweden and Finland (166, 171, 183, 184).

Drinking was described around these ideals, and justifications of drinking emphasised positive experiences with alcohol (165-167, 169, 171-173, 175, 176, 178, 181-184, 187). Many participants described their drinking as appropriate to the context (165-167, 169, 171-176, 178-184, 186, 187, 189), and usually aligned to their companions (166, 169, 172-174,

177, 178, 180-184, 186, 188, 189). Social context could sometimes justify drinking to excess (166, 169, 171-174, 178, 180-183, 186-188). Whilst alignment of drinking with social peers usually restricted drinking, it could also increase consumption in the company of heavy-drinking friends (173, 177, 181, 182, 186-189). A failure to align with companions' drinking could cause relationship problems - particularly with partners or family, but also within wider social groups (165, 168, 170, 171, 178, 186, 188). Those with more problematic alcohol use consequently reported drinking more heavily in private, to conceal their higher consumption, avoiding pressures to align their drinking (168, 172, 177, 178, 182):

*"I do not enjoy going out and meeting people, sitting in pubs and shouting at the top of my voice. When I come home, this is my haven, I want to be here... say I had my friend come over, and she's very moderate, she drinks like a little... you know. So I feel embarrassed then. So I'd rather drink on my own."* Female (178)

Drinking was seen to be acceptable, provided day-to-day responsibilities remained fulfilled. Many personal responsibilities judged to be incompatible with drinking were lost in later life, through retirement (171, 173, 178, 181, 182) or reduced parental responsibilities (165, 172, 175, 178, 181). These changes enabled increased alcohol consumption:

*"I don't really consider the fact that you shouldn't be drinking midday, that you shouldn't be drinking late at night, that you shouldn't be drinking when 'this and that'. I don't mean to imply that I drink a lot, but I do drink, I will drink when I feel like drinking... It changed after I turned 40ish. But now that I am retired I have even more freedom, when you're working you can't have a glass of wine with lunch. But now I can"* Female (181)

However, some older adults acquired new responsibilities during retirement which restricted drinking, including voluntary work, or caring for a sick partner (168, 171, 172, 181).

Conversely, drinking could act as a form of escapism from responsibilities as demonstrated in Joseph's Caribbean-Canadian cricketer community, where family responsibilities were passed on to partners, as drunkenness ensued (175).

Controlled and responsible drinking was often maintained through self-imposed limits or rules (165, 167, 169, 172-174, 176, 177, 179-184, 187, 188). For example, one older woman confined her alcohol use to evenings:



*“I don’t like drinking during the day, and would only have the odd drink during the day. Once I have a drink, I would tend to keep drinking. I don’t normally drink before 6pm. Those are my internal rules, it limits the alcohol intake. I don’t feel right after drinking during the day, which is why I tend not to.” Female (182)*

Heavier drinkers also applied rules and limits to restrict their drinking:

*“I’m probably the one in the group to drink the most. Not outrageously, but when you say winebox; dear god I have a glass from my wine box every night! Sometimes I’ll think, one bottle that should be enough for a couple of days. Just to re-focus myself and make me think a little. It’s not at the state where I would run to the neighbours and steal from their cellar. But I can think; this isn’t good! It is something – dependent they call it. It is extremely rare that I’ll end up intoxicated, I think. But still I can feel like the dependency is there... I always take the car when I go anywhere now, for that reason alone. So that I don’t have to...” Female (181)*

These self-made restrictions played a large part in exerting control and reducing alcohol consumption in later life. Drinking habits in later life were also shaped by stigmatisation of certain drinking styles (165-167, 169, 171, 173, 175, 176, 178-184, 187-189). Inappropriate drunkenness, alcoholism, drinking alone, drink-driving and women’s drinking were all judged to be unacceptable. Older adults avoided identifying with these behaviours (165-167, 169, 171, 173, 175, 176, 178-184, 187-189).

There was a general perception that ‘problematic’ and ‘normal’ drinking behaviours were separate entities (169, 172, 180, 181, 184). Problematic drinking was associated with a lack of control, need, and risk (169, 172, 173, 180, 181). Most older adults identified themselves as ‘normal’ drinkers, framing their consumption as responsible and acceptable compared to problematic use (169, 171, 178-181, 183, 184, 189). However, this perception meant that many did not reflect upon the increased risks attached to drinking as an older person. Those recognising issues with their drinking did so through identification with the problematic drinking discourse (167, 169, 170, 172, 173, 181, 186).

### ***Alcohol and the ageing body***

Older people recognised the positive and negative effects that alcohol could have on their bodies as they aged (165-178, 180-189). Alcohol was valued for its ability to create feelings of pleasure (165, 168, 169, 171, 173, 174, 178, 180-182, 184, 187) and relaxation (165, 168,

169, 171-174, 178, 180-182, 187), which were perceived as an important part of enjoying later life. Alcohol was also believed to have positive effects for health and wellbeing in older age (165, 170-172, 174-176, 178, 180, 182, 184, 187). Many viewed alcohol as protective to health (177, 180), particularly when consumed in moderation (176, 180, 183). This led some to believe that not drinking could be negative for health:

*“So being a teetotaler can be hazardous to your health too! I’m in the middle of the road with what the experts seem to say that is a healthy level of consumption, if there is such a thing, keep it down to a drink a day and I’ll not do it every day, seem to be the feeling. A small amount of alcohol does have some benefits.”*

*Male (180)*

The health benefits of red wine and whiskey were emphasised (165, 168, 172, 176, 178, 180, 182, 184), but this appeared to be a means of justifying preferences, rather than encouraging a change in use:

*“My consultant told me that whiskey was only 2<sup>nd</sup> to red wine for heart disease, and if it’s good enough for him it’s good enough for me [during cardiac rehabilitation].” Male (172)*

The perceived positive effects of drinking led many to view alcohol as a form of medicine (165, 166, 170-172, 174-176, 178, 180, 183-185, 187-189), particularly in Sweden and Finland. Reported medicinal uses were wide ranging. Aside from preventing numerous diseases, alcohol was seen to cure many physical ailments such as colds, pain and digestive problems, (165-167, 169, 172, 175, 176, 183-185, 187, 188):

*“It is said that whiskey is healthy. In any case, for me, it is soothing for my stomach and can sometimes act as a medicine” (165)*

At times, alcohol was used in place of medications (167, 171, 172), as a sleeping aid (165, 167, 172-174, 176, 178, 180, 184, 189), or to promote mental health (165-167, 170-174, 176, 178, 180, 182, 187); particularly amongst women. Alcohol use could, however, become heavy when relied upon to cope with stressors or mental illness in later life (166, 172, 173, 178, 186):

*“Well, [my partner] couldn’t have any [alcohol] in the last six months [of his life]. I drank, coz I was so anxious. It’s easy to say that one is using because of this and that, but at times I was so distressed that alcohol made me feel better in that situation. And the worse [my partner] got in hospital – I, when I got back from the hospital and had a little alcohol, I could get some sleep and it helped. I sort of relaxed. I was just so anxious about it, I got used to it back then. I should have guessed back then that it wouldn’t end well. But I didn’t think of it like that back then. You can’t know beforehand that that’s how it’s going to turn out.” Female, aged 62 years (173)*

Some recognised that using alcohol in this way could negatively affect mental health (167, 169, 170, 172, 178, 180).

Other negative effects of alcohol were recognised (165, 166, 168, 169, 171, 172, 174, 180, 183, 184, 189). Older adults were especially aware of short-term consequences associated with intoxication, such as hangovers, accidents and blackouts (166-171, 173, 180, 184). Longer-term damage was recognised as a potential consequence of drinking (168-172, 175, 178, 180, 183), usually associated with heavier intake. Authors noted that these negative consequences were usually discussed by older adults after prompting, rather than spontaneously described (169, 180). Many older people *were* aware of the dangers of drinking whilst taking medication (166, 167, 169, 171, 172, 177, 178, 180, 184, 185, 189). However some participants, particularly heavier drinkers, described drinking alongside or with medications (167, 172, 180, 185).

In later life, most participants reflected that health was a major priority (172, 180). The ageing body was felt to be more fragile, requiring greater care than before. Some saw the ability to drink in later life as a sign of good health and resilience (175, 176). Many adjusted their drinking because of the perceived effects of alcohol on health (167-169, 171-173, 178, 180, 183-185, 188, 189) - particularly men, who had often consumed at higher levels earlier in life (167, 172, 176). A small number described maintaining their alcohol intake, despite concerns for their health (166-172, 175, 178, 188). Heavier drinkers continued to drink heavily as they saw intoxication to be one of life’s remaining pleasures (quote 3v) (168, 176, 178):

*“I’d like to cut it down altogether, but even the last time – I cannot be going away and just sitting on my own. I don’t smoke, I don’t have nowt else and that’s the only pleasure I’ve got – drinking.” Male, aged 61 years (168)*

Some looked for other explanations for their problems, justifying continued drinking:

*“I started to think about what I was consuming that might be, erm... having an effect [to cause gout]. And the obvious one is drink, but I didn’t want to stop having a drink. But I honed in on citrus... and I thought I wonder, you know, people had said to me there was a connection between citrus fruit, and I wasn’t eating a great amount of fruit, the occasional apple, banana whatever, so I stopped and, dare I say it, touch wood... I haven’t had gout since... It’s a popular explanation for gout, people say oh you’re drinking too much red wine or something... that’s a throwaway remark that everybody seems to make and I ignored it because I found the solution was there for me and with no adverse effects.” Male (172)*

Whether alcohol use was reconsidered in later life was determined by the salience of health issues (169-172, 178, 180, 185). Experiencing negative impact of alcohol on health, either directly or through others’ experiences, led to changes in alcohol use. Others justified their heavier drinking habits through the lack of noticeable effect on their health:

*“I’m 55, I’m perfectly fit, I don’t run about beating everyone up, I’m not incontinent, I’m perfectly healthy, I get a check for my stroke, which coincidentally, they check my bloods, they check my liver, check my pancreas, check my kidneys you know, everything’s fine, so how is half a dozen pints doing any irreparable damage?” Male, aged 56 years (169)*

### ***Access to alcohol***

Financial and environmental factors were strong influences on access to alcohol, and how much was consumed (165, 168, 171-174, 176, 178-182, 184, 185, 187-189). The accessibility of shops and drinking establishments shaped levels of drinking (168, 172-174, 178, 182, 189). Mobility issues could complicate access to alcohol (168, 172, 178, 189). However, drinking could also be facilitated through visits from heavy-drinking friends (168, 178). In retirement villages, the availability of alcohol in social areas increased residents’ drinking (174, 182). Those living in residential care homes with restrictive alcohol policies could have drinking curtailed (188, 189).

Drink-driving legislation was a major consideration, constraining many older people's drinking (171-174, 176, 178-180, 182, 184):

*"If I know I have to drive, I will just have a light beer, or sometimes I will just go without altogether. I find that easier because you don't have to worry about whether you have gone over the limit. Driving has killed a lot of social drinking, particularly living down here (an outer metropolitan suburb). If I'm in Perth, I very seldom drink, if at all. It is a long drive and I'm not only worried about RBT (random breath testing). But I don't want to feel sleepy. It's the driving mainly that would affect whether or not I will have a drink." Male (182)*

Restrictions on drink-driving had most impact on socio-economically advantaged groups, who tended to drink in friends' homes (172). For individuals living in suburban areas, a lack of public transport could enforce the need to drive (176). However, in urban settings, safety became a key consideration, restricting time spent drinking outside the home (172).

Financial considerations also shaped older people's drinking (165, 174, 181, 184, 187, 188). Those with higher disposable incomes increased spending on alcohol and vice-versa (175, 178, 184, 187, 189), although some binged when money was available:

*"I drink usually when I receive the pension – it is a small holiday. We buy food and I drink chekushku [a quarter of a litre of vodka], 250g. Beer I drink about once a week. It is sold in big plastic bottles, 1.5l each. So, I usually finish it during the evening watching TV" Male, aged 69 years (187)*

Heavier drinkers prioritised spending on alcohol regardless of income, adjusting their drinking style to fit with the money available (171, 175, 178).

#### **4.3.2. Synthesis of care providers' perspectives**

##### ***Uncertainty as to whether drinking represents a legitimate concern in care provision for older people***

Care providers were uncertain about whether older people's risky drinking represented a valid issue to their care provision. Alcohol use was seen to be a normal and culturally acceptable behaviour, often representing little cause for concern (191, 192, 194-197, 201, 203-205). Some concern for risky drinking amongst older care recipients was evident in care providers' narratives (194-198, 200, 201, 203). However, excess drinking was seen to be less prevalent amongst older people compared to the rest of the population; particularly

amongst those working in countries where low-level drinking and abstinence was idealised amongst the older age group (196, 198, 201, 205). It was evident that care providers' definitions as to at what level of intake drinking became a risk could vary on an individual basis (195, 196, 199, 203), as was highlighted by a medical surgical nurse, who worked in a multi-disciplinary team:

*"Everyone has a different opinion of what constitutes an alcoholic... or even what constitutes a problem." (Medical surgical nurse, (199))*

The potential for positive as well as negative effects of drinking for older people complicated judgements as to whether alcohol represented a health risk. The positive roles of moderate drinking in older people's lives were seen to contribute to quality of life (197, 198, 205). Domiciliary care providers recognised the social and leisure opportunities associated with drinking amongst older clients (196, 198, 201, 202). Their drinking was accepted and sometimes facilitated within organisations:

*'Several of the interviewees explain that [...] they realise that their [clients'] quality of life is increased when they [...] get to drink "their little whiskey before bedtime". Hence, they don't restrict somebody's consumption as often as they would like to, as long as the individual doesn't harm themselves, or anyone else.' (Comment on elderly care nurses and carers, (198))*

Alcohol was also perceived to play roles in coping with loss of purpose associated with retirement, bereavement and loneliness in later life (192, 194, 200, 201):

*'The informants experienced that many of their older patients were lonely, and therefore, used alcohol [...] to reduce their strain. Structural changes in their lives and in society, such as children having moved out or were too busy with their own lives, loss of friends, dependency because of poor health, and few meeting places for older people, were seen as reasons for loneliness.' (comment on GPs, (194))*

Care providers perceived that this coping role could, for some older care recipients, become excessive and problematic, creating a pathway to alcohol dependence (192, 200, 201):

*"These service users begin using alcohol to cope with the feelings of emptiness and grief following their partner's death and continued to drink until it has*

*become a way of life and they are effectively dependent upon alcohol. They also have very little else to fill their day.” (Social work practitioner, (200))*

The perceived roles of alcohol use in older people’s lives could make it difficult for care providers to intervene when their level of intake was perceived to be risky, concerned that alcohol may be ‘all that is left’ in the lives of their older care recipients (200).

Rather than being viewed as a legitimate issue for care in its own right, risky drinking was framed as an obstacle to providing care. When care providers’ perspectives indicated that risky drinking *was* deemed to legitimise intervention, it was not in view of preventing harm. Rather, this was almost always as a result of emerging health consequences, or indications of alcohol dependence (191-200, 203, 204), as Herring and Thom described in their study of domiciliary care providers’ perspectives:

*‘Home carers had a very ‘black and white’ view of alcohol-related problems: a person was either alcoholic or did not have a problem. There seemed to be little understanding that some older people may experience alcohol-related problems when drinking a moderate amount, for example, because they have impaired balance.’ (comment on domiciliary care providers, (192))*

Care providers associated long-term excesses with negative consequences for the older person’s mental and physical wellbeing (193, 196, 197, 199-201, 203), as well as their self-care (192, 193, 195-198, 200, 201, 203, 204) and social relationships (197, 198, 201). Shorter-term consequences associated with intoxication were also emphasised. Drunkenness was perceived as having a negative effect on care recipients’ behaviour (192, 195, 196, 198, 201, 202, 204). This could threaten the safety of the older individual (191, 192, 195-197, 201-205) and their care providers (195, 202, 204). Alcohol-fuelled behaviour was particularly an issue in domiciliary care, where older clients could be drinking in the care provider’s work environment:

*‘A concern raised by home carers was the risk of fires and accidents when older people smoked and drank. In one case, they were first alerted to the possibility that the client was drinking when: ‘She started to drop her cigarettes badly... she didn’t realise and she actually burnt to death.’” (comment on domiciliary carers, (192))*

*“Many of the staff are harmed as well. Everyone can’t deal with it. Some get scared. I haven’t experienced any fear, but some of my colleagues do get scared to an extent where they don’t want to go to work.” (Nurse, (195))*

It was evident within some studies that care providers’ interest in adverse consequences of alcohol was focussed on heavier or dependent drinking (195, 202, 204). However, studies conducted in a range of contexts, examining various different care providers’ perspectives, suggested that care providers recognised the increased risks of drinking any amount of alcohol with age. Risk was perceived to be attached to reduced physiological tolerance to alcohol, interactions of alcohol with medicines and alcohol’s effects upon chronic conditions associated with getting older (193, 194, 196, 198, 200, 201, 204, 205). However, the only example given of when alcohol was interpreted as a threat by care providers was when they were involved in administering medication to their older clients (195). In this context, care providers’ actions contribute toward interactions between the medication and alcohol which may adversely affect the clients’ health. In Sweden and Norway, where drinking had only recently become a normative practice, domiciliary carers attributed health issues more readily to conditions associated with the ageing process rather than the possibility of harmful alcohol use (195-197, 205).

### *The impact of preconceptions on work with older drinkers*

Pre-existing stereotypes of older drinkers shaped care providers’ practice surrounding their older care recipients’ alcohol use. Cross-culturally, problematic drinking was perceived to be more likely amongst men; the consequences of their excessive drinking were most visible as they often lived alone and tended not to look after themselves (194, 196, 197, 200, 201). In Sweden and Norway, where historic temperance movements have influenced attitudes towards drinking, alcohol use was perceived to be less common amongst certain groups of older people. These groups included women (194, 196, 197, 201), the oldest old (those aged 85 years and over (195, 198, 205)) and those living in residential care (198, 204).

Preconceptions focussed on characteristics associated with heavier drinking styles, which proved most problematic and memorable (192, 195, 196, 198-201, 203). Care providers expected that harmful drinking would have visible signs, and looked for these in their practice. Domiciliary carers expected ill health amongst older drinkers from accrued effects of excessive consumption, which reduced independence and created a need for care (192,



195-197, 200, 201, 205). These expectations guided care providers' exploration of possible risky drinking by older people (192, 193, 195, 196, 201, 203). Where manifestations of their older patient' or clients' problematic drinking did not fit their expectations, prejudices could represent a barrier to detection of risky alcohol use. This was exemplified in one case discussed by Gunnarsson and Karlsson:

*'Another general expectation is that elderly don't consume alcohol, especially not older women, according to the home care managers. One home care manager describes one elderly woman who she first thought had a problem with her memory and the relatives responded with: "Memory problems! She was drunk!" Intoxication with elderly women is often accepted with confusion, if "the smell of alcohol" isn't there or there aren't bottles on the table, or empty bottles found around the house.'* (comment based on domiciliary care managers, (196))

Across professions and cultures, it was a common perception that by later life drinking practices were ingrained (193, 195-197, 199, 200, 203):

*Nurse 1: Our population is probably mid-50s to older- it's something they've been doing for 25-30 years... at that point they don't think they have a problem, it's just normal to them.*

*Nurse 2: Or it's already too long. They've already got the problems that go with it [alcohol use], and think, why bother?"* (medical surgical nurses, (199))

When damage was perceived to already be done, this could affect whether staff felt interventions were worthwhile (197, 203).

### ***Sensitivity surrounding alcohol use in later life***

Excessive drinking was widely perceived to be a morally loaded issue amongst the older age group, because of the common societal expectation not to overconsume (194-196, 198-201, 203-205). As a consequence, alcohol was perceived to be a sensitive topic for discussion (191, 194-197, 199-205). Successful discussion was acknowledged as a factor that could promote an older person's engagement with appropriate support services where drinking had become problematic (195, 199, 200, 203). Rapport was perceived widely to be an essential prerequisite for successful discussion (191, 195-197, 199-203):

*'We understand that when the care takers have built a good relationship with the care recipient, they can be deemed as significant by the care recipient, and the care takers can then approach them with questions regarding alcohol. We interpret this as the care takers trying to show empathy and create relationships on personal levels in order to help the elder. And thus they create trust with the elder enabling this topic to be discussed.'* (comment on care managers/nurses, (195))

As support needs increase with age, care providers are well-placed to build rapport. However, it was clear that rapport was perceived as essential for other aspects of care provision, and could be threatened by discussion that offend the older person. There were examples where care providers recalled this having led to the older person becoming resistant to their care provider and refusing to accept care:

*"You try to go and say "Let's discuss this [alcohol misuse]," and they will swear at you and throw stuff at you, and tell you to "get out"... And the next time you come back to take care of a medical thing, they're spitting at you, because they said, "I told you I don't ever want to see you again."* (medical-surgical nurse, (199))

Care providers reported that older adults and their families may hide the older person's drinking due to the stigma attached to problematic drinking (194, 195, 198-201, 203). This was particularly the case amongst groups where drinking is perceived to be less socially acceptable; for example domiciliary care recipients (195, 198, 201), excessive drinking amongst more socially advantaged individuals (196, 197) and older Swedish women (196, 197, 201):

*'It isn't always that these women are aware that they are alcoholics. "You don't get it out of them that they have an abuse problem, but no I just drunk some beer every now and then... there is no absolute... it's more hush hush. Even amongst their relatives. That mum... dad can drink, but not necessarily mum in the same way, that's harder to accept. Those who do have relatives, it isn't everyone who does have them"'* (comment on domiciliary care providers, (197))

Across countries and professions, sensitivity was perceived to be a major barrier to discussing alcohol use with older patients and clients. Care providers were keen to avoid upset (194-197, 199, 202-204):

*“No, no direct questions [...] Nothing such as: How often do you drink alcohol? Or do you drink a lot of alcohol? You just don’t ask that. You simply don’t.” (Care manager, (203))*

As a result, discussions about possible risky drinking may only be triggered by concrete evidence (194-196, 203, 204), such as visible indications of intoxication and overuse, or blood results, where misuse cannot be disputed:

*“For me it’s easier if I meet them at hospital, because there there’s nurses and doctors that say when they came to us they had a blood alcohol level of 2.8 and maybe drinking has become a bit too much lately. Then I don’t have to bring it up. It makes it much easier. Then you have another opening to discuss the topic.”  
(domiciliary care manager/provider/nurse, (196))*

### ***Negotiating responsibility for older adults’ alcohol use***

Care providers emphasis upon their older care recipients’ right to self-determine their own drinking practices was clear between studies included within this synthesis (191-193, 195-198, 201, 203-205). Responsibility for decisions surrounding drinking were perceived to lie first and foremost with the older person:

*“The elderly decide everything in their everyday life and should live a good life, according to the basic values. Within elderly care the right to self-determination principle is applied, regardless of whether or not they have alcohol problems.”  
(Unit manager, (195))*

Where the older person lacked insight into risks attached to their level of intake, this could present challenges in practice:

*‘They describe that these older individuals often lack the insight about their problematic alcohol consumption and few of them ever admit to having any problems. The interviewees find that when the elderly are in denial about their problems it becomes more difficult to help them in the way they need.’ (comment on care managers, (203))*

A lack of insight could stem from poor understanding of the risks of their alcohol intake, or inadequate capacity to make decisions, which may result from cognitive decline associated with ageing (194, 196, 197, 199-201, 203). The older person’s right to self-determination was

a particular dilemma in domiciliary care provision. Here, the care provider may be expected to play a role in the older person's access to alcohol (191, 192, 197, 198, 201, 202, 204):

*“Buying alcohol. Do we? Don't we? Do we have a quantity that you buy? Do you buy for some people and not for others? All those issues. Our view is that the service user has a right and we are not in there to make value judgements about service users and in certain ways we are there as guests of the service user in their home, and there to do obviously what they are not able to. So we would go out and buy. In fact, I've just recently had to dismiss a member of staff who had just started – only lasted a week. This member of staff actually refused to buy alcohol for people and to me that is an infringement of the service users' rights as an individual. So my view was that worker wasn't able to carry out their full duties.”*  
(domiciliary care manager, (191))

This could represent a barrier to providing appropriate support for older patients and clients, and may even lead to the care provider facilitating excessive alcohol use.

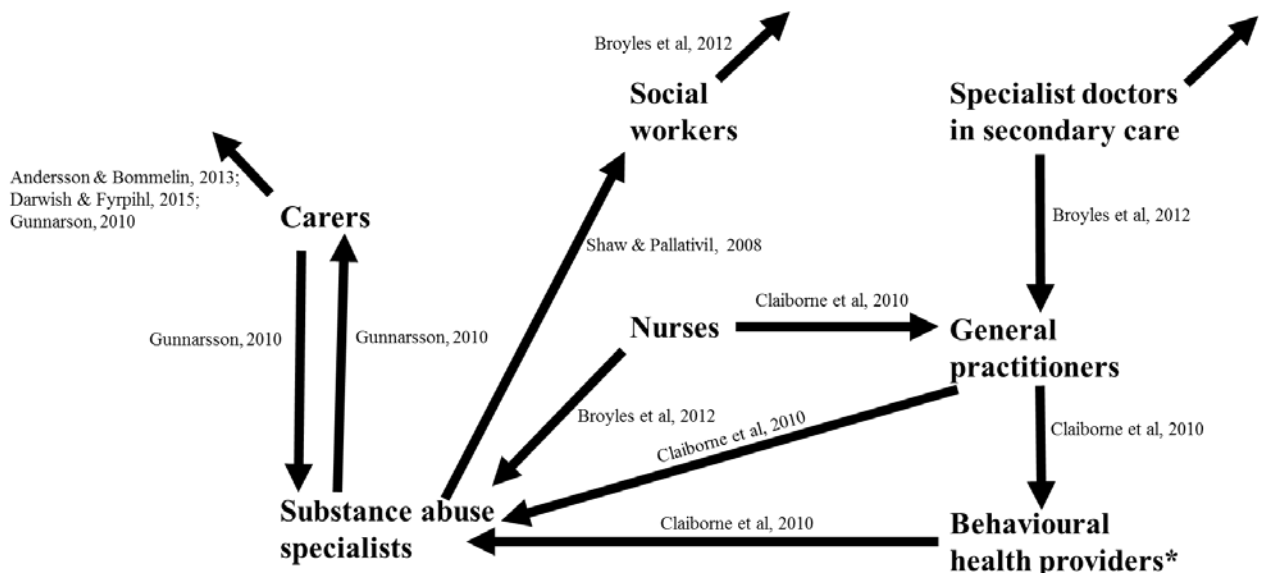
Care providers did broadly recognise responsibility in supporting those misusing alcohol to make healthy decisions about their drinking (193, 195, 197, 199, 202-205). However, their perceived remit in intervening with older people's drinking was often specific (191-199, 202, 203). Health and social care workers have many priorities in care provision that must be negotiated. Discussing potential risky drinking could often be left aside (191, 192, 194-196, 199, 203-205). For example, in post-surgical care, stabilising the patient was the goal. Dealing with 'chronic' issues was seen to be the role of the primary care provider (199). Social care providers discussed how alcohol services focussed on younger people, leaving the older person's unit to provide for all needs of the older clients (200). However, domiciliary carers focussed on supporting the older person in their home rather than on identifying or addressing problematic drinking. Due to these specific remits, there were repeated examples where identifying and intervening with older people's risky drinking was deflected between different health and social care providers (193, 195-197, 199, 200, 203) (see Figure 4-2 for diagram of deflections between different care providers identified in reporting of included studies). Coordination between care providers was emphasised within care providers' narratives as important in ensuring the older person was supported to tackle their drinking (192, 193, 195-200, 203-205). However, this was reportedly difficult to achieve. Where

providers did perceive a role in addressing older people’s risky drinking, they often felt hindered by inadequate training or support for their work (192, 194, 195, 197-201, 203-205):

*“There’s not much I can say, [our knowledge and training is] what we brought with us from school, but any other education or information, we just don’t have that. But at the same time we need to be prepared for this [addressing alcohol misuse amongst older clients]. When we come across these situations, worries can develop in regards to how we should deal with them.” (Domiciliary care manager, (195))*

As a consequence, care systems may not meet older patient and client’s needs regarding their drinking.

*Figure 4-2 Diagram depicting direction of deflection of responsibility for identifying and addressing older people’s risky drinking between different health and social care providers (and supporting references), as identified within reporting of included studies. Arrows with no end-point represent general deflection, rather than that directed towards any particular care provider. Please note that this depiction is based upon deflection reported within the included papers, and does not therefore reflect all deflection described by participants within their primary data, nor is it a full representation of deflection across all health and social care systems and services. There is no system for the positions of different care providers within this diagram, and their placing does not carry any significance.*



*\*Behavioural health providers are care providers working to identify and treat psychosocial, psychiatric and alcohol issues.*

#### 4.4. Factors Identified to Shape Late-Life Drinking

In working towards this thesis’ overarching aim of conceptualising factors that shape late-life drinking practices, factors identified to influence alcohol use in later life within this synthesis

are highlighted below. These identified factors were explored further within the fieldwork to conceptualise late-life drinking. Individual-level characteristics identified to shape older adults' views and practices of late-life drinking guided sampling within this fieldwork phase.

### *Concepts identified to shape late-life drinking*

- Drinking routines and rituals developed across the life course
- The social roles of alcohol within the individual's life
- Social norms and expectations surrounding acceptable alcohol use
- Past experiences of alcohol use
- The individual's wider responsibilities (or lack of) such as work, volunteering and caring roles
- Self-imposed restrictions on alcohol use
- Self-categorisation of alcohol use and associated meanings (such as moderate or problematic – discussed in [Section 4.3.1: Self-image as a responsible drinker](#))
- Health messages regarding alcohol use
- Cultural beliefs about the uses of alcohol (such as medicinal use)
- Perceived fragility of the ageing body
- Availability of alcohol within the individual's local environment

### *Individual characteristics affecting older adults' drinking practices*

- Age: Findings suggested that societal movements such as temperance could influence older adults' views regarding what style of alcohol use was acceptable, and their resulting approach to drinking. Different age cohorts were exposed to different societal attitudes towards alcohol, contributing to age-based drinking norms. Age also affected expectations guiding care practice - care providers sometimes did not expect that their oldest patients or clients used alcohol.
- Gender: Perceptions of how older people felt they were expected to use alcohol differed between genders, creating corresponding differences in alcohol use. The older person's gender also affected care providers' assumptions regarding possible roles of drinking in the individual's life, and their perception of the likelihood that the individual may be consuming risky amounts of alcohol.
- Cultural factors such as ethnicity and religion: The cultures within countries where the individual was born or resided defined the individual's perceptions of norms regarding

how alcohol should be used. These perceived norms shaped the individual's approach to drinking. Local drinking norms dictated care providers' concern attached to their older patient and clients' levels of alcohol use, and whether excessive alcohol use was explored as a possibility within care.

- Socio-economic status: Higher disposable income facilitated older adults' spending on alcohol, and could lead to increased intake.
- Health status: The individual's state of health determined whether they experienced symptoms that could be attributed to alcohol use. Health conditions could also legitimise the use of alcohol for medicinal purposes. Health issues could serve to limit the individual's access to alcohol if mobility was affected. Older adults' experience of health issues, or use of associated medicines, legitimised the possible harms of alcohol in the eyes of care providers.
- Work status: Responsibilities such as work served to limit older adults' drinking, as intoxication and hangovers were not seen to be appropriate for the working environment. Loss of these responsibilities through retirement could increase opportunities for socially acceptable alcohol use.
- Living context: Urban locations facilitated access to alcohol through sources for purchasing within the local living environment. Local alcohol policies could restrict alcohol use. Within rural settings, alcohol use could be limited when driving was necessary to visit social contexts where alcohol might be consumed.
- Marital status: The social roles and alignment of alcohol in a marital relationship were indicated to influence alcohol use. Bereavement, for example through widowhood, could alter the social roles of drinking and consequently the individual's drinking practices. Care providers associated living alone with an increased likelihood of harm through drinking in later life.

Older adults' level of alcohol use and care providers' professional roles also require examination in formulating a conceptualisation of late-life drinking, and related implications for care practice. How the older person reasoned their alcohol use, and underlying perceptions, varied based on the individual's alcohol intake. There were also clear differences in perceptions of older drinkers within practice between different care providers.

## 4.5. Gaps in the Existing Knowledge Base Requiring Further Exploration

The understanding supplied within the existing evidence base lacked coverage of a number of areas relevant to addressing the aims of this thesis; as highlighted below:

### *4.5.1. Conceptualisation of older adults' alcohol use and related perceptions*

My synthesis of the existing evidence base indicated some factors that shape older people's alcohol use, the potential roles of alcohol in older adults' lives, and characteristics of late life drinking practices; as highlighted within [the previous section](#). However, thematic categories and content presented in included studies predominantly offered descriptions of the nature of older adults' alcohol use, associated care practices, and related perceptions. There was little exploration in either body of literature of how different factors shaped older people's drinking practices, or of how such factors led to different profiles of use (particularly through the influences of gender, mental health or culture). Narratives within included studies also lacked critical exploration of reasons underpinning different perceptions, or of how older adults' perceptions of their alcohol use and their underlying reasoning explain or give insight into their drinking practices; particularly regarding their views of the positive and negative effects of alcohol for their health. Existing literature indicated some functions of drinking in older people's lives, such as roles and rituals attached to alcohol use in their social lives and experiences of leisure. However, included studies offered little explanation of the specific roles of alcohol, or of their contributions to older adults' quality of life. The evidence base lacked exploration of how views about the positive and negative effects of alcohol in their lives, for their health as well as for their social lives, were balanced to shape older people's drinking practices. There was also little examination of individual, social or contextual factors affecting care providers' views of and approach to older people's drinking within included studies; although through synthesising findings from studies across countries and care sectors it was possible to identify some intricacies. A deeper and more conceptual understanding of older people's drinking and related perceptions is required to advise responsive intervention within health and social care policy and practice.

### *4.5.2. Relationship between experiences of loneliness and alcohol use*

Loneliness is often cited as a factor affecting alcohol use in later life (23, 50, 207). Literature from care providers' perspectives offered narrative on links between older care recipients' drinking and experiences of loneliness, as detailed in [Section 4.3.2](#). However, none of the



studies reporting older adults' perspectives directly examined experiences of loneliness in relation to alcohol use. This may reflect a sense of stigma associated with isolation and loneliness, or the tendency of included studies to recruit from social groups. Consequently, the relationship between older adults' experiences of loneliness and their alcohol use is unclear. Loneliness was therefore examined further within the fieldwork study in working to conceptualise late-life drinking.

#### ***4.5.3. Care providers' insights into older adults' non-problematic drinking***

Narrative within studies reporting care providers' perspectives was rich with providers' reflections regarding problematic drinking, and of their practice, roles, and underpinning philosophies in addressing alcohol use amongst older care recipients. There was limited discourse regarding providers' understanding of older care recipients' non-problematic alcohol use as developed through their practices, of their insights into factors that might shape non-dependent alcohol use, and of the boundaries between problematic and non-problematic alcohol use amongst their older care recipients and how this defines their approach in practice. Further work drawing from care providers' perspectives and experiences regarding older care recipients' drinking has the potential to give further insight into older people's alcohol use, and factors shaping their drinking practices.

#### ***4.5.4. Drinking in non-temperance cultures***

The majority of this body of work examined perceptions of late life drinking in countries with a history of temperance. As such, the evidence base, and findings of these syntheses, are not rich in insights into older adults' alcohol use or related care practices in countries with no history of temperance. This is an area requiring further exploration, which was not possible within my UK-based fieldwork study.

### **4.6. Chapter Summary**

This chapter presented the findings of the review and thematic syntheses of qualitative studies reporting older adults' and care providers' views and experience of late-life drinking. Forty articles were identified for synthesis. Twenty-five articles studied the perspectives of older adults, and 15 examined care providers' perspectives. Material reported work conducted across 16 different countries. Despite issues regarding transparency in reporting, articles provided thick enough descriptions upon which to conduct a meaningful analysis. Findings of the synthesis of studies reporting older adults' views and experiences were

discussed in terms of four themes: routines and rituals of older people's drinking; self-image as a responsible drinker; perceptions of alcohol and the ageing body; and older people's access to alcohol. Differences between gender, countries, and wider social patterns were highlighted. Findings of the synthesis of studies reporting care providers' perspectives were explained in terms of four further themes: uncertainty as to whether addressing care recipients' risky drinking was a legitimate issue in care provision for older people; the influence of preconceptions of older drinkers upon detection and intervention with risky drinking; perceived sensitivity regarding the topic of alcohol as a barrier to discussing potentially risky drinking; and challenges in negotiating responsibility for addressing older adults' alcohol use. Provider- and country-specific patterns were highlighted. Factors serving to shape late-life drinking were identified within the syntheses. These related to cultural norms, roles and availability of alcohol, routines and their regulation, and perspective gained across the life course and through experiences in later life. Individual-level factors, such as socio-demographic characteristics, cultural identity, and work and living status also affected late-life alcohol use. Gaps in the current evidence base included conceptualisation of older adults' alcohol use and related perceptions; the relationship between experiences of loneliness and alcohol use; care providers' insights into older adults' non-dependent drinking; and drinking in non-temperance cultures.

## Chapter 5. Qualitative Fieldwork Methodology and Methods

### 5.1. Overview

Within this chapter, the fieldwork study design is explained and justified. Insights that guided the conduct of this fieldwork are detailed. The underlying methodology for fieldwork and analysis is discussed. Methods for recruitment, data generation and analysis are then described.

### 5.2. Specific Objectives and Research Questions Guiding Fieldwork and Analysis

The objective of this fieldwork was to examine older adults' and primary care providers' views of factors shaping drinking in later life and how they are influenced, particularly in primary care settings, through qualitative analysis of interviews and focus group data generated on the topic. Research questions for this thesis (detailed in [Section 1.4](#)) guided the conduct of this fieldwork.

### 5.3. Insights Guiding the Conduct of this Fieldwork

This fieldwork was designed and conducted in view of insights from the systematic review findings and involvement of patients and the public, as highlighted below:

#### 5.3.1. *Systematic review findings*

The influence of included studies' research methodologies upon study findings was considered in formulating my approach to this work. I reflected upon gaps in the current knowledge base (detailed in [Section 4.5](#)), and considered how my approach could be tailored to illuminate these areas. Particularly, the tendency for studies to recruit older adults from social groups meant that study participants were likely socially involved, resulting in a lack of coverage of links between experiences of loneliness and implications for alcohol use. This inspired inclusion of a recruitment pathway via patient lists at local general practices. These individuals would not necessarily engage in an active social life. Individual characteristics identified to affect older adults' alcohol use (highlighted in [Section 4.4](#)) influenced the fieldwork sampling strategy. Review findings highlighted areas for further investigation within fieldwork in order to develop a conceptualisation of late-life drinking (as described in [Section 4.5](#)). Findings within the review also guided exploration of potentially relevant social theories. Particularly, the concepts of 'biographical disruption' and 'othering' (introduced in [Section 2.4](#)) were examined as a result of review findings. Specific decisions influenced by

insights from the systematic review are highlighted in the methodology described within this chapter.

The findings of the systematic review did not contribute directly to analysis of fieldwork data. Fieldwork findings and developed themes were grounded in the perspectives of fieldwork study participants. However, as described, review findings contributed to the design of the fieldwork study, guiding data collection and analysis so that understanding of the topic could be progressed beyond that demonstrated in existing literature. Areas highlighted by review findings as requiring further exploration were kept in-mind during the data collection process, and influenced my line of questioning in discussion with participants. Review findings also equipped me with a pre-existing understanding of the topic, which alongside other perspectives I held influenced how I examined and understood data. Temporally, review findings were finalised during data collection and preliminary analysis for the fieldwork study, but before analysis was progressed and the coding framework and preliminary themes were developed. Findings from the review and fieldwork studies are triangulated within the discussion section of this thesis ([Section 7.2](#)), where unique contributions of each body of work are highlighted, and similarities and differences are explored and contextualised.

### ***5.3.2. Patient and public involvement***

Patient and public involvement (PPI) was sought to advise the conduct of this study, including methods and interpretation of data. The group of older adults consulted for advice possessed an invaluable understanding of the research topic through their own lived experience of later life and alcohol use. This group were representative of the population that would participate within this study, and that should benefit from the outcomes of this research. The consultation process was important in ensuring that the design and conduct of the research was aligned to the interests of this group. Their insights also informed how best to approach and discuss this topic and engage the target group with the project (208, 209). They advised the development of an effective recruitment strategy, appealing methods of participation, and topic guides that would incite meaningful and acceptable discussion. A project advisory group was formed from members of 'VoiceNORTH' (now 'Voice Global': a patient and public involvement group based in the North East, composed predominantly of retirees advising studies on ageing (210)). The group consisted of ten people aged 55-88

years, of which six were male and four were female. All of these individuals were white British, but came from a range of socio-economic positions. Most of the group were retired, but a small number remained in work, and many engaged in other voluntary activities. Members of the group had varying relationships with alcohol, ranging from abstinence to heavier use. The advisory group was consulted in face-to-face meetings and via email across the course of the study. They advised on developing research design and methods and data interpretation. Decisions made through consultation of the group are highlighted in the reported methodology that follows.

#### **5.4. Methodological Approach to Data Collection and Analysis**

##### ***5.4.1. Interviews and focus groups***

Semi-structured interviews and focus groups were selected as methods for data generation within this study. Through facilitating participants (older adults and primary care providers) to reconstruct and vocalise their perspectives on the topic, data could be collected on motivations, beliefs and decision processes underpinning their drinking or alcohol-related clinical practice (211). Both interviews and focus groups therefore offered the potential to generate data that could be examined to understand the factors determining these practices. These approaches were deemed suitable to explore the research topic in-depth, covering potentially sensitive topics.

Interviews and focus groups produced rich, complimentary data from both population groups, which can be triangulated for a more comprehensive understanding of the topic (212). Interviews provide an opportunity to gain a deep understanding of the individual, their perspectives, factors affecting these and how these components interplay with the individual's personal context (211, 213). Although focus groups are less conducive to a deep exploration of accounts, participant interaction within group settings can illuminate the topic of study. Focus groups enable participants to refine their views through discussion, facilitating the exploration of individual attitudes in the context of others' views. Attitudes are vivid within generated data, as discussion promotes their direct and explicit communication (213). Focus groups also provide a stage for social phenomena, demonstrating within generated data how social context shapes individual views and self-presentation (213). Given social factors such as behavioural norms influence drinking and

alcohol-related clinical practices (as indicated within the systematic review), such social phenomena provide helpful data for addressing the aims of this study.

The sensitivity of alcohol use as a topic of discussion, highlighted within the systematic review, was an important consideration in determining methods of data collection for the older adult group. Reflecting on attitudes shaping clinical practice within group settings may be sensitive, as care providers could be wary of critique of their approach from colleagues. To ensure rich data were generated, it was important to engage participants with this sensitive topic of study in a manner with which they felt comfortable. In-depth interviews are appropriate for examining delicate issues, and the private setting of an interview can facilitate discussion to venture beyond the limits of what is perceived to be socially acceptable (213). However, sensitive issues can also be explored in group settings if group members have similar relationships with the topic of discussion, and can provide 'safety in numbers' where one-to-one encounters may feel uncomfortable (213). Both approaches had been used successfully in studies included within the systematic review. The project advisory group suggested that preferences for style of participation within the study would differ from person to person. Participants were therefore offered the choice of taking part in an interview or a focus group.

#### *5.4.2. The approach taken to conducting interviews and focus groups*

Conducting interviews and focus groups involves facilitating 'conversation with a purpose', where free discussion is structured to give insight into how participants think about the topic of investigation (214). This process was aided by promoting rapport with participants and incorporating facilitative materials such as topic guides, timelines and vignettes to prompt focussed discussion. My reflections on gaps in the current knowledge-base (detailed in [Section 4.5](#)) influenced how I chose to approach conduct of interviews and focus groups.

Although interviews and focus groups do not resemble normal interactions, they are nonetheless human interactions. The relationship developed between myself and the participants therefore affected discussion. Rapport - a relaxed, cooperative and engaged relationship (215) - with participants is essential for the generation of rich data (216). I came to data collection having become familiar with participants during the recruitment process. Within data collection, I drew on commonalities between myself and participants, and took care to convey a manner that communicated trust, reassurance and likeableness (215). By

reciprocating a level of self-disclosure where relevant, I encouraged deeper disclosure on the part of participants, and avoided asymmetrical relationships that may create discomfort (217).

Focus groups carried an additional level of interaction as they involved multiple participants. Power dynamics within the group and how these might influence individual participants' engagement with discussion were a specific concern. Imbalances in power and status within a group can limit data generation by inhibiting individual contributions and promoting alignment with group consensus (213). I took care to draw together groups with sufficient commonality to form a basis for rapport between participants, facilitating interaction and disclosure to ensure generated data were rich, where complexities of the phenomena of study are evident (213). Older adult groups were drawn from the same gender and age range to minimise the potential for drastic differences in perceptions regarding alcohol use. Individuals were recruited for groups from the same social circle where possible, to increase the likelihood of pre-existing rapport. Similarly, care providers were recruited for groups as colleagues. Power imbalances can pre-exist within multi-disciplinary teams (218), such as those that are common in primary care. I therefore ensured I engaged different providers from multi-disciplinary teams on an individual basis, as well as in team focus groups where contrasting perspectives could be explored (213).

Interview and focus group discussion was semi-structured using topic guides, which were drawn upon flexibly as pools of questions to cover in response to the flow of discussion. Questions were compiled to prompt discussion which may address gaps in the existing knowledge-base. As such, these were designed to illuminate how different factors shaped older people's drinking practices; how individuals' perceptions influenced drinking or related care practices; specific roles of alcohol in older people's lives and contributions to their wellbeing; and care providers' insights into factors shaping non-problematic alcohol use. The resultant responsive line of questioning is detailed in [Section 5.5.4](#). Discussion was not limited to the predetermined agenda. Probes prompted discussion to examine arising issues in greater depth. This flexible approach allowed issues that were important to participants to be explored regardless of whether these areas were specified within the topic guide (219). This was particularly important for understanding the multifaceted roles alcohol played in older people's lives, and for examining the specific work of different primary care providers

in addressing alcohol use within their practice. As an identified gap in the existing knowledge-base, I looked to prompt older adults' discussion regarding the relationship between experiences of loneliness and alcohol use. Through reflecting on the influence of different methodologies upon topics covered in existing literature, I had concerns that stigma attached to the topic of loneliness may stifle discussion. As this topic represented just one area for enquiry, I prioritised promoting free discussion and disclosure regarding the whole picture of alcohol in the lives of older adults through nurturing rapport with participants. As such, I took care in navigating this topic, guiding participants to explore their views and experiences to introduce the concept or related perceptions themselves, rather than labelling their experiences with this potentially stigmatising term (the practicalities of this approach are described in section [5.5.4](#)).

Timelines and vignettes were included within interview and focus group schedules to facilitate discussion. Timelines have been utilised to aid qualitative exploration of substance use in other studies (220). They were employed in one-to-one interviews with older adults to explore patterns and changes in drinking practices across the life course, particularly within later life, and the context within which these took place. This exercise promoted meaningful engagement with the research process amongst participants (221). Timelines supported participants in re-constructing their views, situating their perceptions within the context of their wider life experience (222) and facilitating them to analyse and reflect on their perceptions (221, 222). Timelines created a collective memory, shared between myself as the researcher and the interviewee, facilitating momentum by enabling us both to revisit topics for further discussion (221, 222). Vignettes were formulated to provide concrete examples for discussion with care providers. Stories about hypothetical patients' drinking practices were developed through consultation with the literature and clinical colleagues, conveying plausible scenarios that were relevant to care providers' practice. In response to identified gaps in the existing evidence base, constructed cases were challenging, with risks and benefits of alcohol evident in the lives of the hypothetical patients to incite verbalisation of providers' perceptions of the borders of 'risky' drinking, and how they justified decisions regarding intervention. Each vignette provided enough context for participants to form an opinion, with enough uncertainty to prompt participants to identify additional factors that may influence their decision (223). Vignettes prompted discussion of the knowledge, beliefs and attitudes that underpinned participants' responses (223, 224), and engaged less



dominant focus group members, providing a medium upon which they could comment and contribute to discussion (223).

### *The value of qualitative interview and focus group data*

Within interviews and focus groups, data are actively generated through re-construction of participants' views, as the researcher and participant (and other focus group participants) interact (211). Interviews and focus groups represent social encounters (217). These interactions determine the topics covered within collected data by directing discussion. Interviews and focus groups attempt to access underlying issues via the medium of reconstructed individual perception. In keeping with the critical realist orientation of this research (discussed in [Section 2.2](#)), it is important to re-emphasise here that we cannot assume a full understanding of phenomena from this data (217). However, the methodological approach taken here was designed to facilitate the deepest possible understanding of late-life drinking practices.

### *5.4.3. Sampling strategy*

Purposive sampling was undertaken to promote diversity in the perspectives of study, facilitating a deeper understanding of the topic through analysis (225, 226). Sampling characteristics were identified based on their potential to influence drinking and related care practices, as indicated within the systematic review and through consultation of the Study Advisory Group. Maximum variation was sought for these specified characteristics, promoting diversity within the data. Different perspectives could be examined, and the influence of sample characteristics on perspectives could be explored to understand the role of these influencing factors (227). To ensure maximum recruitment and a diverse sample relative to the characteristics specified for purposive recruitment, older adults were recruited via a number of different pathways. As highlighted within [Section 5.3.1](#), gaps were identified within the existing literature base regarding older adults' perspectives surrounding the relationship between experiences of loneliness and alcohol use. Obtaining measures of loneliness from participants involves administering an additional questionnaire (228). Discussion of factors affecting alcohol was the main focus for data generation. Alcohol use was already being extensively measured along with a long list of demographic characteristics that may affect perceptions (see [Section 5.5.3](#)). So as not to overburden participants with additional measures, and to avoid affecting participation by explicitly touching upon another

stigmatising topic such as loneliness (as discussed in [Section 5.4.2](#)), I worked to access individuals who may be able to offer insights into the relationship between experiences of loneliness and alcohol use via my approach to recruitment; rather than through any specific sampling strategy. As such, two recruitment pathways were designed to engage older adults who were more likely to be socially isolated (as highlighted within [Section 5.5.3](#)) to increase the potential for generating data regarding older adults' experiences of loneliness (which can be associated with social isolation(229)) and alcohol use. I also ensured that older adults living alone represented a substantial proportion of the sample, as individuals potentially more likely to experience social isolation and associated feelings of loneliness (229).

Primary care providers were sampled based on their profession. This study aimed to consult a cross-section of different providers working to address risky drinking amongst older patients and clients. A pragmatic decision was taken not to apply further sampling criteria to this group, as it was envisaged that recruitment may be difficult due to time pressures associated with care provision. However, further care provider characteristics likely to influence their views about alcohol were recorded to advise analysis. As exploration of potentially influential characteristics was lacking in the existing qualitative evidence base (as highlighted in [Section 4.5.1](#)), I drew upon broader literature to identify such characteristics to advise data collection (including work by Kaner et al (230), McCormick et al (231), and Gilje Lid et al (232); characteristics listed in [Section 5.5.4](#)).

Data were collected until the data corpus was deemed to reach theoretical sufficiency. This term, coined by Dey (233), is described as the point at which data reach conceptual density, where analysis has reached a sufficient depth of understanding with which to build a theoretical conceptualisation (234). The term emerged in response to critique of the typically stated goal of qualitative research, 'saturation', which refers to the idea that fresh data would not provoke further theoretical insights or reveal novel properties within developed themes (235). This concept is not compatible with the critical realist orientation of this research. Knowledge and theoretical conceptualisations are deemed to be fallible due to the filter of individual perspective and the effect of contextual factors on the manifestation of underlying mechanisms (73). The concept of 'saturation' therefore represents an over-simplification of knowledge acquisition and would communicate a false sense of completeness within any theory developed through analysis (234). In being guided

by theoretical sufficiency, the sample size was led by the data that were collected, where new data added little additional insight into arising issues.

#### *5.4.4. Data analysis*

The approach taken to qualitative data analysis was grounded in the principles of Braun and Clarke's thematic analysis (146). Techniques described in Charmaz's grounded theory approach (235) were incorporated to deepen analysis and progress the developed conceptualisation to understand the intricacies of factors shaping older people's drinking and related perceptions beyond the descriptive narratives offered within existing literature (as discussed in [Section 4.5.1](#)).

Thematic analysis is a flexible approach, drawing upon generic methods of qualitative analysis to identify and examine patterns (reported as themes) within the data. Data are organised efficiently, and themes are explained with rich contextual detail (236). The methods encompassed within this approach can be employed to explore psychological and social interpretations of the data (146), which are both relevant in addressing this study's research questions.

Thematic analysis is compatible with a range of philosophical orientations (146). It is therefore important to position this analysis and developed findings within the context of the philosophical stance and associated assumptions (146). In taking a critical realist stance (described in [Section 2.2](#)), this analysis examines how people make meaning of their experiences and how these meanings are shaped within a broad social context. Participant perspectives are explored to unpick the surface of reality and identify underlying causal mechanisms (146).

Constant comparison helped refine my conceptualisation of the data through comparing instances to instances, and then conceptualisations of instances to instances (235). This method enabled me to consider the influence of context upon older people's drinking and care providers' practices (213). Negative case analysis helped to encompass different manifestations of phenomena within my conceptualisation through examining instances that appeared to contradict my developing understanding (237). Memos and jottings provided a medium where my developing understanding could be examined and abstracted through articulation (70, 235).

This analysis employed an inductive approach, examining patterns existing within and across the data to begin to construct a theoretical conceptualisation of the phenomenon (238). Associated theoretical perspectives (detailed within [Section 2.3](#)) were identified from emerging findings to aid further interpretation and conceptualisation of the data. Identified themes were therefore grounded within the data. Although early coding was guided by the research questions of this study, I repositioned the focus of analysis as I developed an understanding of the phenomenon through engaging with the data. As discussed in [Section 2.6](#), I initially looked to explore how older people's drinking and related health and social care practice were shaped through reasoning of perceived positive and negative consequences of using alcohol. However, as I came to understand external and unconscious influences on drinking practices, I broadened the analysis to examine these factors.

In conceptualising the mechanisms underpinning patterns observed within the data, I worked towards an interpretative level of analysis. Understanding of the data was progressed beyond a semantic level through drawing on principles of grounded theory and engaging with relevant literature and social theory. Claims made within the analysis are therefore grounded within, but reach beyond, the surface value of the data (146).

#### ***5.4.5. Reflexivity***

In keeping with the constructivist perspective underpinning this work, it is acknowledged that I, as the researcher, played an active role in constructing generated data and the findings presented within this thesis (239). My own individual perspective of the topic contributed to developed research questions, my chosen methods of inquiry, my interpretation of data, and how findings are framed (240). Through engaging in reflexive thought, I explored my position and reflected upon the influence this may have had upon my work. This process ensured that I was able to provide a transparent account of study findings, and how these arose.

### **5.5. Methods**

#### ***5.5.1. Ethics and governance***

Ethical approval was received in November 2016 from the East Midlands – Nottingham 1 Research Ethics Committee (reference: 16/EM/0435) and from Newcastle University (reference: 9525/2016). Health Research Authority approval was received in January 2017, authorising the involvement of the Clinical Research Network in this study's recruitment

process. The approval letters are provided in appendices [H](#), [I](#) and [J](#) respectively. As required by NHS ethical approval, each prospective participant was given an information sheet explaining the study to ensure consent to participate was appropriately informed. These information sheets (specific to older adult or care provider interview or focus group participation) detailed the reasons for and aims of the research, criteria for participation, procedures involved in participating, and who to contact with any queries (see [Appendix K](#)).

### *5.5.2. Sample criteria*

#### *Older adults*

Adults aged 65 years or over who had consumed alcohol at some point in their life and lived in the North East or North Cumbria, England were eligible to participate in this study. Individuals who were identified as possibly dependent upon alcohol or indicated that they had previously engaged in treatment for alcohol misuse were excluded from the study for reasons described in [Section 1.3.1](#). Possible dependence was identified through responses to the Alcohol Use Disorders Identification Test (AUDIT), specified by a score of 20 or higher (241). Due to issues relating to informed consent and participant engagement, individuals who had received a formal diagnosis of dementia were excluded from the study.

#### *Care providers*

Primary care providers working with older people within the community who may consume alcohol at a non-dependent level were eligible to participate within this study. Care providers working exclusively with substance misusers were excluded from this study, as their perceptions were unlikely to relate to the population of interest (non-dependent alcohol users).

### *5.5.3. Recruitment strategy and sampling*

#### *Older adults*

Older adults were recruited via four different pathways:

Pathway 1: Advertisements were produced for dissemination in materials accessed by older adults, including elders' council and rotary club newsletters ([Appendix L](#)).

Pathway 2: Social groups were contacted in order to arrange recruitment presentations, where the study was explained to potential participants and recruitment materials were

disseminated. Groups were approached if they were likely to include individuals with characteristics relevant to those identified for purposive sampling (detailed further below).

Pathway 3: With the involvement of the local Clinical Research Network (CRN), invitation letters were disseminated to individuals who were eligible for inclusion on the patient lists of general practices within the study area. As this strategy was employed later on in the recruitment process, practices were identified for involvement if they had high proportions of patients meeting remaining purposive recruitment criteria. Practices with patients who were likely to be socio-economically deprived and/or minority ethnic were selected, as these groups were poorly represented within the sample attained at that point.

Pathway 4: Recruited participants were supplied with study invitation letters for dissemination to eligible individuals within their own networks.

Pathways 1 and 3 were designed to engage individuals who may be socially isolated; as social connectedness is not prerequisite to receipt of a newsletter or listing with a general practice.

Interested individuals made initial contact via telephone, email or post using details provided within recruitment materials. Upon this contact, the individual was screened against eligibility criteria and demographic data were collected with which to advise purposive sampling of prospective participants. The individual's preference for interview or focus group-based participation was also recorded. Contact details were taken, and the participant was mailed the appropriate participant information sheet, consent form and AUDIT for completion. Following the return of these materials, selected individuals were contacted to make arrangements for their participation in the study.

Older adults were sampled for maximum variation in the following characteristics:

- Age strata (65-74 years, 75-84 years, 85 years and over)
- Sex
- Self-reported pattern of alcohol use – indicated by participants' self-ascribed label for their alcohol use (i.e. 'frequent', 'occasional' etc.)
- Level of socio-economic deprivation - gauged as a crude indicator of socio-economic status based on the individual's post code using the English Indices of Deprivation. This

index provides a measure of local area deprivation based on income, employment, education, health care, disability, crime, housing and living environment (242).

- (Former) occupation - categorised using the International Standard Classification of Occupations based on self-reported (former) job role (243). This detail was taken as an additional indicator of the individual's socio-economic status, as the English Indices of Deprivation reflects the individual's living location and is not specific to personal circumstances.
- Health status - self-reported from 1 (terrible health) to 100 (perfect health)
- Living context: alone or with others
- Location: self-reported rural or urban
- Ethnicity
- Religion
- Work status: retired, semi-retired, part time, full time

Data corresponding to these sampling criteria were recorded for each participant in a sampling grid, which was kept up-to-date across the course of the data collection period.

This grid highlighted characteristics that remained underrepresented within the sample, and directed further recruitment and participant selection. Within this study, individuals with a lower socio-economic or minority ethnic status were initially difficult to engage. Such under-represented criteria were targeted with further recruitment efforts through pathways 2 and 3.

### *Care providers*

Invitation letters were circulated alongside a participant information sheet via email within my professional network and across the local Clinical Research Network. Professions identified for sampling were general practitioner, district and practice nurse, health care assistant, pharmacist, dentist, social worker and social care provider. Primary care providers specified for consultation who proved difficult to engage within the study, such as social care providers, district and practice nurses, dentists and pharmacists, were targeted via flyers distributed on social media (Twitter and Facebook, provided in [Appendix M](#)). Interested care providers made initial contact using the details provided in recruitment materials. Those who got in touch were asked to specify their preference for an interview or focus group (with colleagues).

### *Gauging theoretical sufficiency*

Ideas and topics of importance were recorded in field notes during data collection. This guided my assessment of the adequacy of accumulated data for theoretical conceptualisation, to gauge at what point theoretical sufficiency was reached and therefore at what point data collection should cease.

#### *5.5.4. Interview and focus group process*

Interviews and focus groups were arranged at a time and location specified by the participant for their comfort and convenience. Data collection took place either at the individual's home, within the university or in a care setting. Care providers completed a data collection form prior to participating, detailing demographic information which provided contextual information to advise data analysis. These characteristics included: rurality of practice area, years spent in care provision, gender, age, ethnicity, religion and self-labelled drinking status (i.e. moderate, social, binge, light, infrequent – because care providers' alcohol use is known to affect their attitude towards drinking (231)).

Before beginning each interview or focus group, I explained the process of taking part and highlighted the focus of discussion. Particularly, care providers were directed to respond regarding their perspectives non-dependent older drinkers, to ensure generated data addressed the aim of this research, and gaps in the evidence base for care providers' understanding of older people's drinking. Written, informed consent was sought from each participant for the audio-recorded interview or focus group. All participants agreed to audio-recording.

Topic guides were constructed and utilised as a tool to focus discussion and elicit responses that helped illuminate the research topic. Questions were initially designed to gather data that built upon the understanding, and gaps in understanding, established through the systematic review phase of this study. Questions for older adults were centred around older adults' own drinking practices, to incite contemplation, reflection and articulation of perceptions affecting their practices; how they positioned their drinking practices; the weight of different influencing factors upon their drinking practices, and the contributions of alcohol to their own lives. Questions guided exploration of older adults' views of the effects of alcohol for their physical and mental health and wider wellbeing, and looked to examine potential knowledge sources affecting their perceptions and attitudes. Questions for care



providers guided discussion of their perceptions regarding positive as well as negative effects of alcohol for their older care recipients. Care provider topic guides were designed to incite articulation of circumstances under which older care recipients' drinking does and does not prompt intervention, and underlying perceptions. For both participant groups, I probed to establish underlying reasons for their perspectives, and the influences of these perspectives upon their drinking or related care practices. Across the course of data collection, I actively took a critical view of participants' responses; probing to establish the direction of causality between perceptions about alcohol, and associated drinking or related care practices. As the relationship between alcohol and loneliness was not explicitly prompted by the content of topic guides for older adults, I listened for potential indications that loneliness may be an explanatory factor in older adults' alcohol use. I directed discussion to prompt older adults to divulge on the topic where I perceived this may be relevant. In discussion with care providers, I probed to explore how they tailored their responses to older adults' alcohol use based upon the roles of drinking in their lives. This was aided by vignettes, discussed later in this section.

As my understanding progressed during early data collection and analysis, I amended my guides to examine arising issues requiring further exploration through related data. Wording was adapted for interviews and focus groups with the different populations (older adults and primary care providers). The areas covered within these guides were aligned to aid comparison between these groups. Developed topic guides are available in [Appendix N](#). Topics of discussion with each participant group are presented in Box 5-1.

*Box 5-1 Overview of topics covered in discussion with older adults and care providers during data collection*

**Older adults:**

- How would you describe your drinking? *Participants typically began by providing a label for how they used alcohol, e.g. 'moderate'. I probed in response to gain details of what was consumed in what amounts in which contexts and how frequently.*
- How do you gauge what type of drinker you are?
- Do you consider anything before you drink?
- What are the upsides and downsides to using alcohol? How do you know about these? How do these effect the way you use alcohol?
- Has anybody influenced the way that you use alcohol?
- Can you describe any interactions you have had with care providers about your drinking? What did you think about these interactions?
- Are there any other contexts where you have discussed the way that you use alcohol?
- What particular reasons would you give for drinking the way that you do?

*In focus groups settings, older adults were encouraged to respond in terms of the older population generally, and were not instructed to provide personal responses.*

**Care providers:**

- What do you think about alcohol?
- Are there any specific considerations for practice surrounding older people's alcohol use?
- What happens when you give advice to older people about their drinking?
- What effects whether you give advice to your older patients about their drinking?

Timelines were incorporated within one-to-one interviews with older adults. The task required participants to communicate, visually and verbally, times when their drinking had changed since birth. I discussed the context and reasoning behind these changes with participants, and referred back to what was discussed across the course of the interview.

Vignettes describing hypothetical patients' non-dependent drinking practices were introduced into discussion within interviews and focus groups with care providers (provided in [Appendix O](#)). These cases incorporated both potential risks and benefits attached to hypothetical patients' alcohol use, to incite articulation of providers' perceptions, and the influence of different characteristics of patients' drinking upon their responses in practice. Care providers were asked to explain their suggested approach to the patient and their underlying considerations.

All interviews and focus groups were audio-recorded and transcribed verbatim, ensuring I was able to focus on interactions and data generation whilst retaining a detailed record of the discussion for analysis. Written field notes were recorded to provide context to aid interpretation of the data.

## 5.6. Methods of Data Analysis

Data collection and analysis were conducted iteratively. Data collection and earlier stages of analysis occurred concurrently. I periodically took stock of the data to identify emerging themes and developing conceptualisations, so that these could be explored through further

data collection. I limited interviews and focus groups to two per week, integrating pauses between waves of data collection. This allowed time to process data, reflect and conduct early analysis. I took a case-oriented approach to preliminary analysis, looking to explain each data item in terms of the research questions and other details relevant to understanding the data (244), whilst periodically looking across cases to develop my understanding (70).

The employed thematic analysis consisted of a number of recursive phases, as described by Braun and Clarke (146). I familiarised myself with the data through the processes of data collection, cleaning and anonymising data transcripts and immersion through repeated and active reading, where I considered meaning and patterns within the data. From these initial ideas, I then began to identify ‘codes’, or concise labels, for basic elements of patterns identified within the data that helped to address the research questions (236). This initial phase was documented in a tabulation (items for tabulation presented in Box 5-2), ensuring developed codes were tied to the data, but also addressed the stated research questions. Case maps were produced for each data item. These maps visualised how ideas and codes were interrelated and helped to conceptualise factors shaping drinking and alcohol-related clinical practices for each interview and focus group (see [Appendix P](#) for an example).

*Box 5-2 Categories guiding initial coding for each data item*

<b><u>Older adults:</u></b>	
<ul style="list-style-type: none"> <li>• Perceived positive consequences from alcohol use</li> <li>• Perceived negative consequences from alcohol use</li> <li>• Considerations shaping drinking practices</li> <li>• Priorities underlying drinking practices</li> <li>• Engagement with health professionals</li> <li>• Self-identity (as influencing alcohol use – could include self-labelled drinking style, health status)</li> <li>• Individual’s pattern of drinking</li> <li>• Risks in reported drinking practices</li> <li>• Changes in drinking</li> <li>• Other notes</li> </ul>	
<b><u>Care providers:</u></b>	
<ul style="list-style-type: none"> <li>• Perceived positive consequences from patient or clients’ alcohol use</li> <li>• Perceived negative consequences from patient or clients’ alcohol use</li> <li>• Considerations shaping approach to patient or clients’ alcohol use in practice</li> <li>• Priorities guiding approach to patient or clients’ alcohol use in practice</li> <li>• Perceived risk factors attached to alcohol use in later life</li> <li>• Perceptions of older drinkers</li> <li>• Who is responsible for addressing risky drinking amongst older adults?</li> <li>• Other notes</li> </ul>	} Each recorded for general patient or client group, and older patient or client group

Recorded codes were examined to consider how they might be categorised into explanatory themes. Case maps were also examined to identify common factors across data items, and how factors might differ between contexts. This helped me to develop an overarching conceptualisation of the data that encompassed similarities and differences between cases. I further developed my ideas through considering relationships between codes, and then potential categorisations of codes (themes) and groupings within these (sub-themes). I used a visual representation to aid this process, grouping codes (recorded on post-its) that explained patterns in findings within and across cases and connecting links between these. This phase produced a collection of candidate themes and sub-themes, representing a broader unit for data analysis to guide further interpretation (236). Themes and sub-themes were applied systematically to each transcript (focussed coding) in order to categorise data and collate evidence with which to review and develop my conceptualisation through themes (see [Appendix Q](#) for a record of how this sorting process came to develop candidate themes and subthemes). NVivo 11 (164) was utilised for data management during this process of focussed coding. Having applied the developed coding framework to the data, themes were refined. Sub-themes deemed redundant during focussed coding were removed, and any additional explanations were incorporated. The content of themes was reorganised in reflection of this coding process, ensuring each theme told an internal story distinct from others in content and explanatory value. Themes were then defined, and further refined in reflection of their consisting data. Memos (described later) and corresponding data extracts were collated for each theme, and organised to produce a consistent narrative with accompanying exemplary extracts. In this phase, I looked to define the meaning of each theme, the underpinning assumptions, associated implications, and the conditions and context that gave rise to the occurrence of underlying mechanisms. I also examined why concepts were presented in the way that they were within the data, and looked to determine the overall story conveyed between the themes about the topic (146). The story underpinning these themes was then crafted to produce the findings reported within this thesis, with data extracts provided to aid their portrayal.

Jottings and memos (as described by Charmaz (235), and Miles and colleagues (70); introduced in [Section 5.4.4](#)) helped to record and crystalize my understanding, providing a medium to progress my understanding to a higher level through articulation and active exploration of the data across the process of analysis (70). Early jottings recorded brief

notes, where I reflected and commented on the data as they were collected (70). As my understanding progressed to the point where I could begin to conceptualise and consider potential themes, I elaborated my understanding into memos. Within memos, I developed assertions (declarations about the data) and propositions (interpretive proposals such as if-then or why-because statements grounded in the data that progress understanding towards theoretical conceptualisation (70)). Exemplar quotes were also examined within memos, facilitating me to ground my developing understanding and conceptualisation within the data. I also examined constant comparisons and negative cases within these memos (235). In the later stages of analysis, clustering (comparable to mind-mapping, (235)) was used as a technique to help visualise and finalise my conceptualisation of developed themes for reporting.

Constant comparisons and negative case analysis were employed as techniques to deepen my understanding of the data and mechanisms underpinning identified patterns (introduced in [Section 5.4.4](#)). Within constant comparison, accounts were compared and contrasted within and between data items. Active examination of the data was guided by suggestions cited by Charmaz (235) to examine:

- Common meanings underpinning contrasting narratives
- Subtle differences between comparable narratives
- Contrasting narratives within individual data items, for example between focus group participants, and across an older adult's life course
- Systematic differences between groups of participants. These included comparisons guided by factors suggested to effect drinking and care practices emerging from the data, or within the literature, such as age range, gender, level of alcohol use, socio-economic status, mental health state, loneliness and social isolation, care profession and years in practice. Particularly, I ensured my analysis was sensitive to the effect of individual, social and contextual factors upon care providers' views of and approach to older people's drinking (addressing a gap in current understanding highlighted in [Section 4.5.3](#)).
- Different manifestations of developing concepts, for example instances of othering (introduced in [Section 2.4.3](#)) where participants presented their drinking as less risky than a) other people and b) their alcohol use earlier in life.

- Uniting and contrasting elements within and between themes
- Discrepant cases
- My own interpretations versus participants' stated perspectives
- Defining static factors and dynamic processes

Tendencies within the data were examined for deeper interpretation through consulting others and relevant literature. I discussed data with other researchers, my supervisors, and the Project Advisory Group to explore alternative interpretations of my data, helping me to develop my understanding and conceptualisation. In adopting a more inductive approach to analysis, I used concepts identified within data to guide exploration and integration of relevant theory. Theoretical constructs were drawn upon to clarify rather than shape my analysis (235), including Bury's theory of biographical disruption (84), and Bourdieu's theory of practice (described in [Section 2.4](#)).

#### ***5.6.1. Methods for reflexivity***

Across the research process, I kept a reflexive journal. This gave me the space to explore my views on the topic of study, and how this may have affected my conduct of the work and developed findings. Supervisory meetings provided a context where my plans and conduct of this study were discussed. My own perspectives were revealed and challenged through discussion of my supervisors' divergent perspectives (76). Key considerations from this process for data and study findings are provided within [Section 2.6](#).

### **5.7. Chapter Summary**

This chapter presented the methodology and methods for the fieldwork study. This work aimed to examine older adults' and primary care providers' views of factors shaping drinking in later life and how they are influenced, particularly in primary care settings. Considerations from the systematic review, and input from the study advisory group, influenced decisions for the approach to and conduct of this work. Data were generated through semi-structured interviews and focus groups, enabling in-depth exploration of the topic. Timelines and vignettes were utilised in discussion with participants to aid exploration of their perspectives. Older adults and care providers were sampled purposively via several recruitment pathways, guided by factors identified to shape late-life drinking and related perspectives within the review. Data were collected until theoretical sufficiency was reached. The approach to analysis of fieldwork data was grounded in Braun and Clarke's

thematic analysis (146), and drew upon techniques described in Charmaz's grounded theory (235) to deepen analysis. I explored and reflected upon my position regarding the research topic and its potential influence upon my work across this process.

## Chapter 6. Qualitative Fieldwork Results

### 6.1. Overview

In this chapter, the demographics of study participants are provided, and an overarching conceptualisation of older people's drinking practices is explained. The findings underpinning this conceptualisation are then presented in terms of four themes: 1) socially-situated drinking practices; 2) established and disrupted drinking routines; 3) roles of drinking in late-life socialisation, leisure and wellbeing; and 4) tangibility of health risk from alcohol use. Each theme is discussed in turn, and quotations from the data are provided to illustrate their content. Relationships between the themes are highlighted, patterns relating to participant characteristics are discussed, and coherence and disparities between care providers' and older adults' perspectives are detailed.

### 6.2. Participant Demographics

A total of 24 older adults and 35 health and social care providers participated in this study. Fifteen older adults participated in one-to-one interviews, and nine older adults participated in one of two focus groups. Eight care providers participated in one-to-one interviews, and 27 participated in one of five focus groups. At this point, the data were deemed to have reached theoretical sufficiency (discussed in [Section 5.4.3](#)), as further data items were adding little additional insight to my developing understanding. The duration of recordings of interviews and focus groups ranged between 17-200 minutes (interviews with older adults 43-200 minutes; focus groups with older adults 75-96 minutes; interviews with care providers 17-70 minutes; focus groups with care providers 32-43 minutes).

Sample characteristics are described below for each of the participant populations, and portrayed visually in Figures Apx-R-1 (older adults) and Apx-R-2 (care providers) in [Appendix R](#). Individual participant demographics are detailed in Tables Apx-S-1 (older adults) and Apx-S-2 (care providers) in [Appendix S](#).

#### 6.2.1. Older adult sample characteristics

The age of participating older adults ranged from 66-89 years. There were equal numbers of men and women in the sample. Participating older adults were almost exclusively white British with the exception of one Indian participant. Most participants identified as Christian (particularly Church of England), with around a fifth identifying as atheist or not specifying any religious identity. Most participants rated their health highly, with a few reporting poor



health. As can be expected from the 65+ age group, almost all participating older adults were retired, with the exception of three individuals who still retained some work responsibilities. Most of the older adults lived in urban areas, with a quarter from rural environments. Similar numbers of participants lived with a partner as lived alone. Of those living alone, just under two thirds were widowed; the rest were divorced. Participants came from a range of socio-economic positions, although a small majority were socio-economically advantaged, as indicated by their location and former occupation. Participants came from a variety of (former) occupations, however as might be expected from a more socio-economically advantaged group, there was a high proportion of (former) professionals and managers in the sample, relative to other occupations.

Most participating older adults reported using alcohol frequently, which is reflective of the majority of the older population within the UK (24). Just under a third of participants only consumed alcohol occasionally, with one participant reporting 'binge' use. Participants' Alcohol Use Disorders Identification Test (AUDIT) scores indicated that they were all either lower- or increasing-risk drinkers. However, numerous potential risks relevant to participants' alcohol use were identified within fieldwork data (detailed in [Appendix S](#), Table Apx-S-1). These were not always indicated by participants' AUDIT scores. Identified risks included weekly intake in excess of alcohol-use guidelines (five participants), binge use of alcohol (nine participants), co-use of alcohol with medications or conditions that may be negatively affected by alcohol use (13 participants), and driving following intake that I felt may have taken the individual beyond lawful limits (five participants).

Most older adults were recruited either via advertisement or presentation to social groups, with around a fifth recruited via their GP and one interviewee recruited by another participant. The two focus groups were made up of three unconnected women over 85 years of age recruited from an organisation for older adults (Focus group 1) and six men who were recruited as members of the same social group (Focus group 2).

Pseudonyms are used in presenting individual participant characteristics and quotes.

### ***6.2.2. Care provider sample characteristics***

Participating care providers included general practitioners (GP), practice nurses (N), district nurses (DN), health care assistants (HCA), pharmacists (Ph), dentists (DEN), social care

practitioners (SW) and domiciliary care providers (Car). Care providers are numbered by profession (as labelled) in presentation of individual characteristics and quotes. Most provider types contributed to two items of data (interviews and/or focus groups), although GPs were involved in four data items, and domiciliary care providers and social care practitioners were only represented in one data item each (both team focus groups). Participating care providers were mostly under the age of 40 years, although five of this sample were from the older age group themselves. Providers had practiced for between three and 40 years. Over two thirds of participating care providers were female. Most were white British, with two participants of black British and one of black African heritage. Similar numbers of care providers practiced in rural and urban areas, and in socio-economically deprived and advantaged areas. Most participating care providers described their own alcohol use as either moderate or lower level, with four participants identifying as non-drinkers and one participant describing their drinking as binge use.

Details of practice relevant to different care providers' work with older care recipients were identified within their narratives, and are tabulated in Table Apx T- 1. These factors affected care providers' understanding of and approach to addressing older care recipients' alcohol use. They included:

- How alcohol-related discussion was systematised and incorporated within their care practice. Screening for risky drinking was systematised within the work of health care assistants, pharmacists, dentists and social care providers. Intervention to address alcohol use was systematised within the work of practice nurses and pharmacists; and feedback regarding level of intake was systematised within the work of dentists. Alcohol-related discussion and intervention was relevant in managing particular issues in general practice and social care provision. Alcohol-related discussion was not systematised within the work of domiciliary care providers.
- Providers' level of training regarding alcohol-related health risks and intervention relative to other providers in the sample. General practitioners, practice and district nurses and social care providers had high levels, and pharmacists very high levels of training. Health care assistants and dentists had relatively low levels of training regarding alcohol-related health risks and intervention. Domiciliary care providers reported having received no training.

- Notes on providers' perception of their professional accountability, and role in the care system for addressing non-dependent drinking. Details are provided within Table Apx T- 1, and highlighted where relevant within reported findings.
- Supportive materials available to the provider for alcohol-related health risk screening and discussion. Practice nurses, health care assistants and dentists utilised Alcohol Use Disorder Identification Tests (AUDIT). Dentists working in private practice used the Denplan Previser Patient Assessment (DEPPA) – an oral health risk screening tool that included an assessment of alcohol-related risk to oral health, giving a coloured grading of patients' personal risks of specific diseases given their current behaviour. GP7 utilised his practice's software, SystmOne, which provided a visual indicator of risk from patients' reported alcohol intake.
- Signs indicative of potentially harmful alcohol use available to the provider through their practice. Care recipient presentation could indicate harmful alcohol use, and was available to all providers. District nurses, social care providers and domiciliary care providers had access to additional signs within care recipients' home environments; such as empty drinks bottles. General practitioners, practice nurses, health care assistants, dentists and social care providers had access to alcohol use screening test results. General practitioners and practice nurses also had access to additional potential indicators of excessive alcohol use; such as blood test results. Dentists could identify signs of heavy alcohol use during oral examinations. Pharmacists discussed care recipients' level of intake, and were aware of relevant medicines and medical conditions that may mean alcohol poses heightened risks when used by the individual. General practitioners were also aware of individual patients' medicine use and medical conditions.
- Frequency of providers' interactions with individual care recipients. General practitioners, practice and district nurses saw older patients on a variable basis, which could reach up to several times per year. Health care assistants saw older patients less frequently during health checks. Pharmacists saw older care recipients annually for medicine use reviews if they were using higher risk medicines, or over four medicines concurrently. They also interacted with older adults more frequently when dispensing medicines. Dentists saw their older care recipients once or twice annually. Social care providers generally worked with their older care recipients for

concentrated periods. Domiciliary care providers generally saw their older clients weekly or more frequently.

- Whether the provider worked exclusively/predominantly with older people. District nurses, health care assistants, pharmacists, social care providers and domiciliary care providers reported working exclusively or predominantly with older people; whilst general practitioners, practice nurses and dentists did not.

Details relevant to understanding intricacies in the findings between different providers are highlighted within themes.

Most participating care providers were recruited via my own university links. Ten were recruited via advertisements on social media, and one responded to an invitation circulated by the Clinical Research Network. Participating care providers stated varying levels of professional concern for older care recipients' alcohol use. GP7 and Ph2 expressed a specific interest in working to identify and address older care recipients' alcohol use.

Focus groups were made up of 10 members of a general practice team (Focus Group 3), 5 members of a team of social workers working specifically with older adults (Focus Group 4), three members of a team of dentists (Focus Group 5), seven dentists completing their training (Focus Group 6) and two members of a team of domiciliary care providers (Focus Group 7).

### **6.3. Conceptualising Drinking in Later Life**

The conceptualisation of factors shaping older people's drinking developed through this analysis is portrayed in Figure 6-1.

Older people's drinking practices were shaped by perceived societal expectations for appropriate alcohol use, learned socially across the life course. This formed a 'habitus' – a taken for granted pattern of behaviour - that disposed particular tendencies in their alcohol use. The motives underpinning older people's drinking practices were therefore socially-situated.

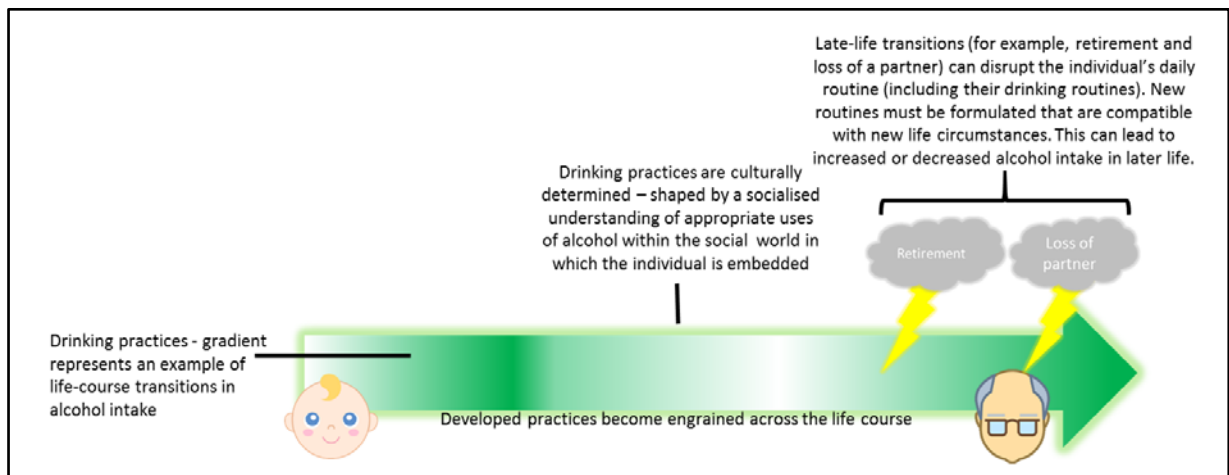
Older adults' alcohol use became embedded within their day-to-day routines, reflecting their view of socially appropriate alcohol use given their social identity, responsibilities, health

and resources. Common late-life transitions could cause changes to older adults' alcohol use, as day-to-day routine was disrupted and their personal circumstances changed.

Both older adults and care providers generally valued the roles of drinking in older adults' social and leisure lives, particularly in the face of late-life transitions where the roles of drinking could become more important to their social and mental wellbeing.

Health risks associated with drinking were rarely a priority in older adults' alcohol-related decisions and associated practices. The responsible self-image created through their socially appropriate drinking practices meant that risks associated with alcohol use were deflected to 'problematic' drinkers, and seen to be irrelevant. Only risk messages perceived to be personally relevant, given their individual health concerns and personal circumstances, prompted any changes in older adult's alcohol use motivated by associated risks. Surviving until late-life was seen as evidence that their alcohol use was harmless. Exposures to the positive or negative alcohol-related experiences of others with relatable drinking practices and personal circumstances led older adults to reflect upon their own alcohol use and associated risks, potentially leading to change.

Figure 6-1 A visualisation of the conceptualisation of factors shaping older people's drinking developed within this analysis.



This conceptualisation is explained in terms of four themes, below. Further intricacies within this conceptualisation, and care providers' approach to the factors they perceived to shape older adults' drinking, are discussed within these themes. The term 'participants' refers to contributions of participating older adults. Findings relating to care providers' responses are

highlighted as such. Within provided excerpts, BKB indicates myself as the interviewer/facilitator.

#### **6.4. Theme 1: Socially-Situated Drinking Practices**

Older adults' drinking practices were shaped by their understanding of norms for alcohol use and perceived social expectations for drinking. Older people defined their drinking in relation to these social rules and how they used alcohol relative to others.

##### ***6.4.1. Social rules and expectations***

Older people's drinking practices were guided by a socialised understanding of what represented 'appropriate' drinking, which created 'social rules' that guided their drinking practices. These social rules defined the types and amounts of alcohol that were appropriate to consume in specific contexts. Social rules for drinking provided intuitive guidelines for appropriate alcohol use that were internalised across the life course, as 'habitus', and reproduced to define participating older adults' alcohol use.

Older adults' understanding of appropriate alcohol use developed across the life course. They described how societal expectations for alcohol use had changed within their lifetime. Older adults acted based on family values for alcohol use learned early in life, merged with those learned across the life-course. Consequently, their understanding of appropriate alcohol use carried artefacts of historic expectations for appropriate drinking practices. For example, it was apparent that gendered social expectations for drinking had softened within older adults' lifetimes. For the older women participating in focus group 1, this meant that they now engaged in practices that would formerly have been frowned upon. However, they still felt that certain drinking practices were only appropriate for men:

*VALERIE: I wouldn't dream of joining a men's club, would you?*

*SHEILA: No, I don't want to.*

*JILL: No, I don't.*

*VALERIE: No. I mean we have our own gatherings.*

*SHEILA: I was going to say because men have theirs. I mean like the Masons, there was the men's and then there was the Eastern Star for the women.*

JILL: *You were saying about men drinking and that, men go and have a drink at night, we just have a coffee. A woman on her own. If a man's a widower, he'll go out to the pub. We still wouldn't think of doing that on our own.*

VALERIE: *Well no, not on our own. [...] But the women, I'm reluctant to go out at night myself. I like a drink at lunchtime.*

VALERIE: *I think women tend to socialise at lunchtime or the afternoons, where we can knit or sew.*

BKB: *So where would you typically drink then as women?*

VALERIE: *Well of course you see me, I'm a member of the Conservative club, I'm sorry if everybody else is Labour but I go to the Conservative club. Now if I go in there by myself, there's always the barman or somebody will talk to me and then my friends all come in. I would be a little bit reluctant I think to go into a bar by myself.*

SHEILA: *I've never done that.*

VALERIE: *No, I haven't either but then on the other hand, if it was a question of going in and then eventually your friends would arrive I suppose that would be alright but that's the reason. Whereas men will go straight up to the bar and have a pint and then look round who they know, don't they*

JILL: *That's another thing, if I went into a hotel when I was young to meet somebody. [...] I wouldn't ask for a drink in those days, now I would. I would say, "I'll have a white wine, a large one seeing, see if it's chilled."*

VALERIE: *I know, because you feel comfortable sitting with a drink.*

SHEILA: *I mean at one time you wouldn't have thought of sitting drinking on your own.*

JILL: *No, you wouldn't.*

Other generational proscriptions were described that affected drinking practices. Financial considerations restricted many participants' alcohol intake due to a value of frugality they had developed as a post-war generation. This finding cut across socio-economic groups.

Former, now outdated proscriptions were also recalled by the oldest participants, such as the medicinal uses of alcohol that were purported by their parents' generation.

Older people drew on the way they used alcohol to convey positive personal qualities in their narratives. Through aligning descriptions of their alcohol use with what was considered to be socially appropriate, they conveyed that they were responsible. In later life, responsibility was expected and valued across the participant group, which served to constrain their alcohol use. Excessive alcohol use, with its associated consequences, were not excused in later life, as Alice explained:

*Alice: I think women my age, they don't want to let themselves down, but they enjoy a drink. So there's this cut-off point. [...] I think somebody like [friend], I don't know his drinking habits. He enjoys a drink. Nobody enjoys a drink more. But he would be like me; he wouldn't drink a lot if he was driving. If he had children to look after, he wouldn't drink a lot. Responsible situations, you take total responsibility for your drink. Otherwise, as long as you know when to stop...*

Self-control and retaining the ability to fulfil responsibilities was important to older adults. Different qualities that could be signalled through the older person's drinking were valued, based upon their social identity. For men identifying as working class, drinking alcohol conveyed masculinity, which was a valued attribute. For John, the expectation amongst his peers that men should consume alcohol was a major motivator for his alcohol use in social situations:

*John: I would look silly if I went out with my friends and [did not drink alcohol]... On one or two occasions I have drunk soda water, but you get skit. Do you know what I mean? [...] Sometimes, I just want to keep off it, and I just drink soda water, and they'll say, "Yes, you're being like a girl."*

John's masculinity had previously been brought into question when he did not conform to this gendered expectation for alcohol use. Similarly, people self-identifying as working class viewed intoxication as an appropriate result of alcohol use. However, middle class participants distanced themselves from this effect of drinking in descriptions of their drinking, as was evident in Fred's narrative:



*Fred: [My visits to the pub are] entirely because I'm meeting friends. Usually once a week, at a pub, because they don't live near. They live a little distance away, so for many years we met on a Friday night. For social, not for huge amounts to drink but simply from a social point of view. The actual amount of alcohol we drink is fairly modest.*

Other focus group participants had previously criticised pub-based drinking as an activity attached to drinking to get drunk. This led Fred to qualify his alcohol use in this setting as 'modest' and 'social', re-establishing his drinking as responsible. Older adults identifying as middle class often conveyed specific preferences that confined their drinking, distancing themselves from intoxication as a motivator for alcohol use and presenting themselves as controlled drinkers enjoying alcohol for its taste. Billy explained that it was the fact that a drink was wine, which he enjoyed, rather than the alcohol content of that wine and associated effects that appealed to him:

*Billy: I don't think, if you are going to a supermarket, it's following that up. If you went to a party or whatever, it's not really the fact, "Oh I must have this because it's alcohol." I think it's the fact, you will have a drink and that's the obvious one that you would have. But it's not just a question of thinking, "Well here I am, it will be alcohol I'm going for." which I think, perhaps in the younger generation, would be saying, "I want that to get myself going and relaxed," and all the rest of it. I don't think we would do that to the same extent*

Aspects of the individuals' social identity determined relevant rules for older adults' choices in their drinking. For example, middle class participants associated particular spirits such as vodka with intoxication and the negative qualities attached to 'problematic' drinking. Their tastes served to convey that they were responsible drinkers. Data were suggestive of socially-desirable responding; particularly in focus group settings where there was an audience. For example, within Focus Group 2, there was agreement early on that older middle class men do not consume beer. However, this statement was contradicted by some participants who had been in agreement later in discussion. As such, this finding is more reflective of how expectations relevant to social identity shape how an individual is prepared to be viewed as behaving.

Participants invariably distanced themselves from indicators of 'problematic' drinking and associated negative attributes. 'Problematic' drinkers were viewed as irresponsible through not fulfilling responsibilities due to their excessive alcohol use, and were consequently perceived to be selfish, immoral and deviant. Drinking alone, drunkenness and a need to drink were associated with 'problematic' drinking. Malcolm, who had faced criticism of his alcohol use from his partner, was keen to highlight that his alcohol use was not driven by any need:

*BKB: What do you enjoy about drinking?*

*Malcolm: I find it the perfect accompaniment to a meal... Erm, and I find it, how would I - I'm just trying to think of the right word here without making it sound as though I need a drink because I don't need a drink. Erm - I find it an ideal accompaniment to dining. Having said that, a month ago, I dined for five nights without a drink. But - we didn't, we didn't feel the need to go looking round for a licensed hotel where we could have gone in for a drink and just, "Thank God for that."*

*BKB: You didn't make that extra effort.*

*Malcolm: No. Erm - the benefits of drink? I don't think excessive drinking is a benefit to anybody except the government. Erm, it probably puts a bit of a burden on the NHS, but I don't feel that my drinking has been a burden to anybody. And - I don't think it's impinged on my family life, my social life. Er - I think it's been, I think it's been one of, er - the ability to enjoy a drink without needing a drink has been quite a plus factor in my life.*

Malcolm highlighted the inconsequential and therefore unproblematic nature of his alcohol use, conveying his responsible drinking as a positive attribute. It was evident across participants' narratives that they took care to clarify that their drinking practices were appropriate when their described use of alcohol skirted the boundaries of what they considered to be socially acceptable. For example, Alice explained how her intoxication was confined to particular environments, free from social judgement, and for appropriate purposes:

*Alice: I feel that, for me, I am not drinking too much, except on odd occasions. That's especially when I'm with my family, for the simple reason, I can relax, in*

*case I become too tiddly, which I wouldn't want to do publicly. Right, so when we're a family, all together, you can go over the odds a little, and it doesn't matter if Granny starts talking gobbledegook, because it's part of our fun. Really relaxing. It's relaxing.*

*BKB: So it sounds like it's part of your family culture, and you find this an environment where it's acceptable to do it, and a safe place to do it.*

*Alice: And relax. A safe place to do it, yes.*

By keeping her more excessive use out of public sight where it might receive negative judgement from peers, Alice conveyed that she was conscientious and controlled in her alcohol use.

Drinking was qualified as appropriate in most social settings across participants' narratives. In such social contexts, particularly when alcohol was involved in celebrating, not drinking was deemed to be inappropriate, and those who had previously not aligned with this social practice had been challenged by others, as Julia described:

*Julia: I'm quite capable of saying I don't want a drink, but I think a lot of people have the peer pressure. I think, as you say, you know, when you go into a pub, it would be the norm to have an alcoholic drink; there's very few people who don't, unless they're driving. You can see- you can understand it. So we need to change that culture a bit because, you know, in terms of people thinking 'why?' instead of looking at you and thinking 'why are you drinking orange?' which people have done in the past, they've said to me, and I think you could say 'well, why are you drinking – you know, why are you drinking alcohol?*

Julia expressed frustration regarding the expectation to drink in social settings. For a number of older adults who did not otherwise consume alcohol, social contexts and celebrations could instigate alcohol use through social expectation.

In particular individual circumstances, drinking at all was conveyed to be irresponsible. Not drinking was then socially excused. Such circumstances included where the individual was known to have a 'problematic' relationship with alcohol, was unwell or was taking medications known to be incompatible with drinking. Driving also excused non-drinking across the participant group. The unlawfulness of 'drunk-driving' was conveyed as deviant,

risky and unconscientious, and none of the participant group identified as drink drivers. Driving constrained and even curtailed their alcohol use; particularly amongst those living rurally or when they were the only driver in their home. However, perceived intoxication qualified the level of intake viewed to make a person 'under the influence', rather than legislative guidance. A number of the sample described having driven following consumption of quantities of alcohol that (I felt) may have taken them beyond lawful limits (indicated in [Appendix S](#), Table Apx-S-1). For example, Oscar frequently drove home from visiting his friends following half a bottle of wine. He did not feel intoxicated, and did not feel that his alcohol use would affect his ability to drive this simple and familiar journey:

*BKB: So would you consider whether or not you're driving?*

*Oscar: Oh, yes. But I don't knock off the alcohol for 24 hours before I drive, I must say, because I only drive for a few miles, you know, from my home to, you know, to [local town], for example, to shop. Well, not that I'm doing that, just after drinking, anyway. Well, the only times I drive after I've been drinking anything, I suppose, are back from my friend's home, after he has given us lunch. And I don't refuse to drink any wine because I'm driving home, no. But I've only had half a – not half a glass – half a bottle, anyway. And I think I can find my way home safely enough (Laughter) with that on board. All the turns are left turns, funnily enough, so I can't really get lost. (Laughter)*

*BKB: So, is this to do with the fact that, like you were saying, you don't really feel affected by alcohol, generally?*

*Oscar: Yes, yes.*

*BKB: So you don't think that would affect your ability to drive?*

*Oscar: I don't think so, no. I'm not sure what the police would say, if they stopped me for some reason, and did a test. I don't know. I might be over the limit, because the limit keeps on coming down, doesn't it?*

*BKB: Yes, it does, yes. And would that bother you?*

*Oscar: Well, oh, yes, I suppose, yes. (Laughter)*

*BKB: Yes. I mean, I suppose it would bother you if you were in trouble with the police, but it would it bother you that you were over the limit?*

*Oscar: No, not really, because I've got my own information, you might say, on whether I'm still driving the same way, as I would anyway.*

There were evident contradictions in Oscar's views of drinking under the influence of alcohol. On the one hand, he recognised that his alcohol intake may be in excess of lawful restrictions for driving, conveying his discomfort with the social consequences attached were he to be caught. However, he did not view his own use of alcohol whilst driving as irresponsible. The acceptability of his alcohol use in terms of social rules justified drinking that may contradict lawful definitions.

Participants commonly explained within their narratives that they had developed an understanding of their own response to and tolerance of alcohol across the life course. By older age, they felt assured of their competency for drinking in line with their view of appropriate alcohol use. They felt familiar with the level of alcohol they were capable of consuming without becoming drunk or inappropriate, and confined their alcohol use within these socially appropriate bounds. This was demonstrated in an exchange with William:

*William: Well, of course, I know my limit. I won't go over above, say, four pints.*

*BKB: Why is it four pints?*

*William: Well, that's about what I can handle. I'm safe and I know I'm not going to have a bad head the next morning.*

*BKB: Brilliant. Okay, so you've learnt, over the years, what you're comfortable with drinking and what would be excessive for you?*

*William: Yes. [...] There's no way I would even try to keep up with people. If people are drinking fast, I'll say, "Oh, miss me out this time. I've got enough." I just know what my... That's now. I mean, I've mellowed now, like. Maybes in my younger days, I would have kept up with them.*

It was evident across the narratives of both older adults and care providers that drinking practices were understood as a conscious, individual choice. Although William was aware of official recommendations for appropriate alcohol use, he emphasised that drinking should be self-determined:

*William: Just because I know the government figures, that doesn't rule me. I just drink when I want to drink and when I want to drink.*

*BKB: What do you think about the fact that they suggested units?*

*William: It doesn't really bother me. [...] Well, I think they're a good thing if... How can I put it? If somebody is worried about their health and that, then it's a good thing to know what they should do and what they shouldn't do. Then, it's an individual thing, what you do.*

Like many participants, William viewed alcohol use guidelines as a reference-point that could be drawn upon by people concerned about risks attached to their own intake. This perspective of alcohol use as self-determined conflicts the evident grounding of decisions underpinning older adults' drinking practices in external social rules. However, care providers working with more socio-economically deprived care recipient populations (as indicated in Table 2, Appendix S) conveyed that they recognised societal influences upon their older care recipients' choices for alcohol use.

#### ***6.4.2. Positioning drinking practices***

Drinking was often verified as appropriate and acceptable by older adults through positioning their alcohol use relative to how they had used alcohol earlier in life, through contrast to stigmatised 'others', and within the context of norms amongst peers. These social comparisons were employed as a mechanism for gauging risk from their own drinking practices, but in fact served to dissociate them from the possibility that their drinking might be risky. Risky drinking was deflected to 'alcoholics' and younger 'binge' drinkers, who were seen to be qualitatively different from themselves. 'Problematic' drinking was seen to reflect differing values, or a disposition they did not personally possess, as demonstrated within Focus Group 1:

*SHEILA: Well I think, as you say, we're fairly sensible about it [drinking alcohol].*

*VALERIE: Well this is the thing you see but of course trying to tell somebody to be sensible or encouraging them, it's nothing you can do. People are either blessed with it [the ability to control their alcohol use] or they're not blessed with it.*

This group felt that they possessed self-restraint as an asset in contrast to ‘problematic’ drinkers, enabling them to drink responsibly.

Care providers broadly recognised how these mechanisms for gauging risks from drinking meant older people did not recognise risk in their own alcohol use. For example, N3 explained how the tendency to associate risk with younger people’s dramatic excesses meant that older patients did not see the practices typical of their age group as problematic:

*N3: I think, obviously, youngsters do tend to binge drink. I think older people, from my perspective or what I’ve seen, tend to drink, you know. If they were drinking too much, they would be drinking every day, so it would be a routine for them rather than binge drinking at a weekend.*

*Older people, possibly, depending again on the patient, but I think they would probably tend to think that actually they didn’t have a problem, because they’re not going out at the weekend and getting really drunk. They’re just doing that kind of -*

*BKB: So, comparing it to the way that they see younger people [drinking]?*

*N3: Yes, I think that’s possibly how they justify that they’re not drinking too much, possibly.*

GP7 had a specific interest in addressing alcohol use in his practice, and through experience in alcohol-related discussion with patients, had developed strategies for challenging older adults’ dissociation attached to these mechanisms for positioning their alcohol use. He encouraged older care recipients to make upward social comparisons in cases where their drinking was aligned with norms of excess intake:

*GP7: We are in [deprived area in the North East]. Therefore, when people compare their drinking to the social norms, there is always somebody in their family or in their street who’s drinking twice as much as they are, because there are some real drunks in this part of the world. (Laughter) [... I respond by] reminding people not to benchmark themselves against their best mate that they see at the pub every day, that they need to benchmark themselves against people who are living longer, happier, better lifestyles. So I say, “Why do you think somebody in Tunbridge Wells is likely to live 12 years longer than you are? It’s not genetic. It’s the life that you live, and there’s a choice to that.”*

Across their narratives, older adults implied that their drinking was socially acceptable and responsible through the labels they gave their alcohol use. Labels such as ‘not really a drinker’, ‘moderate drinker’ and ‘social drinker’ were used to convey benign drinking practices. Older adults self-ascribed these labels to reflect how they positioned their drinking relative to norms for alcohol use within their social environment. Julia reflected upon this when I questioned how she had categorised her own alcohol use:

*BKB: [Summarising Julia’s narrative so far] and you’re quite a low-level drinker?*

*Julia: Yes.*

*BKB: Er, so - but, without knowing the guidelines, how did you know this yourself?*

*Julia: That I was a low-level drinker?*

*BKB: Yeh.*

*Julia: Probably - you’re right, well probably just - probably just looking at everyone else, I think. Because you know when you go out, because – oh I dunno, you know, if you stay sober, almost, over the years you can see what people are drinking – erm, and you can see, you know, in your family or anyone else. You know that they’re having quite a few drinks, you’re not, so there’s that, so I think you just always know that; you just know what kind of drinker you are. You know – you know, if you admit to yourself, you know, you think, ‘I probably had too much to drink last night’ or ‘I think I probably drink too much’ or ‘I can take it or leave it’.*

*BKB: So, it’s more of a relative thing than paying attention to the guidelines?*

*Julia: Ah yes, yeh - I think so.*

The labels older adults used to describe their drinking could give an inaccurate impression of their alcohol intake. For example, John consumed two or three pints of beer and two or three vodka cokes twice a week when he met up with friends at the pub, and a beer or a glass of wine at home most other evenings. He described his own drinking as moderate, because he consumed less alcohol than his friends did:

*BKB: How would you describe your drinking?*



*John: Quite moderate .*

*BKB: Yes? Can you elaborate on that?*

*John: Well, I only go out socialising – erm, twice – well, go out drinking, sorry, with friends, twice a week: Thursday night and Saturday afternoon. But I can't drink as much as what they drink.*

*BKB: Oh, right, okay. So you drink less than they do.*

*John: Oh, yes.*

John believed he could not be drinking to excess due the benchmark for normal intake set by his peers. The labels employed by older adults, connoting low-risk drinking practices, may have contributed to the lack of concern for their older patients' and clients' alcohol use conveyed by many care providers. A number of older adults had experienced harm attached to their drinking practices, but had never discussed their drinking with any care provider because the way that they conveyed their alcohol use implied that they were at little risk. For example, Denise described how she had been injured when she fell having consumed alcohol in combination with her pain medication. She reported that her GP was unaware of this, as she described herself as a non-drinker and was not questioned further about her alcohol use.

Care providers with a specific interest in addressing alcohol use recognised, or experienced through a focus upon alcohol in their work, the false impressions given by older adults through the way they described their drinking. Older adults' labels for their drinking had to be unpacked when exploring their alcohol use in their practice:

*Ph2: When I'm talking to people, especially people over 65. It does sometimes, sort of amuse me to some extent, that I say to people- this doesn't happen all the time, but it happens more regularly for it to make it have a real impression on me. The fact that I say to older people, "Do you ever drink alcohol at all? How about alcohol?" [...] and they say, "I never go down the pub now, I'm too old for that." So, they give the impression that they don't drink alcohol, so I actually pin them down on it and say, "Do you drink any alcohol whatsoever?" And then the answer is, "Yes, I drink alcohol, I like a glass of wine with my evening meal. Then before going to bed, I like to have a whisky." Then the next question I ask is, "So, how*

*often would you do that?" And they say, "Oh every night," and I'm thinking, "Flipping heck, from giving the impression that they don't drink alcohol because they don't go down the pub, they actually have a glass of wine every night and a glass of whisky every night." So, that is quite a large amount, even if it's spread out over a week, it's still regular drinking on every night. [...]But it does amaze me and amuse me, how many people over 65 give the impression that they just don't drink alcohol anymore. But then when you actually question them further, they do drink quite a bit.*

In contrast, care providers with limited experience in addressing older people's alcohol use, through limited systematised discussion of alcohol in interactions with care recipients (as detailed in Table Apx T- 1), were uncritical when describing their views of care recipients' labels for their drinking practices. This was particularly evident within discussion amongst trainee dentists participating in Focus Group 6; where alcohol-related discussion was restricted to screening and very brief advice; and they had spent few years in practice compared to other participating care providers.

Examining these self-ascribed labels required time as a resource, which was not readily available in all care settings; particularly where plentiful time dedicated to alcohol-related discussion was not systematised within interactions with care recipients, such as within general practitioners' consultations. Screening for and addressing alcohol use was a key component of health promotion within hour-long medicine use reviews in pharmacy settings. Time afforded within the private consultations of dentists participating in Focus Group 5 enabled work to explore care recipients' reported drinking practices and translate these into units for comparison with guidelines. GP7 had also integrated strategies to quickly unpick older adults' alcohol intake within consultations, which he had developed through his experience in practice.

#### ***6.4.3. A social understanding of risks attached to drinking practices***

Older adults reflected on how their drinking practices aligned with social expectations for alcohol use within their narratives when gauging their own risk from drinking. For example, in conveying her belief that her alcohol consumption posed little risk to her health, Alice discredited official views of 'appropriate drinking', such as guidelines, as a gauge for risk attached to drinking. Instead, she presented her alcohol use in alignment with perceived social rules:

*BKB: You were talking a little bit about the guidelines around drinking. What do you think of the guidelines that we have?*

*Alice: I think they're far too low.*

*BKB: Yes? Why do you think that?*

*Alice: Well, I really don't see that one glass – one very large glass - a glass-and-a-half of wine every day, but just at night, when you're relaxed, can harm you. I would very rarely drink through the day, because I just go sleepy.*

Alice's concerns relating to her alcohol use were shaped by her social understanding of risk from drinking. She expressed worry about the effect of neat liquor, a drink considered to be less socially acceptable, upon her memory, but had no concerns about her frequent consumption of wine, as a socially appropriate beverage. Similarly, Malcolm perceived that his alcohol use was low-risk because he constrained his intake so as not to become intoxicated, despite accruing a high intake of alcohol relative to other participants through his regular drinking practices.

Care providers recognised how the social rules employed by older adults to gauge 'risk' in their drinking practices meant that they were often indifferent to the fact that they consumed in excess of the alcohol use guidelines that framed risk screenings and health risks indicated. Alcohol use considered to be socially appropriate by older care recipients often had the potential to be harmful. SW1 described this phenomenon, where norms of excess drinking meant older adults did not identify with the risks attached to excessive but socially appropriate practices:

*SW1: Most of the time we identify drinking problems during initial assessments when you ask them, "So how many pints do you drink at home? How many pints do you drink a week?" "Ah, I tend to have two to three a day." That's when you realise, "Wow, he's drinking quite a lot." To them, it's not quite a lot. It's normal.*

A number of care providers described how older care recipients associated different drinking practices with particular connotations of risk, as defined by their social understanding. Particularly, they highlighted that care recipients viewed certain types of alcohol as socially acceptable to consume, and therefore not attached to any level of risk:

*Ph2: There seems to be this perception amongst older people, that especially the more well to do ones, that they call drinking alcohol, "Oh yes, I like a glass of wine," as though, that's socially acceptable. But if they said, "I had a pint of lager," or whatever, that would be like a complete no-no. But at the end of the day, they're both alcohol, so it doesn't really matter to me, whether they drink John Smith's beer or you know, or Dom Pérignon champagne, or whatever they drink. They almost seem to have this perception that drinking wine with an evening meal, is quite a good thing to do, and quite socially acceptable.*

Care providers conveyed within narratives their sense, from experience in practice, of norms for particular groups of older care recipients, such as older men, to consume well in excess of alcohol use guidelines because this level of intake aligned with expectations for appropriate drinking relevant to their social identity. Those utilising lower-risk alcohol use guidelines in screening for risky alcohol use (as detailed in Table Apx T- 1) broadly viewed current guidelines to be unrealistic for practical application in their practice, as they were discordant with older care recipients' socially-situated understanding of appropriate alcohol use, as GP7 explained:

*BKB: How about the alcohol guidelines? How do you feel about those?*

*GP7: well- I think they do live a little bit in a sort of parallel universe, where they tightened the guidelines recently – this sounds sexist – when they became safe for men and women at a low level. I think for most people they look at that and say, "Well that's ridiculous. I don't know anybody on that sort of level." You only need to have a small glass of wine after work each day - that's pretty much it gone.*

*BKB: So, like, no room for excess.*

*GP7: You can very easily have your weekly allowance in one evening. To classify that as binge drinking, that's not what Joe Public thinks of. A binge drink is one that makes you fall over, or at least walk into things or take your trousers off and sing silly songs, not that you've just gone over an arbitrary number of units. So, when you're kind of saying, "This is what we recommend," people look at you as if 'well, you don't live in the real world.'*

Members of the general practice in Focus Group 3 also reflected upon this, highlighting how this made alcohol-related discussion challenging:

*N1: Well, we do [use lower-risk alcohol use guidelines in our practice], because that's what we've been given to use and they're evidence-based, hopefully, but sometimes I think they are a little bit... unrealistic.*

*GP6: I find that recently for most people that I see that drink, that we talk about they're over the guidance, that actually it almost seems like the guidance is too low. Then it's difficult conversation to have because there's visibly quite a gap.*

Older care recipients also utilised discordant, social definitions for clinical terms relating to problematic drinking, such as 'binge drinking'. The recent alignment of men's recommended alcohol use limits with those for women created particular challenges in care practice, according to participating care providers. These aligned guidelines conflicted the social expectation that men can drink more than women.

Care providers are also members of the social environment. Those with less of a specific interest in addressing alcohol use, or less focus upon this within their remit, based their understanding of risk, and consequent concerns regarding care recipients' drinking, more on their social understanding than upon alcohol use guidelines. For example, HCA3 described how her concern regarding older patients' drinking was led by signs that they were drinking in a socially inappropriate manner, indicating 'problematic' alcohol use:

*HCA3: I do think it is much nicer to drink with people. I think I would be more concerned about people that are drinking on their own.*

*BKB: And is that something you talk about with your patients?*

*HCA3: Yes. Because actually, just having that conversation, saying, "So when would you -?" you know, "What would you normally drink in a normal week?" And then they kind of follow the -volunteer information. Or I would be more concerned if people were sitting at home, drinking. Very much so.*

*BKB: Drinking routinely, then?*

*HCA3: Yes, absolutely. Yes. On their own.*

Relative positioning of risks associated with particular drinking practices also influenced the perceptions of many care providers. Perceived risks attached to older people's drinking practices were viewed to be far less of a concern compared to the consequences attached to

the dramatic excesses of younger 'binge' drinkers and 'alcoholics', as Focus Group 3 discussed:

*GP5: You probably don't think- dependency, it's not really a thing that I would think of in terms of elderly drinking so much as you would in the young in a way. I don't know whether that's just me, it's more of a label, a category that I'd use for younger people.*

*GP4: Yes, me too.*

*GP5: I don't know why.*

*DN1: It is and that's strange, isn't it? There's a lot of elderly people that drink but when you think of drunkenness you think of kids getting paralytic on a Saturday night. Having sex at the end of the road. (Laughter) Do you know what I mean?*

*GP3: Then you probably wouldn't have the 85-year-old down the end of the road.*

*DN1: No, that's what I'm saying. No, that wouldn't happen, would it?*

*HCA2: It's more drunkenness, isn't it with the young?*

Care providers working with care recipients across the life course drew more upon contrasts of older care recipients' behaviour than those working specifically with older adults, such as district nurses, pharmacists, social workers and domiciliary care providers (see Table Apx T-1) - where there is more scope for such preconceptions to be challenged; as SW4 reflected with reference to perceived stereotypes for problematic drinkers:

*SW4: You've got people who are of working age, really, who are still classed as older people and a lot of those people will drink, because it's helped them cope with their job, with the stresses that they've had on professional people are coming through. Because I think there was a bit of a stigma kind of that it wasn't professional people that it would be, you know, maybe somebody like an old man in the pub, but it's not men. We've got women. You've got professional people. There are lots of different types of people coming through, now. Not your stereotypical kind of person who you would see maybe as being, you know.*

Care providers were more likely to employ their social understanding of risk attached to drinking practices when they themselves lacked understanding of alcohol use guidelines.

This was particularly the case amongst provider groups who received limited alcohol-related training (as detailed Table Apx T- 1); and was especially pronounced in domiciliary care providers' discussions. Having received minimal training on addressing alcohol use amongst their client group, their concerns were shaped entirely by how their clients' drinking aligned with their own view of appropriate alcohol use. They perceived their older care recipients' drinking practices as relatively low risk, which represented a barrier to identification of potentially harmful alcohol use.

#### *6.4.4. Dissonance through discordance*

When the subject of discussion contradicted older adults' perceptions of their drinking as responsible and appropriate, I felt a sense of tension between myself and the participant. This tension reflected dissonance – a sense of discomfort attached to perceived discordance between one's identity and actions. This instigated participants to work to justify their alcohol use or seek validation that their practices still categorised as socially appropriate. For example, when Malcolm's responsible and low-risk portrayal of his own drinking was challenged by exploration of how his drinking fitted with guidelines for low-risk use, discussion became strained. Malcolm's rebuttal worked towards discrediting lifestyle guidance and society's current focus upon risks attached to behaviour, attempting to requalify his drinking as responsible and low-risk:

*Malcolm: I feel I'm not damaging my body with the amount of alcohol I consume now. I just hope, touch wood, that my excesses 40 odd years ago, that my excesses won't come back to bite me. That's why I look at some of my buddies, and some of the younger lads and think, "Do you realise?" – and I think, perhaps, looking at my work colleagues of a similar age who needed to go to the bar at the end of their shift, even at 6:15 in the morning, having worked all night, they needed three bottles of brown ale before they could go home. I like to think that, I don't know how many of them... I've been to a few funerals of lads I worked with, erm - but I wonder how many of them are suffering from liver failure and the problems that go with... I think some of them were virtually alcoholics. And I - some people have used that term to me; you know - "You're, you're virtually an alcoholic," I say, "No I'm not." I take that as an insult.*

*BKB: Aha. And why - why would they say that to you?*

Malcolm: *Because I drink nearly every day.*

BKB: *Okay, but it's just a different definition.*

Malcolm: *Yes, because I feel I don't drink to excess. It would be different if I drank... a few every day but probably tonight, I'll probably have a bottle of beer and then I might have a noggin. I almost certainly will have a noggin. So I'll have - What's a whisky? Two units?*

BKB: *It depends on the size. Officially, one measure of spirits a unit.*

Malcolm: *That's two units, yes.*

BKB: *A double, yes.*

Malcolm: *Military. So it's a measure, it's a measure of whisky and a bottle of beer. One unit, so that - that's about three units, today. Tuesday... probably the same. It's very rare for me to exceed three units, in any day. So seven threes, 21, a few more weekends, I'll - I'll not hit 30 units a week. What's the recommended units for a male?*

BKB: *For a male? fourteen.*

Malcolm: *A day?!*

BKB: *Yes, 14 a week. It's 14 a week.*

Malcolm: *A week?!*

BKB: *Yes, it's changed. So I'll keep all this quiet. I have to keep it quiet but it is, it's 14 a week for men and women now. And that's associated with a 1% increase... so by drinking within 14 units a week, you have no more than a 1% risk of having a negative effect of alcohol on your health. That's how it's calculated.*

Malcolm: *So what - when you hear people with excess drinking, and they're having drinking problems...*

BKB: *It's a lot more than that, a lot more than 30.*

Malcolm: *Yeh, I was going to say.*

BKB: *No, it's different things.*



*Malcolm: But - what does alcohol attacking your body, obviously your liver?*

*BKB: All sorts. Erm – so, I have a pack actually if you want it, it's a fact pack about alcohol, the fact that you can read when you can go if you like. It's totally up to you. I don't need to give it to you but it's up to you if you wanted to know more, just because you're asking me. But it affects your...*

*Malcolm: I don't think I need to read that.*

*BKB: That's okay. It's just there in case people wanted it. I just keep it for when people ask me, just so that I can be accurate [...]*

*Malcolm: I know you just gave this 14 unit... 14 a week!*

*BKB: I know, it doesn't seem much, does it? It doesn't seem much at all.*

*Malcolm: Well that's - if you don't mind me saying so, that's getting back to what I was saying about, erm, media coverage, doctors saying if you - you shouldn't eat this and you shouldn't eat that.*

*BKB: It's like nanny state you'd say?*

*Malcolm: Yes. I was thinking of the word and that's it, bloody nanny state. A while ago, it wasn't, only, less than two weeks ago, I got an email from somebody. And it's got 'baby boomers', this term for my generation, baby boomers, just after the war. Erm, climbing trees, we drank milk, we didn't have freezers, erm - this, that and the other. It was going through loads of things. We actually did this. And, er - there wasn't guards for this, and, we wore plimsolls and, stuff like that. All this thing, nanny state, we're still here. Bloody hell. It – you know?*

This worked to alleviate this threat to his positive view of his own alcohol use, and associated positive attributes attained through these practices.

The tension, and older adults' response to this tension, may explain why care providers often described alcohol use as a sensitive topic of discussion. Care settings represent a context where older adults' self-image as a responsible drinker may be contradicted when their practices are discussed in terms of alcohol use guidelines. A number of care providers remarked on how tensions attached to challenging older care recipients' drinking practices

could damage their relationship, which demotivated them from addressing alcohol use, as participating social workers discussed:

*SW1: I used to have a gentleman who used to say, "How come you asked me to stop drinking now? And yet I've been drinking all along and I'm still here with my bad drinking habit, so what's going to change then?" And the more I tried to educate him about drinking that sort of fractured my relationship with him. He tried to avoid my appointments and block me off totally.*

*SW3: It's a fine line sometimes isn't it?*

*SW1: Yes.*

*SW5: I don't usually interfere unless it is a problem. And even then it will fracture your relationship, of course it will and it's really difficult to get them engaged. But, yes, I think that's a real problem ...*

When working to convey risk attached to their care recipients' drinking, those working with alcohol-related discussion systematised within their practice, and who had practiced for a number of years, had developed responsive approaches through experience (as detailed in Table Apx T- 1 and Table Apx S-2). They described how they introduced the idea that care recipients' drinking may be risky delicately, acknowledging the social view of appropriate and responsible drinking. For example, N3 reported discussing alcohol more cautiously with older women having recognised more rigid social expectations implicating societal perceptions of their alcohol use:

*BKB: How do those [alcohol-related] chats tend to go? Are they easy to have?*

*N3: Sometimes no, but it depends if there's a barrier there. I think women... tend to be a bit harder than men. I think men, I don't know if it's just, I don't know, if society thinks men drink regularly. I don't know, but I find it more difficult speaking to women about their drinking if they're drinking excessively. I normally, maybe, say, "You know what it's like nowadays. People do tend to have a glass or two with their meal, but you do get into a habit of doing this. Actually, do you know that you're actually drinking a little bit too much?" Try and do it gradually rather than saying, "Actually, you're drinking way too much."*

She integrated acknowledgement of norms for drinking when promoting older patients' understanding of potential health risks.

## 6.5. Theme 2: Established and Disrupted Drinking Routines

### 6.5.1. *Maintaining established drinking routines*

Older adults broadly discussed how their alcohol use had become habitual in later life. Their drinking practices had become established within their day-to-day routines. Developed routines were individual, as relevant social rules learned across the life course were integrated into the structure of their daily lives. Their drinking routines defined what they consumed, in what amounts, and in what settings. Older people's drinking was not dictated by conscious considerations and was automatic, prompted by practical considerations such as contexts where they would usually consume alcohol, as Stanley described:

*BKB: So, what shapes your drinking... particularly?*

*Stanley: Well, what's going on, really. Well, in my case, it has become a part of the social routine, like having a meal.*

*BKB: Okay. Yes.*

*Stanley: In other words, I usually do the cooking. Before I cook the evening meal, I will have a drink. Right? Three nights, and then one night off.*

*If I'm going out to something, I will hope that we will get something to drink*

The routinised nature of older adults' alcohol use gave them a sense of security that their drinking practices would not stray from the confines of their social understanding of safe drinking. These routines were developed in alignment with social rules for appropriate drinking, and they rarely deviated from these routines. Jenni recognised that her drinking routines confined her alcohol use to lower levels, and therefore held no concerns about potential risks:

*BKB: So, we were talking about driving – this is a good example of this – is there anything else that you might consider, before you drink?*

*Jenni: No. Do you mean as far as, like, health-wise?*

*BKB: Yes, I mean, I have got examples here: driving, looking after family, health, as well, anything like that.*

*Jenni: Yes, as I say, because I don't drink very much, I really don't have to think about that, you know- because... as I say, I only maybe have a drink on a Saturday night and a Sunday night, with a meal, and then it doesn't continue. I don't sort of come through and sit and drink, I just go onto tea or coffee.*

Cognitive impairment associated with the ageing process could disrupt routines in alcohol use. This was emphasised within the narratives of domiciliary care providers, who worked closely with their older care recipients; a high proportion of which were living with cognitive impairment relative to the care recipients of other providers. They described this as a common occurrence across their client group. Through causing older adults to repeat or miss elements of their day-to-day routines, the condition could lead to increases or decreases in alcohol use. One particular case described had involved great increases in a client's drinking:

*Car1: I think the older generation know where to draw the line, most of them, unless they've got dementia and stuff like that, where they forget. They would just say, "Oh, I've just had one," and they would. [...] We've got a client at the minute that's very alcohol dependent and she doesn't realise it because she's got dementia. [...] It started off with just a few bottles of wine – to like six bottles of wine – and a bottle of brandy. You're trying to say to her, "Oh, well, you'll probably not need all that. We'll come back another day." "No, no, I've got enough money. I'm going to buy it."*

*Car2: But her alcohol use has gone from, say, a mild drink of wine to something more...*

*Car1: To a few bottles. You'll take her shopping, say, on a Wednesday and buy all of it, and then, say, by Friday, you would go back and she would have all these empty bottles, because she doesn't realise that she's drinking. She forgets. She'll, maybe, just think she's had one glass, but she's had two bottles.*

### **6.5.2. Self-regulating routine alcohol use**

Many participants described regulatory strategies that they had integrated into their drinking routines to align their alcohol use with their perception of socially acceptable practices. For example, William limited his drinking to four pints per occasion to avoid

hangovers; a consequential drinking behaviour that did not fit older adults' ideal of responsible drinking:

*William: Sometimes, when we've had the car, if I've gone in and just said, "No, we're only going to have one and then we're coming straight out," and it's been a good pint of beer, I'll turn around and say, "Oh, yes, I could sup another one of them." But I didn't.*

*BKB: So, when it's three or four, you don't really feel like having any more after that but when you have to have one because you're driving...?*

*William: I say, "I'm just going to have one drink," and then, "Oh, I could sup another one of these." Well, the best thing on that one, sometimes, is, if there are three of us - my son-in-law, my grandson and me - and we maybe say, "Oh, this beer is lovely today. Shall we have another one?" [...] Many times, I've thought, "Oh, I could sup another one of them," but I don't.*

Commonly described self-regulatory strategies included limiting alcohol intake to a set number of drinks per drinking occasion; buying, and restricting consumption to, a specific quantity of alcohol per week; consuming alcohol from smaller glasses; choosing rich alcohol such as red wine, which must be consumed slowly; setting a daily time-frame within which drinking was restricted; and having two alcohol-free days per week. Reducing the frequency of alcohol use, without changing the roles alcohol played in their routines, was a common strategy recommended by care providers to older care recipients routinely consuming in excess of guidelines, where screening and intervention for alcohol use was systematised within their work (see Table Apx T- 1). Ph2 had integrated this approach into medicine use reviews with his older patients, guiding them to explore reducing their intake:

*Ph2: We try and get to the conversation where, "Would it make much difference if you could have a couple of nights where you didn't have any alcohol whatsoever, just to give your liver a chance to recuperate?" We get into that sort of conversation and they usually are sort of given the homework, that if they drink seven days a week, how about cutting down to five days a week, to start off with? And then maybe have a chat in the future in a few weeks' time to see how they're getting on with that, and then maybe try and reduce it again from there.*

Domiciliary care providers were involved in older adults' acquisition of and practices regarding alcohol within their work. They described being in a position to regulate older care recipients' drinking practices, making suggestions to limit their intake where the individual no longer had the capacity to make healthy decisions and self-regulate their alcohol use; as Car2 described with reference to one of her clients:

*Car2: This male client: if I go in and he's sitting having his can, I encourage a pint of water first [...] I know by the time he's had a pint of water, he won't want another drink.*

Through her developed relationship with this individual through regular work with him, she was able to identify and encourage him to engage in regulatory strategies that would restrict his alcohol intake.

### **6.5.3. Routine excesses in alcohol intake**

Some participants' drinking behaviour demonstrated regular excesses and risky combinations of alcohol with medications and health conditions (detailed in [Appendix S](#), Table Apx-S-1). Although John did not feel he drank to dramatic excess on any single day, his narrative suggested that he was consuming more than double current recommended limits for alcohol each week through his day-to-day drinking routines, despite multiple chronic health conditions and medications that may be negatively affected by drinking.

Care providers consistently highlighted these routine excesses in alcohol use as the main risk attached to their older care recipients' typical drinking practices. Where alcohol use screening was systematised in their consultations (as detailed in Table Apx T- 1), health care providers highlighted how their older care recipients often did not identify with risks in their alcohol use. N3 had insights into this through experience in discussing alcohol with older patients in chronic condition reviews:

*N3: Getting people to look at it differently, that's not very much on a daily basis, but actually, when you add it up and when you're looking at how many units you're having over a week, it maybe is a little bit too much, and looking at it like that. But it is sometimes difficult to get people to... think like that.*

They discussed how they worked with older care recipients to examine their routine practices, supporting them to recognise excess intake. GP7 utilised drink diaries to facilitate

this exploration, providing a basis for discussion of potential risks associated with their alcohol use:

*GP7: If they agree to keep a drink diary, you know you're kind of on a winner, most of the time. Some will do it to please you, and some will lie on the diary, obviously, but- whether they do that or not, they will have been surprised by how much they drink, probably. Then it begins to dawn to think, "Maybe there was something in what the doctor was saying, because he was right to say I drink more than I thought I would. The guidelines do say that this is in the orange part of the traffic light, or the red part, or what have you."*

The established nature of older care recipients' potentially risky drinking practices within their routines often meant that older adults resisted care providers' suggestions that they might reduce their intake. This view of older adults' alcohol use meant many care providers had low expectations for the success of intervention, which, for those less equipped with intervention skills (see Table Apx T- 1), served to demotivate them in addressing alcohol use amongst their older care recipients. This perceived futility resulted in a sense of discomfort and apathy for dentists participating in Focus Group 6, who had received little training to support alcohol-related discussion beyond feedback regarding the individual's level of intake:

*Den9: I have to say, I don't really feel comfortable telling older people what to do with their drinking.*

*Den 5: So I feel like even someone comes in and says, "Oh, yes, I have a couple of bottles a night on a Saturday." I just think, "Okay..." (Laughter) "You're like 75, I'm not going to change your ways now."*

*Den4: You're going to struggle to teach old dog new tricks, really aren't you? They're going to be that fixed in their ways.*

However, where alcohol-related discussion was systematised within their practice (as detailed in Table Apx T- 1), care providers' generally reported that they raised alcohol with older care recipients regardless of any misgivings about their capacity to make changes to their drinking practices. For example, experienced dentists participating in Focus Group 5 discussed alcohol consistently with care recipients:

*Den3: I think the response often that you might get from somebody who's older is exactly what [Den1] said, it's kind of "I'm not going to change now." It doesn't stop me raising it because it's there on a piece of paper, so I have to. I have to explain why that figure is what it is.*

More in-depth intervention, or intervention at any level where it was not systematised within the provider's practice, could be demotivated by this common assumption amongst care providers.

#### ***6.5.4. Late-life transitions and disruptions to developed drinking routines***

Older adults acted to maintain their developed routines. Many discussed how changing these established practices could only be prompted by a major disruption to their life circumstances.

Transitions commonly experienced in later life caused changes in older people's drinking routines. These could lead to increases, decreases or maintenance of older adults' overall alcohol intake depending on the roles alcohol played in their reconstructed routines. The effect of life transitions upon drinking practices was not unique to later life. When discussing participants' alcohol use across the life-course, changes to individuals' drinking practices were consistently tied to life transitions. However, participants often framed their perceptions of how their current drinking practices were shaped within the context of a number of transitions associated with the later life phase, including bereavement and widowhood, children becoming independent and leaving home, retirement and ill health.

Transitions could alter the structure of older adults' day-to-day lives, disrupting the drinking routines embedded within this structure. Alternatively, they could alter older adults' personal circumstances, and therefore the relevant social rules around which their drinking practices were shaped. Alcohol could also serve to fulfil new roles in older people's lives in the face of disruption to their routines and identity; providing a daily structure for new routines, or an escape as they adjusted to new circumstances.

The loss of responsibilities by later life, such as working or caring for children, represented a loss of constraints upon alcohol use. 'Fields' of leisure and socialisation, representing contexts in which alcohol use was commonly viewed to be appropriate, came to represent a greater proportion of daily life in older age. There was consequently more opportunity for



drinking, which for some led to an increase in alcohol use. For example, Jenni discussed how her alcohol intake had increased since her children left home, as she no longer had parenting responsibilities that were incompatible with drinking, and there were fewer financial constraints upon her purchase of alcohol:

*Jenni: when the boys were younger, I probably almost didn't drink. It would probably be maybes be Christmas and New Year because, you know, a) it was the expense of it; you couldn't afford it when you had young children and b) it just didn't come into the equation, at all. I mean if we maybe's went to – [husband] was [j4], and if we went to a do at Christmas or New Year, you would maybes have a drink but, really, I was almost, I suppose, nearly teetotal in a sense, because it was so infrequent. Now, and I think a lot of our age group probably started drinking more from about fifty onwards, when the children were away and you had a bit more cash, a bit more a relaxed time.*

*BKB: So, yes, that was to do with having more finances and less responsibility?*

*Jenni: Yes, finances and responsibilities*

New roles and responsibilities acquired through transitions in later life, such as grandparenting, voluntary work, or caring for a sick partner, could all create new constraints upon older people's alcohol use.

Overall intake sometimes remained static in the face of late-life disruptions to older people's drinking routines when alcohol played similar roles in their restructured day-to-day lives. For example, Helen began to socialise with friends at the weekend in place of her husband following his death:

*Helen: For years. For years that's what I've done. My husband died seven years ago, but previous to that I always went out on a Saturday night with him, but I still went out with my friends on a Friday only. So Saturday and Sunday, I used to go out with my husband. Luckily, I had friends to fall back on, the same friends, so that's my social life, yes.*

*BKB: So when your husband died, you started seeing them a little bit more and that gave you some social activity at the weekend?*

*Helen: Yes. At my age I can't think of anything worse, as I said to you, if I was just sitting here every day and getting up tomorrow and doing exactly the same thing.*

Late-life transitions such as widowhood could also lead to reduced intake. For example, Jack's drinking practices had formerly been shared with his partner, and her death meant that he spent less time in a social context where drinking would be considered appropriate:

*Jack: My wife was unwell for a long time, she didn't drink, but I would quite often open a bottle of wine and then consume it myself. Since she is no longer with me, I hardly drink at all now [...] I haven't drunk since, and I don't see myself doing so. Except perhaps in a social environment. Invited out or invite somebody back. My drinking habits have changed markedly over the last couple of years, is really what I'm saying.*

Similarly, Helen had been unable to engage in social contexts where drinking would be appropriate while she recovered from an injury. Her alcohol use had consequently been temporarily curtailed through the disruption associated with illness:

*Helen: Now I had a fall last November and for three months I couldn't go out. So I never had a drink in that time. It didn't bother me. But as soon as I could start going out again, I walked with a stick and I only had two pints of cider, because I wasn't sure. I'd get a taxi out and a taxi back all the time. Until I got my confidence back and got rid of my stick. But it didn't bother me for three months, that I couldn't have a drink.*

Domiciliary care providers highlighted how many of their care recipients no longer consumed alcohol in later life, because their ill health meant that they could not engage in the social settings where they would routinely have drunk. Illness also created a context with which drinking was often socially viewed to be incompatible (discussed further in Theme 4).

## **6.6. Theme 3: Roles of Drinking in Late-Life Socialisation, Leisure and Wellbeing**

### ***6.6.1. Social facilitation***

The roles of alcohol in social contexts meant that drinking became a fundamental facilitator in some older adults' social lives. The socialisation within which drinking was involved, and the opportunity to 'get out' that drinking provided, often motivated drinking, rather than any affinity to alcohol itself. For William, drinking was attached to key opportunities for seeking social interaction:

*William: To me, drinking now is just to socialise with other people. I don't go out to drink to just have a drink. I only go out if I have to meet people and then have a drink with them.*

Drinking was involved in most of William's socialisation after he was widowed. Visiting the pub for a few pints formed the basis of time spent with his Grandson each week, offered an additional social and leisure opportunity when he visited the pub to play dominoes, and extended the time he spent with his friend from bowls as they went for a drink after practice. Similarly, all of Helen's social interactions occurred in the context of drinking after she was widowed, and she engaged in little other routine social or leisure activities, otherwise spending her time in the house watching television.

Alcohol appeared to play a greater role in older men's social and leisure activities than in older women's, particularly when single. This may be an artefact of gender differences in expectations for drinking, and how women's activities were grounded in different contexts; as was conveyed within participants' narratives. However, drinking was still central in the social lives of many participating older women.

Where older adults had disengaged from social 'fields' such as work (through retirement) and sports (through declining physical function), or lost partners and friends in old age, their social networks could deteriorate. In the face of losing relationships through transitions associated with later life, older adults discussed rebuilding their social network, often in the context of alcohol use. Following his divorce, John began socialising with old friends with whom he had lost touch during his marriage. Their former ritual of pub drinking was resumed, which represented the basis of their social contact:

*John: It's only recently I've been going out regularly with the lads from the club. It's very recently. Well, it's actually in the last 2 years, because I used to devote my life to my wife. I used to take her to work and things, and so I drank very little then.*

*BKB: Yes. So when you got married, that was in your 40s. You were saying that you used to take your wife out and things, so you'd drink with your wife then. Was that rather than going down to the club to drink with your friends, or were you doing that as well?*

*John: Oh, no, I never used to go- When I was married, all my free time, if she wanted that, we used to go out together. So after the divorce, I didn't have many friends. Do you know what I mean? The lads who I drink with now, I used to go to school with them. So it's been a long time since I've seen them.*

This new context for John's socialisation had led to a large increase in his alcohol intake. Similarly, Serena befriended her neighbours following her husband's death, socialising with alcoholic drinks. It was in this context that Serena's drinking escalated. However, for those without the social abilities or contacts to build new relationships, declining social networks served to curtail drinking practices, as associated social opportunities were lost.

Care providers broadly recognised and accepted the role of alcohol in providing social and leisure opportunities to many older adults. Those working to promote older care recipients' emotional wellbeing in their work considered and even facilitated these activities in the lives of these individuals. Domiciliary care providers supported older adults with physical or cognitive impairment in their daily lives who may find it difficult to engage in such opportunities, and worked to promote their general wellbeing. They assisted their older clients to engage in socialisation through drinking for this reason. Care providers valued its contribution to preventing boredom and loneliness in later life in the absence of other social and leisure opportunities; as social workers discussed in Focus Group 4:

*SW3: I think, for me, more attention needs to be paid to the fact that as an older person, the social network shrinks. Their ability to access, you know, even just the outdoors, that has a huge impact. And it's not just about mental health, it's about the physical abilities and how -reduced mobility and all of these sorts of things impact on that, which a younger person doesn't necessarily have to contend with. So, yes, I suppose it's just that shrinking circle, if you like, of support and just generally what's out there and what's available to them.*

*SW5: Friends pass away, children leave home and it's kind of social isolation time isn't it?*

*SW2: [...] If they're going to the pub and that means they get to see people and have a couple of pints and they've got a structure to their day and it's something to look forward to, it's something that gets them up and out and makes them get washed and dressed and makes them head out, then that's better.*

This group prioritised older adults' social and emotional, as well as physical, wellbeing in their work. They described instances where they had investigated health care providers' concerns over older care recipients' excessive alcohol use; but had excused this due to positive overall contributions to the individual's wellbeing:

*SW3: Sometimes we have referrals for people who will go to the pub on a daily basis and they'll have a few pints at the pub and then they'll come home. And people around raise concerns about that. And it's not necessarily concern. It's about them getting out and having this social aspect, you know, it's a chance to meet up with old friends and things like that, whereas otherwise they would be very isolated at home.*

Similarly, Ph2 worked in a pharmacy with a wellbeing theme. Again, the social and leisure opportunities that drinking may be part of represented a legitimate consideration in his alcohol-related practice with older care-recipients, in parallel to any health-related concerns:

*BKB: Okay, and what about the role of alcohol? You were saying about the role of alcohol in people's social lives. Are there any particular considerations around that for older people?*

*Ph2: Yes, because it is very easy for people to become socially isolated, and their maybe only contact with other people, in a positive way, is maybe like the old fellow who goes down to the local club, and he has a couple of games of snooker and a couple of pints with his friends. He's a widow, so he lives by himself, and if it wasn't for that interaction, he probably wouldn't have any interaction with anybody. So, from a health risk point of view, maybe that is – it's a case of weighing up the benefits against the risks. Maybe that is something that's less of a risk than not drinking, because he wouldn't have the social interaction and that could end up quite depressed if he was just isolated by himself. So, it does have those beneficial effects.*

Socialisation in the context of drinking was a relief from social isolation for a number of participants who had lost partners or friends in old age. For William, new relationships formed in the context of social drinking had protected him from the feelings of loneliness he had experienced after he was widowed:

*William: [drinking] brings you out and takes you into the social atmosphere [...]  
You see, when I went away on my holidays on my own, 9 times out of 10, I'd meet  
up with somebody. Then, I'd say, "Oh, well, do you want a drink?" or vice versa.  
Somebody might ask me. Then, you've got a friendship type of thing. "Oh, see you  
tomorrow. See you in the morning." Oh, aye, to me, having a drink is a very good  
thing.*

*BKB: It's healthy to be sociable and, yes, healthy to be...?*

*William: Yes, and to me, it brings you back into the world, type of thing. You  
haven't got to be a loner.*

Care providers often conveyed particular concern about older care recipients who had been widowed. The protective effects of drinking against loneliness were an important consideration in determining whether they chose to address any alcohol use associated with these drinking practices; particularly where intervention to address older care recipients' alcohol use was not systematised within their work, such as within general practice (and as detailed in Table Apx T- 1). GP7 discussed how he prioritised alcohol's role in social engagement over promoting reduced consumption amongst his older patients:

*GP7: The men, particularly the widowed men, I often weigh up a cost-risk benefit  
and probably guilty of turning a bit of a blind eye to the men who are going out  
drinking with their mates, because widowed Geordie men particularly, I think, are  
clueless about looking after themselves, become very socially isolated [...] I would  
be more... That sounds probably quite sexist the way I've said it. It's really not  
meant to be.*

*BKB: No, I understand.*

*GP7: The women's networks of protecting each other and themselves, and their  
pattern of socialising, tends to be less high-risk than the men's round here.*

*Therefore, if getting pissed on a Friday is the price they pay to avoid total social  
isolation, I will roll with that, yes.*

Drinking was not the only source of socialisation sought by older adults. William had worked to engage in other meaningful social opportunities when he came to rebuild his social life, having recovered from the grief of his wife's death, by joining walking and bowls groups. His alcohol intake reduced as the roles of drinking became less important to satisfactory social

engagement, once these alternative social opportunities were integrated into his weekly routine. In addition to John's social visits to the pub, he had also moved into sheltered accommodation, where he valued opportunities for social engagement with other residents. Nancy had consciously reduced her alcohol intake, and had replaced the roles that alcohol had previously played in her social and leisure time. Nancy had come to value the stimulation offered by these alternative social and leisure activities, which she felt were more meaningful than drinking. Alcohol had become less pertinent to her enjoyment in later life:

*BKB: So are there any specific reasons that you could give for why you drink the way that you choose to, at the moment?*

*Nancy: Yes. Some of this might be going back over old ground. But I suppose there are other things that I enjoy more, I just enjoy being out and about, and not drinking, sometimes. I enjoy being a bit more energetic. [...] Yes, I guess I kind of enjoy not being as excessive. [...] I've thought about this a bit. I don't even know what it is, particularly, about my lifestyle, that's changed. It's just, it's less important to me, about drinking a lot. [...] I don't need to get blindingly drunk to have a good time now.*

Nancy was socio-economically advantaged, and engaged with a multitude of available opportunities in her local environment, facilitated by her physical ability and possession of a car. However, a number of older adults felt that there were few other activities of value or interest available to them in old age; particularly those with poorer physical function, or living in deprived areas. In the absence of such opportunities, drinking became central to their engagement within social and leisure spaces. For Helen, who lived in a deprived area with few alternative opportunities, drinking was an activity that she could 'look forward to', preventing her life from becoming 'dull and meaningless' in old age.

Care providers practicing with prevention of harmful alcohol use as a priority, and time systematised within their consultations to enable this discussion (see Table Apx T- 1) worked where resources were available to support the older adult to engage in alternative social opportunities, in order to make alcohol less fundamental in their social lives. Ph1 practiced in a deprived area, where drinking was central to many of her older care recipients' social

activity. She described her work in signposting them to other opportunities that she knew were available in the local area during hour-long medicine use reviews:

*Ph1: Because of where I live, a lot of people are out of work. Where I work, a lot of people are out of work so they do spend a lot of time in the pub and in social clubs – that's where they go. I do try to suggest, "Well, why don't you do this instead of going there?" There are certain local health groups that have been set up to help older people as well, so I often signpost people to there. Like, "You don't have to go to the pub to hang out with your friends, you can do this instead."*

### **6.6.2. Social benefits of disinhibition**

The disinhibitive effects of alcohol served to facilitate older adults in their social exchanges. Alcohol was valued by the majority for increasing the quality of social interactions, and positively changed the nature of conversation. For Nancy, this was achieved through the effects of drinking upon her approach to socialisation:

*BKB: So what would you say are the up-sides to drinking?*

*Nancy: Removes inhibitions [...] I think I'm much more witty, and things. I know I'm not, but you know? Even though you know you're not, you're just a bit more free. And there's something very nice about drinking with other people. I really enjoy that experience of getting mildly, or more than mildly drunk, with other people. Releases their inhibitions as well, so you have a bit of a... I know it can have a down-side, but generally speaking, I would say I like getting drinking with other people. I really like the feeling of, the conversation flowing. Certainly when we did... A couple of friends of mine, who are also fine wine-drinkers, and we were all doing dry January. Not this year, the year before. We decided we'd do it. And they came round for dinner. And God, we had the most boring night ever (Laughter) It was like, "Oh, is it 9 o'clock already?" You know? So generally, we have a great time when the conversation flows.*

Although Nancy had previously described how drinking was less central to her enjoyment, the disinhibitive effects of alcohol played important roles in social interactions and relationships with particular friends. As Nancy described, she found less satisfaction in her social exchanges when abstaining from drinking.



Social disinhibition was a major motivator for engaging in alcohol use in social contexts for some; particularly those who otherwise lacked confidence in social situations. Alcohol enabled them to engage in social interactions. Care providers recognised this important role of alcohol conveyed through exchanges with their older patients, as GP7 described:

*GP7: There's the social, but actually I think for both sexes, it depends on personal confidence and what have you. Okay, there's a social norm that, if you're socialising, you pour a drink. It happens a lot, but there's an appreciable number of people that actually need a drink to relax enough to socialise, or they just have a lack of confidence, poor body image, a lack of self-respect or what have you. They actually need that lubricant to function in a social situation. It's not just, "well if I go out, I don't want to be the only person who doesn't have a Prosecco." It's actually, "I can't really have a good time unless I've had a couple of Proseccos, because I don't relax enough to enjoy my friends." That goes across all ages. I think where it hits the elderly it's the single elderly. You've got Ethel, who was married to David for 50 years, and he died 2 years ago. She's going out for the first time in half a century as a single woman again. She last got practice at this when she was 22, and, okay, it's a completely different dynamic, but other people are in couples. I think it needs quite a lot of bravery to function as a single person in some situations.*

As GP7 highlighted, the confidence provided through drinking was especially important for those who had lost their partner, as they navigated social settings and forged new relationships alone, often for the first time since early adulthood. This function served by drinking was evident in the narratives of some-such participants. William looked to engage in new social exchanges after he was widowed. Drinking enabled him to interact in higher-pressure social settings, such as meeting new people or engaging with large groups, facilitating him in making social connections:

*BKB: Do you think the drink helps with the conversation?*

*William: Oh, yes. I would say yes, because there are certain things when I'm on holiday where I need Dutch courage to do it, type of thing. When you have a bit of Dutch courage, it relaxes you. I feel more relaxed and I will probably act daft or something, but I wouldn't have had without a couple of pints. [...] Then, if I'm in company or it's biggish company or things like that, it's a help.*

For Helen, who was also widowed, the disinhibitive effects of alcohol enabled her to participate in enjoyable social activities that she felt otherwise unable to engage in:

*Helen: [Drinking makes conversation] easier for me. Because as I said, I'm not a good mixer with people I don't know. As I say, we sit in company and we've got the same friends for years and years. So, it's so easy to get on with everybody. On the Sunday night there's a live band on at the club and I get up and dance, which I really look forward to. Yes, that's part of my social life as well, yes. [...] I love it. But then I've had a few drinks by then. I've had two ciders by then.*

*BKB: So it helps, the alcohol helps with the confidence when you're getting up?*

*Helen: gives me a bit of confidence. Yes.*

Alcohol's function in enabling social engagement could serve to increase the quality of older adults' social activity. However, not all viewed the disinhibitive effects of drinking as positive. Janice, who was forthcoming with her opinions across the course of the interview, felt that alcohol led her to behave inappropriately:

*Janice: [When I drink] I talk too much, it is alright in my own house, but if I was at somebody else's house and they have got people who don't know you so well, I have sometimes been conscious of having talked too much. [...] I can be a bit argumentative, so, sometimes, I think – I shouldn't have said that [...] it's more people that I don't know so well, I think If somebody has a dinner party or something, and there are people there that you are not close to. And sometimes, I can be a bit nervous in big groups- it sounds a bit strange- and the drinking probably makes that a bit worse, I think.*

*BKB: Yes, it makes the nerves worse?*

*Janice: Probably, well, I suppose I am not controlling it, you see, I am not sure whether it makes the nerves worse, or makes the verbal diarrhoea worse.*

Positive or negative experiences of the effects of disinhibition on older adults' social exchanges appeared to be defined by individual personality characteristics. Participants had gained across the life course a sense of their own response, and used or avoided alcohol in social settings accordingly.

### 6.6.3. Social and leisure rituals

Drinking was described as an integral part of many rituals attached to socialisation and leisure in later life. Alcohol use changed the nature of social and leisure activities. Drinking could create social cohesion in older adults' social interactions, improving the quality of their relationships. As a shared activity, drinking had symbolic effects in engaging people in conversation with one another, which Charlie valued:

*Charlie: I enjoy getting out to socialise with people and mix with people it's a means of socialising and mixing with people as opposed to just going and sitting talking. [...] I think it's just a little bit like having a cup of tea and a biscuit now, as opposed to just sitting and talking. It breaks things up, I think it's just enjoyable.[...] I could have a Coca-Cola or a non-alcoholic drink and that would be okay, I think it's just like having a cup of tea now, it breaks things up and it's just a nice thing to do between human beings.*

Some care providers described how they valued this contributing role of alcohol in promoting social connectivity amongst their older care recipients. Through attention to overall wellbeing in his work, and dedicated time to discussing older care recipients' experiences with their alcohol use in hour-long medicine use reviews, Ph2 understood this role as a motivator for drinking. He was sensitive to the contribution of alcohol to some of his older patients' social lives:

*Ph2: I was saying about the fellow that goes down to play snooker. He could probably go and play snooker and just have a coke or lemonade or something. But he just maybe feels one of the group, if the rest of the group are drinking alcohol and he drinks alcohol as well, then he becomes one of [the group]. So, I suppose in a way, like a teenager would have peer pressure, it's just not thought of in that way. But actually that's probably what it is. You just feel part of the gang, doing what everybody else is. If everyone else is having a pint and having a game of snooker or a game of cards or dominos or whatever they do. It just brings you that social inclusion into a group, and avoids isolation.*

Older adults also described the symbolic effects of alcohol in establishing downtime within their narratives. Drinking facilitated their transition to leisure time where this space was less distinguished following disengagement from the 'field' of work. This was achieved partly through pharmacological effects in creating a state of relaxation, but also through the idea

of alcohol as an indulgence and reward, which were viewed to be important aspects of leisure. This ritualised role of alcohol was discussed within the older men's focus group:

*Thomas: It's convivial as well. Warms you up.*

*Billy: I think if I was sitting in the evening, and thinking, "Yes, I'm going to have a drink." I would probably tend to take a cold beer or a glass of, it would obviously be a white wine or a red wine. Really on the basis of sitting there relaxing, watch television or whatever, a nice glass of cold wine. As opposed to normally, like Alan, I would take some red wine with meat etcetera. Now, if am wanting to sit down and relax, and watching the television on the odd occasion, etcetera with a glass. It would be that that I would take. That's the sort of upside of saying, "Well that's actually more relaxing, to just sit back with that." sort of refreshing but also calming. On that basis.*

*Jack: A little bit of luxury too, I think?*

*Billy: Yes. Yes, it is, that's right. You do. You think, "Right, okay, this is pleasurable. I've earned this. I've done a lot of pottering about all day."*

*Jack: We do, because we can.*

Alcohol use could be important in setting the mood that was essential to the leisure experience. This was an activity engaged within upon completion of other tasks, rewarding productivity. Drinking had become part of an evening leisure ritual that Jill shared with her husband, creating a valued state of relaxation in the absence of other activities:

*Jill: If we've had a busy day working around the house and things like that, he'll [husband] say, "I know it's only 6:15pm but we'll have a drink." It's a reward, and we sit down and say, "Isn't that lovely." Then he'll say, "Is anybody coming tonight?" "No." "Well there's a nice bottle in the fridge," and that's our evening and it's lovely.*

Due to its role in creating a state of relaxation, drinking was incorporated into many older adults' evening and bedtime routines, and represented part of winding down from the day's activities. Care providers often described excusing the ritualised uses of alcohol in older care recipients' leisure time, accepting that this was a normalised role with positive functions.

The down-time created by drinking was seen to contribute to recuperating in later life, and an earned part of retirement following a lifetime of productivity.

A number of other practices had interchangeable functions with alcohol in terms of its roles in older adults' social and leisure rituals. The functions served by drinking, in creating social cohesion and relaxation, were paralleled with those of hot beverages by numerous participating older adults. The oldest old also recalled smoking as a former parallel; a practice that had historically occupied many of the roles that alcohol now played in their social and leisure rituals, before it was discouraged through public health campaigns and legislation. Older adults' affinity for these different practices affected their alcohol intake through the roles of alcohol in their lives relative to other alternatives.

#### *6.6.4. Drinking as pleasure*

A number of older adults described how they consumed alcohol as a way of experiencing pleasure. For some, pleasure was found in the feelings of intoxication associated with drinking itself. They enjoyed associated feelings of warmth and conviviality, which motivated their alcohol use. Although middle class participants distanced themselves from the idea of enjoying intoxication due to associations with 'problematic' drinking, many described appreciating such drug-like effects of alcohol on their experiences of the world. Individual participants experienced different psychological effects of drinking. Some described never having experienced feelings of intoxication through alcohol use, and for these participants it was the roles of alcohol in social opportunities that motivated their consumption. For others, the effects of drinking represented an important way of accessing pleasure in their lives, which motivated their alcohol use.

The integration of alcohol within enjoyable social and leisure activities across the life course meant a number of participants had made strong links between alcohol and enjoyment. Drinking acquired symbolic meaning as a pleasurable activity in the minds of these older adults, and they consumed alcohol because of consequent expectations of positive experiences when drinking. For example, when explaining her alcohol use across the life course, Serena reflected on how her drinking made her feel happy; formerly through the enjoyable occasions during which she consumed alcohol, and now directly, by association:

*Serena: Really, everything was associated to happiness. Maybe with that thought, if I drank, it would make me happy [...] My association is happiness, so drink and happiness is together because the only time you drank was at a special, happy occasion.*

Ph2 again drew on his understanding of older people's alcohol use developed through discussion and focus in his practice; explaining how the pleasure that his older patients symbolically associated with drinking was an important part of enjoying later life, as other opportunities for enjoyment were lost:

*BKB: What benefits do you think that older people get from their drinking then, overall? Mostly social, you were saying?*

*Ph2: Yes, that sort of association that makes them feel like they're in a good place when they're having a drink, because of their lifestyle, over 60, 70 years. That they might just associate- like people do with smoking, they associate a particular activity, with a good time. So, even though, it no longer actually is a good time, it in itself, it's just that thought association process, it can be quite comforting and relaxing and they think, "Oh yes, just put my feet up and have a glass of wine, and everything is alright."*

Older people had fewer accessible activities for pleasure in later life, particularly when they had experienced a decline in their physical function which meant they could no longer engage in activities that they had formerly enjoyed. Stanley had become paraplegic in mid-adulthood, and explained how drinking represented one of few remaining pleasurable activities that he could engage in easily:

*Stanley: There is an argument, as you get old, that it's one of the few things you can still enjoy. A lot of the other enjoyments... You aren't going to go out and play football. Right? Many of the activities that you had... Having a bit of fun with a girl gets a bit more difficult probably. A whole lot of things get... The pleasures... go off... and there aren't many left. Alcohol is one of them. That remains, you see. I think, for older people, it becomes something which they can... Of the activities you can enjoy, it is one of them. There's a whole list of them. Doing the crossword in the paper, for some people who can do the crossword... Travel gets more difficult. Nobody wants you if you're old. The insurance people jack the price up. You need to have a minder with you. You need all sorts of medical tests, etc.,*

*before you can. So, things become more and more difficult. Of all those other pleasures... Not only more difficult, but more risky. [...]So, alcohol remains one of those things.*

Stanley conveyed his sense of exclusion from society with age, experienced through barriers attached to the ageing process itself, and ageism in the accessibility of available opportunities. Drinking, in contrast, provided an accessible pleasure.

Care providers recognised that drinking could represent a key pleasure in the lives of their older care recipients. This was a legitimate consideration that they worked to negotiate in their practice. For those where intervention to address excessive consumption was not systematised within their work, this could make them wary of recommending reduced consumption. This was typical amongst care providers working in general practice and dentistry (see Table Apx T- 1). They felt that their care recipients were resistant to making changes to their alcohol use, and questioned whether it was even ethical to suggest that they lessen their engagement in such a positive aspect of their lives. Providers with more dedicated time to discuss care recipients' drinking - such as pharmacists during medical use reviews, and social workers providing ongoing support to individual care recipients - acknowledged the pleasure experienced through drinking in formulating recommendations for reducing intake to promote contemplation of change; as Ph1 described:

*Ph1: You don't want to say to people, "Don't drink. You shouldn't drink alcohol, it's bad for you." You're not going to get anywhere with them. People like having the drink, they enjoy- A lot of the people associate having a drink with having a good time. Even if it's only one, and it's not making you feel even a little bit tipsy or anything, it's still associated with having a good time. You don't want to be somebody who is taking away their fun, but you also need... It is that balance of, "Okay, that's great. That's great, that you do that. Carry on doing that if it makes you happy, but maybe you should have a bit less. Because it would maybe feel a bit better."*

#### **6.6.5. Emotional diversion**

For a number of participants, drinking became a source of escape from negative emotions associated with late-life stressors, such as bereavement and loneliness, through its roles in accessing pleasure and social opportunities. Older adults, particularly older men, could come

to depend upon the social opportunities provided by drinking as a distraction from low mood. Following his wife's death, William began visiting the pub to avoid solitude, which he found uncomfortable in the context of his grief:

*BKB: How old were you when your wife died?*

*William: She was 56 and I was 53.*

*BKB: What happened then?*

*William: Well, then, I started going out more. Then, they weren't open all day like they are now. I didn't like staying in the house on my own. I had to be out. I was going out regularly. I took early retirement. I just did it for the taxman and that type of thing. Then, I just started... Well, I was not getting drunk, but I was drinking a lot more every day to get out of the house. I was also meeting people in the bar to play dominoes. I was playing dominoes all the time*

This 'social dependence' upon alcohol led to a great increase in William's alcohol intake. Similarly, Charlie sought socialisation and stimulation within the pub to distract him from the grief and sadness he felt following the death of his close friends.

Through its' roles in accessing pleasure, alcohol was used by some as an emotional diversion. For Serena, later life had brought sadness through serious health concerns and the effect of ill-health on her ability to engage in enjoyable activities and face-to-face social opportunities. This had caused her to experience boredom and loneliness. She began to use alcohol as respite from this negative emotion, enabling her to experience some pleasure whilst drinking.

*Serena: If I'm in company in bad weather, I'm happy, but if I'm on my own, obviously, I'm not because, otherwise, I wouldn't be having a drink of wine. [...] I think it's just to try and make yourself feel happy, just a cover [...] I would be having, at night, a drink of wine, in the evening. Then, it became where, say, I'd been seriously ill and, the winter, stuck in and too ill to go out. Yes, so I really used having a drink in the evening as more emotionally...*

*BKB: Yes, to cope with...?*



*Serena: I felt the difference, yes. It changed. So, I find, when you're happier, you're active and you're happy, you don't have a drink for the same reasons. That's all I've learned about myself is the danger of why I was drinking changed.*

*BKB: Yes, so, recently, when you were ill and you were in in the winter and it was cold, did you start to drink more often?*

*Serena: Yes. Yes, because it was just total boredom and I was too ill. Because I always had projects, but, being ill for the last three year, it got worse, the illness got worse. And I found, I looked upon it, thinking about my reasoning, there wasn't any reason at the time, but, looking back, there was. It must have been loneliness, sadness and like, "[whispered] I've got to have a drink." [...] I think it's got to do more with your emotional wellbeing and no company. Everything is FaceTime, everything is devoid of personal... [...] I know I do use it and it's on an emotional level, yes. [...] So, I think it's to do with happiness, and I must relate all of these things now I've done it. I've only drunk when it's been happy times.*

*BKB: Sometimes, you were using it to be happy?*

*Serena: Now, I'm using it when it's bad times, yes.*

Serena was consequently engaging in what she viewed to be problematic drinking practices. Such reactive uses of alcohol were not universal. A number who enjoyed the pleasures associated with drinking consciously avoided using alcohol in response to low mood, having recognised through experience that the disinhibitive effects of alcohol meant they lost control of their emotions and worsened their mood.

Examples of this reactive use of alcohol were described across the life-course, however common late-life stressors and disruptions triggered this role of alcohol use in older age. Care providers who had developed an understanding of factors affecting their older care recipients' drinking with experience through systematised discussion in their work described such stressors as a trigger for increased alcohol use amongst their older care recipients, as GP2 discussed:

*GP2: I've had a few patients that drink more than they should. And it sometimes, it becomes, when you talk to them, sometimes it's out of their previous habits and sometimes it's out of times of stress. You know, they might have had disruption in their life or something happened. If it's the end towards, you know, if it's before*

*they retire, sometimes that can be a very stressful period of time. [...] So sometimes, I think it becomes like a crutch, or a relaxation technique, or whatever you want to call it. It becomes a little habit, but maybe they're not necessarily drinking to the point they're dependent.*

Reactive use was broadly perceived as a negative role of alcohol, and instigated concern in their practice. Practitioners' approaches to addressing this form of alcohol use depended upon the remit of their profession, and how alcohol-related discussed was integrated within their practice (see details in Table Apx T- 1). Addressing mental illness and supporting patients through bereavement fell within the remit of general practice. GP7 used patients' bereavement as a cue for exploring patients' alcohol use to gauge risk attached to reactive drinking:

*GP7: Somebody will come in, floods of tears, "I lost my mum last week. Can I have a note from work? Should I have any tablets? Can I have some sleeping tablets?" There's pros and cons of that, mostly cons. There, most times I will say, "How much is alcohol? Are you using alcohol to cope with this?" and I'm often a little fearful as to whether that will come across as a bit unfeeling and uncaring, but I'm sort of saying, "We all do in a crisis, but part of the grieving process is that you have to remember bits and pieces and you have to think things through, so you've got to be careful of this." But I've become aware in that bereavement situation is probably when it's important but sometimes the most difficult to raise it.*

He saw reactive drinking as an unhelpful response, and worked to intervene accordingly. Reactive drinking was indicative of possible mental illness for GP2, and she looked to identify and treat this within her practice. The social care team responded to acute cases of mental illness associated with reactive drinking within their work, intervening with resultant self-destructive behaviour such as self-harm and attempted suicide. In the longer term, they worked to identify and address the stressor leading to reactive drinking as the root cause of excessive alcohol use, and support the individual to develop alternative coping responses.

#### **6.6.6. Alcohol and wellbeing**

Older people highlighted the importance of alcohol to their wellbeing where alcohol had come to play a central role in socialising, leisure time or accessing pleasure. The positive roles of alcohol in older people's lives could sometimes outweigh perceived risks attached to their drinking. For example, John had numerous health concerns that meant his doctors had

recommended he reduce his alcohol intake. However, he maintained his alcohol use because of his sense of the importance of drinking to his social and leisure time:

*John: I go beyond them [alcohol use guidelines]. As I say, I'm never a great drinker, but I do go beyond them. So I think that they don't apply to everyone (laughter) [...] I know it has the same effect on everyone, the amount of alcohol you drink. I know that, but I'm not prepared to just sit in the house all night on my own. Do you know what I mean? [...] I believe that alcohol is bad for you. I do believe that, and I do believe that these units you're allowed in a week is a true figure. But people tend, well, not to ignore them, but to try to put them to the back of their minds, because their social life and getting out and meeting people is more important to them.*

The contributions of alcohol to older adults' overall wellbeing and quality of life represented a key consideration in most care providers' practice. These roles of alcohol in older adults' wider wellbeing meant alcohol was a complex issue for care, requiring contemplation and negotiation for individual cases. For Ph2, the wellbeing theme within his pharmacy meant he prioritised social and emotional health as well as physical health in his approach. The effect of alcohol on health and wider-wellbeing represented equivocal concerns in his practice:

*Ph2: From a social and psychological point of view, in that it can have quite a big impact on people. Sometimes a beneficial impact and sometimes, you get someone who is sort of 85, and their wife died a year ago, and they were really close and they say 'oh, I really miss her, and they have the odd can of lager on a night and watch the telly'. And you think, well, "You know what, if you're 85 years old, you're obviously doing something right, and who am I to say, 'Don't do that?'" Sort of, he said that, and just enjoys it, and that was the conversation I had with someone. And you kinda get that balance, between depriving someone of something that actually is, from a social point of view...Or they might go around a friend's house and have a couple of drinks and socially that's really nice to do. So, you wouldn't want to deprive people of that. But equally, you don't want them putting their health in danger.*

The positive roles of alcohol in many older people's lives meant that they were reluctant to consider changes to their alcohol use. This demotivated many participating care providers from broaching alcohol-related discussion and intervention. The established roles of alcohol

in these important facets of older adults' lives served to sanction drinking in some cases, particularly when it was consumed exclusively in socially appropriate contexts, or when they felt that the care recipient had few other positive experiences in their life. Care providers' perceived remit shaped how they negotiated the social concerns attached to their older care recipients' drinking within their practice. Although dentists in Focus Group 5 were empathic to the potential roles alcohol could play in their older patients' wellbeing, their decisions regarding intervention were led by oral health concerns and indicators of excess from health screens:

*Den2: We don't consider why they're drinking, and you don't see they go off in the afternoon for two pints to see their mates every day because they've got nothing better to do. We don't really think of it in that aspect. If you work it out it builds up over time. You just sort of consider the general health at that point rather than what they're doing. You tend to focus more on what you're trained at, which is the head. And you don't consider – well, you don't regularly consider outside of that.*

Care providers working in general practice, as well as Ph1 were oriented towards promoting physical health. Conversely, social workers looked to support older care recipients to make choices in their drinking that were best for their overall wellbeing, given both health and social considerations.

Differences between providers' roles, and their consequent interactions with care recipients, meant they had different experiences and developed understanding of older people's alcohol use (see Table Apx T- 1 for details of such differences). For example, time constraints in general practice, and a focus upon addressing health concerns, meant they were less familiar with, and less concerned with, the positive contributions of alcohol for older people's social and emotional wellbeing; as highlighted in discussion within Focus Group 3:

*GP3: We don't see many of the good benefits of alcohol, do we? "Oh, he's had a really good night out last night. He had two gin and tonics," you know?*

*GP6: I think what you're aware of is the wider fallout as well. At work, you don't really see the positives.*

Similarly, because dentists participating in Focus Group 5 paid little regard to social concerns in their practice, they conveyed that they had not reflected upon the potential roles of alcohol in older people's lives prior to discussion within the focus group setting. Social

workers, who worked with older individuals over a stretch of time with their overall wellbeing at the centre, communicated thoughtful and reflective understanding of the roles of alcohol in older people's lives; as did Ph2.

#### **6.7. Theme 4: Tangibility of Health Risk from Alcohol Use**

Older adults assessed the individual relevance of potential health risks from drinking with three indicators: personal health concerns, relatable cases of harm from drinking, and general public health messages. Health risks attached to drinking were not a major consideration for most interviewees unless there was a tangible reason that made these risks personally relevant. Perceptions of the effect of their lifestyle upon their health state, quality of life and longevity affected whether health risks from drinking were perceived as relevant, and prompted concern and reduced consumption.

##### ***6.7.1. General public health messages for health risks associated with alcohol use***

Alcohol use guidelines and associated public health messages conveyed an indication of risk that older adults found abstract and difficult to relate to. The abundance of transitory and contradictory messages about the effect of health-related behaviours that older adults were exposed to across their life course delegitimised these messages as a knowledge source. Changes in guidelines for alcohol use, and conflicting research findings for risks and benefits associated with drinking, meant a number of older adults expressed scepticism about their validity. Stanley, for example, disregarded alcohol-related risk communications:

*Stanley: I do pay a certain amount of attention to the government's rules, but if they keep changing them. We've been told- I view the alcohol rules very much like all the other ones about food intake. It is, after all, food. We've been told not to eat butter, not to eat eggs. "Eat eggs. Eat butter. It's good for you. It's got a good mix of fatty acids. White meat's good for you, but red meat isn't." [...] You're just told a load of rubbish, basically. You don't believe a word of it. So, you reach the point where you look at what you think is sensible rather than believing the letter of the law, because it keeps changing.*

Older adults used their own social understanding of low-risk drinking. 'Moderation' in drinking and other health-related behaviours represented a consistent health message that many older adults ascribed to. However, this did not reflect a defined level of alcohol use,

and was of limited value as a benchmark for low-risk drinking. Many assumed that health risks, and therefore associated risk messages, were only relevant to ‘others’ with a ‘problematic’ relationship with alcohol.

Within their narratives, care providers reflected that older people were only responsive to alcohol-related health messages when they were tailored to individual circumstances and drinking practices. However, personalising these risk communications required a critical understanding of current alcohol-related health messages, and experience in integrating this into personalised practice. Although a number of care providers had gained experience of discussing alcohol through this being systematised in interactions with older care recipients, advanced knowledge regarding such health messages was not typically demonstrated by any care provider group within their narratives; with the exception of pharmacists (see Table Apx T- 1). Care providers with less training in alcohol-related intervention, such as dentists, took a prescriptive approach, employing guidelines in a black and white manner to convey to their care recipients whether their drinking was safe or unsafe, without highlighting the patients’ specific risks:

*Den1: I think in our training... It’s quite a while now since I was an undergraduate. I’ve been on a specific course where they’ve talked about alcohol consumption and dental effects. We’ve had very little training in the advice that we need to provide. Like you were saying earlier, your knowledge is limited, so we don’t... You know you think, “Oh, cut down, yeh.” But that’s all we’ve got to go on really.*

These impersonal approaches were viewed to be ineffective by both care providers and older adults.

### **6.7.2. Personal health concerns**

#### ***Expectation of signs and symptoms***

Participants expected that they would experience symptoms if their alcohol use was excessive. Reductions in intake motivated by alcohol-related health risks were often prompted by the perceived consequences of excessive drinking, rather than proactive changes made to prevent harm. Where older adults experienced symptoms, and the cause was attributed to alcohol, alcohol-related risks became personally relevant, and led the individual to reconsider their alcohol intake. For example, Nancy recognised the effect of her

alcohol use on her weight and energy levels, and made the decision to reduce her alcohol intake:

*BKB: You said, with regards to having the nights off a week. Is that a conscious thing that you do on purpose, or is that a side effect of the way that you drink now?*

*Nancy: It's a conscious thing, it is a conscious thing.*

*BKB: Yes, and what made you come to that? Was that a decision?*

*Nancy: Yes, a couple of things. Because, I know you can't tell really, but I've lost quite a lot of weight over the last couple of years. Quite slowly, and that's part of that. Because alcohol forms... I mean, if I'm drinking alcohol there's two things. A, I eat more, if I'm drinking. And B, in itself, it's quite...*

*BKB: Yes, calorific.*

*Nancy: Yes, so, I was drinking more. [...] I thought, actually, I'm falling asleep in front of the telly, sort of. Which I don't do if I don't drink. And I just thought, yes, time has come. I think I can do it, and I did do it, yes. So it's a couple of things, but it's definitely conscious, yes.*

Other participants had recognised negative effects of alcohol upon their mood or when combined with particular medications, and consequently restricted their intake. Denise used numerous medications to manage her health, and vividly recalled falls she had experienced through use in combination with alcohol. She had subsequently curtailed her alcohol use. Personal experiences of harm attributed to drinking provided tangible evidence of the personal relevance of risks attached to alcohol use, motivating change.

Signs of harmful alcohol use legitimised care providers' practice in a resource-limited care system. This finding was highlighted in data from providers working in general practice; where time constraints and a number of health concerns to cover within consultations limited opportunities for addressing older care recipients' alcohol use. As a result, care providers' approach was similarly oriented towards responding to consequences of excessive alcohol use, rather than harm-prevention. Although GP7 conveyed his investment in disease prevention through promoting healthier lifestyle behaviours, his exploration of older patients' alcohol use was prompted by symptoms potentially caused by excessive drinking:

*BKB: How important is talking to an older patient about their drinking, compared to talking to them about other health or social care issues that they might have? Where would that come, in priorities?*

*GP7: Overall it's important, but you can't really answer that question, because- it depends totally on context, and what's going on, and what you've established beforehand. If it's someone you've asked about drinking beforehand, and you don't have any worries, and they've come for a chest infection, which could put them in hospital, it's just not on the agenda at all. If it's about falls, chronic depression, and abnormal liver function tests, it's the first thing you think of.*

Different care provider groups had different signs available to them to indicate potentially harmful alcohol use (as detailed in Table Apx T- 1). Most providers had access to brief alcohol use screening scores, as well as indicators from their care recipients' presentation, and any reported signs and symptoms. Where alcohol-related discussion was systematised within care providers' work (detailed in Table Apx T- 1), there was more scope to identify potentially harmful alcohol intake; as social workers in Focus Group 4 discussed:

*SW3: The GP has a 10-minute window when we go out to do an assessment, you know, you could be there an hour, you could be there two hours. And that's the difference ... You know, as much as we are very pushed, that is our process. We take that time to do that full assessment, whereas the GPs just haven't got that.*

*SW4: [...] When we go, we do an assessment for social opportunities and we smell alcohol and we're asking about it and we want to find out more about it.*

Domiciliary care providers were able to identify problematic drinking through one-to-one work with older care recipients within their homes, where they were able to observe how the individual was using alcohol (as described in [Section 6.5.2](#)). In contrast, other care providers had commented on how it was difficult to gauge older adults' actual alcohol intake in interactions with care recipients; as discussed in [Theme 1](#). Although domiciliary care providers had access to such behavioural indicators, their level of training regarding alcohol use was insufficient to enable them to identify risky drinking amongst their older clients.

Across care providers, the most commonly cited and easily recognised signs of potentially harmful alcohol use were those that would typically be associated with dependent drinking.



As GP2 explained, associated symptoms were generally visible and of obvious clinical relevance:

*GP2: The ones that present themselves quite easily and they're easy to pick up are the ones who are dependent, who come in for another reason. Particularly if they're still drinking and they have what you call- DTs or whatever you want to call it, but they have withdrawal symptoms. They're quite easy, or they've had an admission that suggests it. You often get patients that are kinda... often drinking more, or you get alerts, so there are quite a lot of prompts. Prompts in terms of how they present, if they got some kind of illness or is it abdo-pain? Even sometimes just the way they look prompts you.*

A number of care providers who were better versed in alcohol-related health risks (those who had received higher levels of alcohol-related training; as indicated in Table Apx T- 1) acknowledged that not all harms experienced through non-dependent levels of alcohol use would be symptomatic. This level of alcohol use was consequently less likely to be addressed in practice.

Care providers involved in intervention to address alcohol use highlighted that where their older care recipients had not experienced any evidence of harm from their drinking, it could be difficult to motivate them to reduce their drinking to lower-risk levels. Their older care recipients commonly cited reaching old age as indicative that their drinking was not harmful. Alcohol-related discussions were consequently unlikely to prompt contemplation of change, as participating social workers explained:

*SW4: You've got people who have been doing this for 50 years and you've got people who you're trying to break that habit and nothing bad has happened to them. So then for you to come and say, "Actually, this isn't good." Sometimes, as well, you'll get the other end of, "Well, I'm in my 70s kind of, what's going to happen?"*

*SW3: [...] there is that sort of dismissive attitude to that really, "Well, I've done it..." Like SW4 said, "I've done it all my life and I've never come to any harm yet."*

This perspective was echoed by some older adults. Valerie, one of the oldest participants, viewed herself as an expert in safe drinking practices having lived well into old age. She expressed frustration when health risks were ascribed to her level of intake:

*Valerie: I get very cross about somebody saying, "Don't do this. Don't do that and don't do the other," because I say to myself, "Well I've reached 89, we're all there." We've reached this age doing what we think is the right thing [...] I just feel that there is a general tendency to tell us what to do. I keep saying, "I wouldn't be 89 if I hadn't just done what I fancied doing and in moderation at the time."*

Many care providers respected their older care recipients for having reached the later stages of life, and saw little legitimacy in attempting to intervene with excesses in their drinking. GP1 explained that this discouraged her from addressing alcohol use amongst her oldest patients:

*GP1: Because I might think, "They're 85 or 90, they're doing this. Is it really worth me getting involved and trying to say, 'Look, you really should be cutting down to 14 units of alcohol per week,' when it's something that they're enjoying, they've done for years?" It's socially their social life, it's the norm, and they're ostensibly not coming to much harm from it, so I guess I might be slightly influenced by the age in that respect.*

A number of participants were wary of the increasing relevance of alcohol-related health risks in old age. However, this view was often grounded in their personal experiences of decreased tolerance of alcohol and consequences attached to an intake that had formerly been inconsequential. For example, participants of Focus Group 2 discussed having restricted their alcohol intake with age, having recognised their bodies' reduced resilience to alcohol, and their experiences of discomfort:

*Billy: I never used to drink a lot when I was younger, pints wise. Maybe I would have two or three, exceptionally, if I went out to the pub or whatever. Now, I think I'm pushing it at about two, because it just doesn't feel comfortable. You do drink less. Yes.*

*Jack: It bloats you up.*

*Thomas: Or you can't sleep properly.*

*Jack: It does put pressure on the bladder.*

*Alan: You have to get up five times in the night.*

Those who were more health literate, often former medical professionals, had an understanding of abstract messages regarding increased risks of drinking with age, which they viewed to be personally relevant to them as an older adult.

Alcohol screening test outcomes provided a concrete indicator of excesses in individual care recipients' drinking, and were an integrated component of practice in many care settings. Alcohol-related risk scores highlighted potentially harmful alcohol use that guided care providers' concerns, and conveyed risks to older care recipients in a tangible format. Den3 explained how the products of these tools supported their patients to link their behaviour with effects on their body:

*Den3: The DEPPAs [Denplan Previser Patient Assessment – an oral health risk screening tool that included an assessment of alcohol-related risk to oral health, giving a coloured grading of patients' personal risks of specific diseases given their current behaviour] with them having a written piece of paper in their hand describing their risks, then that's something visual they go away with. I think it helps them to make that link between, "Well actually, you know, what I'm doing to my body or what I'm putting in mouth affects..." There's that sort of general body link, isn't there? [...] I think because you've got a visible report, as I said that physical piece of paper in your hand with a number on it. It's easier to talk about it in some respects because it's there and it's in colour, isn't it.*

Care provider groups had access to different risk assessment tools to support their practice with older care recipients (as detailed in Table Apx T- 1). The visual portrayal of risk created within private dentistry consultations through the DEPPA was felt to be helpful in communicating individual risk to care recipients. GP7 described similar benefits in visuals created by his practice's computer system, SystemOne. Verbal indicators of risk, such as those supplied to care recipients on completion of the AUDIT-C (utilised within general practice and NHS dentistry) provided a less tangible indicator for risk associated with alcohol intake.

Other screening results, such as blood tests, also provided tangible indicators of the effects of alcohol upon the body. However, some participating older adults responded with specific rather than general reductions in their alcohol intake, curtailing their drinking only prior to future tests. In doing so, they mitigated the effects of their drinking upon this tangible indicator of harm, rather than the asymptomatic and therefore abstract effects of alcohol

upon their body that these results reflected. This practice was discussed in Focus Group 2, where Paul reduced his intake prior to monitoring of his condition:

*Paul: If you are on medication, probably of any sort, you've got to be careful. Certainly, if you are on warfarin you have to be careful. Just before you have a test. It doesn't matter if-*

*BKB: That's to do with the doctors.*

*Paul: It sends it shooting up.*

*BKB: Yes, okay. You don't want to be overmedicated. It's interesting, saying that it's important surrounding the test. That would be to do with your doctor's evaluation of what medication you were going to have, rather than to do with the effect it has on you when it shoots up?*

*Paul: Yes.*

*BKB: Okay. You wouldn't worry about the effect that it has on you, when it shoots up?*

*Paul: It doesn't. I don't know whether it's up or down. You don't know.*

Paul's peers had responded by suggesting he change his medication, reflecting a similarly incomplete understanding of risks indicated by screening tools. A number of health care providers recognised that it was important to guide their older patients' understanding of screening results to avoid misconceptions that may result in maintenance of harmful intake.

Older adults expected that their care providers would communicate any personally relevant health risks attached to their drinking, and otherwise assumed that their drinking practices were safe. Malcolm did not perceive that his co-use of alcohol with prescription medications represented any risk to his health, because his care provider had not conveyed specific concerns:

*BKB: Do you ever consider anything to do with your health when you're drinking?*

*Malcolm: Could you elucidate on that? Could you -*

*BKB: Er, so - so an example might be how you take your tablets. Do you ever worry about how it might affect your medication? Do you ever worry about how it affects your health?*

*Malcolm: Well I just took the assumption when I told the practice nurse who was doing this count on my units, and I - in fact [wife] was there and [wife] said, "Do you know he takes his medication at night with - alcohol?" the practice nurse says, "Really?" - but she didn't say you can't do that. Er, and - because I haven't been told otherwise, I just assumed - I use that word - I assume it's safe to do so.*

*BKB: Yes. You think they'd say if it wasn't safe.*

*Malcolm: I would have to stop doing it.*

*BKB: Yeah. Do you ever read the packets for your medication?*

*Malcolm: Erm - the - the small print?*

*BKB: Yeah.*

*Malcolm: No, I haven't read it. But I did ask my doctor. I says, "Are these safe?" well, in the absence of a warning on the box, "not to be taken with alcohol", because some medication is - because it doesn't say it, I assume it's okay to do it.*

Similarly, where screening results did not indicate harm, older adults used this within their narratives as evidence that their drinking practices did not represent a health risk. Despite drinking well in excess of alcohol-use guidelines, Malcolm felt that his normal blood results demonstrated that his alcohol use was not problematic:

*BKB: How do you know that it's not affecting your health?*

*Malcolm: I don't. I'm not a doctor. But, there is no - when I get my bloods checked every six months, er, the practice nurse will say, "Your bloods are spot on. Erm, there's nothing in your internal organs ringing bells." So because I've been following this drinking habit for quite some time, 30 years now, it obviously isn't having a det- I don't think it's having a detrimental effect on my body*

Older adults did not appreciate the limits of care providers' knowledge, and placed much faith in providers' communication of personally relevant risks. Older adults generally viewed

their care providers with high regard, and some assumed that they were all-knowing. For example, through her care providers' role in managing her health, Serena expected that her care providers had access to indicators of harmful alcohol use:

*Serena: I think they [care providers] know you so much, they would sense that there were things about you that was caused with drink. I would imagine, through blood tests or whatever, they would know if you had a problem, yes.*

However, care providers working in general practice, who were involved in such clinical examinations, explained that blood samples are not systematically screened for indicators of harmful alcohol use. In the event that these were screened, they commonly only identified dependent or near-dependent levels of alcohol use. This element of older adults' alcohol-related risk perception could be problematic in practice, given older adults' health state is often otherwise closely monitored.

### ***Health priorities***

Older people's personal health priorities and concerns dictated which alcohol-related health risks were thought to be cause for reduced intake. By later life, participants often had particular health concerns that they looked to manage by any means. They were more open to adjusting their drinking practices when they perceived doing so would enhance their quality of life through alleviating health complaints. For example, John's arthritis was affecting his mobility, and he restricted his alcohol intake in an effort to control his weight and its effect on his condition:

*John: I've got arthritis in some of my joints, and I'm having difficulty getting about. I can't walk as much as I would like to, or used to, so it's inactivity which I'm concerned about. So I'm trying to eat less and just drink not necessarily every day or every night. Do you know what I mean? [...]*

*BKB: Yes. So is it more about making your life longer, or is it more about making your life easy, would you say?*

*John: I would say making my life easier and more acceptable.*

Older adults' specific health concerns determined which health risks they felt were personally relevant. For example, when discussing the increased risks of cancer attached to

excess alcohol use, Malcolm did not perceive these to be a relevant concern. His worries were linked to managing his risk of death from heart disease:

*Malcolm: So have they dropped the men's limit down?*

*BKB: Yeh, it's the same as women now, yes.*

*Malcolm: Bugger.*

*BKB: I know. We'll not tell you why [laughs] but that's associated with the increased risk of cancer, that's specifically. The reason why they drop men's down to women is that everybody has the same increase...*

*Malcolm: You see, er - I'm of the mind, and I'm speaking privately here, obviously confidentially here, yeh, but - I don't think I've even told [wife] this, when - you've got a long way to go. When you get to my age, mid 60s, you starting to think a few things. First of all, especially if you're lying, if something wakes you in the night, and you're lying there thinking... and I think to myself, "How long have I got left?" and then I think, "What's going to get us?" And I think, I think - what will get me is probably my ticker because it runs in the family[...] but I'm convinced when I do go, if it isn't, when a plane takes the both together, if something happens in the sky, it will be my ticker - because it runs in the family [...] So, [brother's] into family history and he couldn't find any history of cancer in our family. It's all been cardio. So if anything is going to... the law of average is if anything's going to get me it will not be cancer of the liver or anything like that.*

*BKB: So the risk that you're bothered about is cardiovascular risk really, cardio?*

*Malcolm: Well it nearly got us, in 2009, so - but I've got these stents in. Because we live in this wonderful technological world... erm, but I think, if anything gets me it's going to be my ticker.*

Within time-constrained care settings typical within general practice, general practitioners and nurses worked to prioritise their older care recipients' specific health concerns within their consultations; as discussed within Focus Group 3:

*GP4: I think in some settings they're probably expecting almost to be asked as well in those sorts of clinic situations where it's a health check or something.*

*Whereas I think with us, if they're coming in with something that they don't think is related to alcohol they might find it a bit more-*

*N2: They might think, "Do I look like a drinker? You know, I've only come for a sore on my finger."*

*GP4: I think it maybe means we don't do it as much.*

*N1: It can be a bit random, can't it? If they come in with something totally unrelated.*

They had experienced their care recipients' frustration when the topic of alcohol use was raised without obvious links to their specific concerns. In contrast, pharmacists had dedicated time to addressing older care recipients' health-related behaviours within their medicine use reviews having already addressed the individual's experiences of their health and medicine use. As such, alcohol-related discussion was more acceptable within this interaction.

Alcohol was seen to be relevant to a number of particular health concerns that were common amongst older care recipients; such as diabetes, falls, high blood pressure and obesity. Where intervention to address alcohol use was systematised within their work (see Table Apx T- 1), health care providers worked to highlight the relevance of care recipients' alcohol use to such health conditions. Ph1 explained how she highlighted the relevance of health risks to her older patients' health state and medication use in alcohol-related discussions:

*Ph1: Falls risk, I tend to bring up. It's an issue for all older people, generally. If they're on certain medications, I tend to make more of an issue of it. I have, obviously, a lot of patients who are on anticoagulants. I have a lot of patients who are on hypnotics, or some sort of hypnotic. I make more of an issue with them, like, "Did you know you're putting yourself at more risk? Do you think, maybe, that's not a good thing?"*

*BKB: Yes. So you'd bring in the medication risks, and then their susceptibility to falls more generally as well?*

*Ph1: Yes, trying to link it all together.*



Framing reductions in alcohol use in terms of potential benefits to older care recipients, given their specific concerns, represented an effective way of prompting reduced intake. Ph2 explained how he highlighted the potential gains that his older patients could make through reducing their alcohol use to motivate healthy drinking practices:

*Ph2: I know a fellow in his 90's came in to see me and he'd been getting really bad itching on his skin. And he'd seen the doctor and he'd given him E45, and all the usual sort of emollients and such like. And I asked him about alcohol and how much he drank, and he said how he drank every day, and went to the club on the lunchtime and maybe had a pint or two there, but also had a couple of cans or a pint or two when he was at home on a night as well. I said, "You know what? It could be the alcohol you're drinking, that's causing the itching and the skin irritation. It's probably worth having a check with your GP about that, but just give it a try, where you reduce it a little bit and see if it makes any difference." Because it was driving him nuts, and he came back to see me a week later and said that he'd just cut out alcohol completely because he said he reduced the alcohol and it reduced his itching and then he knocked it on the head, and the itching has gone completely. So, it's sort of depending, it's horses for courses and the advice has got to be individualised to what the dangers are, what the risks are, or what the patient can get from drinking or not drinking, giving up drinking. What difference could it make to their lives? And sometimes, it can make quite a drastic difference, as with this gentleman who had really bad skin irritation. Apparently, he'd been getting creams off his doctor for about six months and no one ever asked him the question, "How much alcohol do you drink?" So, it is worth keeping alcohol just in the back of your mind when you're having conversations about all sorts of things. Like you say, pharmacists are in a really good position to do that. So, it's just gauging what's the right conversation to have, to have benefit for the patient to reduce risk and also something that they're going to take away and actually do. Because if I'm just saying, "Reduce your alcohol intake or give up drinking," just for the sake of it. They're going to go out, not really take much notice. But if it's something specific where I say, "right, this might actually be the cause of the itching, try reducing your alcohol intake and see what difference it makes then come back and see me in a couple of weeks." [...] So, you can make an impact, but you've got to be realistic. I think the person's got to see that they're getting something out of it, rather than just a lecture.*

Similarly, GP2 was responsive to her care recipients' specific complaints in addressing their alcohol use; motivating reduced intake by suggesting it to be a potential resolution:

*GP2: It's actually kind of planting a seed about it. And then also find a hook, so whatever they've come in the consultation, if they say, "I'm tired," or, "I'm not sleeping well, my mood is low." I'll often reflect back to them, if they've drunk a lot, "Do you know alcohol lowers your mood? Have you thought about that?" Or, "It doesn't help you sleep. Maybe that would help, if you cut it back." It's finding a hook that can make sense to them rather than just going, "Don't drink alcohol, 14 units and less." That's not going to work. It's got to be holistic to them and their life.*

Weight-related concerns were a common motivator for decreased alcohol use amongst older adults, even where alcohol played valued roles in their daily lives. Many struggled with maintaining a healthy weight in later life. The high calorie content of alcoholic beverages was common knowledge, and the effect of alcohol on their weight was visible and immediate enough for them to form a clear association. Jack explained how many older adults, including himself, worked to restrict their alcohol use in an effort to manage their weight:

*Jack: I'm very well aware, that for example, I'm overweight by at least a stone, a couple of stones. And conscious of the fact that sugar is a major component of that, and white wine, particularly, and rosé is basically sugary water, isn't it. I think one does cut down one's alcohol because of one's weight or other medical conditions.*

Health care providers, who were involved in managing their older care recipients' weight, fostered and exploited this common health concern concurrently with alcohol-related discussion; motivating them to reduce their alcohol intake as part of reduced calorie consumption. As DN3 described, the more tangible risks associated with the calorie content of alcohol were more likely to lead to changes in their drinking:

*DN3: Alcohol is a huge part of weight management, because there's usually hidden calories. So I actually make people aware that your bottle of wine could be between 700 and 1,000 calories, and that might be why the weight is not coming off as quickly as they thought, if they were still obviously having alcohol. It's easier to talk about alcohol in the context of weight management, than health issues.*

*Like, sometimes that's the way that you can get people to think about their alcohol intake, rather than about all the negative effects, about, you know, cancers, and heart disease, and all that sort of stuff. So actually tangible things, results that they can see. Because actually, most people come in- because we send our results out, before they come to me for their review. So actually, they've looked at their results, and quite often, you'll say to somebody, "What do you think about your results?" And they'll say, "I'm too fat, I need to lose weight." And the majority of people, that's what they focus on. So actually, that's a great way in, to then explore their calories and their diet, and alcohol is a big part of their calorie consumption, as a way of trying to reduce it.*

Falls represented another tangible concern amongst the oldest participants, who recognised that age heightened their risk. They avoided drinking to the point of intoxication to prevent further impairments to their coordination. Falls risk was a commonly cited concern amongst care providers, particularly amongst those working with the oldest old within the community, such as district nurses, general practitioners and domiciliary care providers. They worked with their care recipients to motivate reduced alcohol use in order to reduce these risks.

Care providers' perceived remit of care narrowed the alcohol-related concerns they worked to address within their practice with older care recipients. This determined whether their response to alcohol use was prompted by identified risks of harm or existing consequences, the evidence they had as a resource to indicate potentially harmful alcohol use (as discussed [earlier in this section](#)), how alcohol-related discussion was systematised within their interactions with older care recipients, their capacity to intervene, and their perception of professional accountability for alcohol-related health promotion (relevant details for different provider groups are tabulated within Table Apx T- 1). For example, pharmacists' high level of training regarding alcohol-related health risks meant they conveyed particular concern about potential interactions between their older care recipients' medications and alcohol use, and looked to identify and address this in their practice. Dentists focussed upon concerns about risks of trauma and disease to the mouth associated with health-related behaviours which could include alcohol use, and had little training to support them in advising care recipients on other reasons to reduce drinking in later life:

*Den1: I've got to say, I put less effort into [drinking] behaviour modification as I would into sugar consumption or oral hygiene behaviour modification. Because in my particular world the main disease we're looking at are tooth decay and gum disease and because of that we try and modify sugar consumption and oral hygiene. And so we spend quite a bit of time saying, "Try and do this. Change your lifestyle in these sort of ways." And alcohol seems... probably a lower priority in modifying their behaviour.*

*Den3: I would completely agree with that. You know you said what about alcohol in relation to their general wellbeing and all the rest of it and other health issues. I'm not quite sure that I know enough about how good or bad alcohol is for you to be able to justify going any further with it apart from, "Did you know alcohol is linked to mouth cancer?" That's kind of like, as far as it goes really. And other cancers, but I don't go into any depth or any detail because I don't have the knowledge. I don't have the knowledge that I know is necessarily correct and isn't going to be skewed by my own perception.*

They perceived that other care providers, such as general practitioners, were better equipped to address older care recipients' alcohol use. Domiciliary carers had access to many indications of potentially harmful alcohol use within care recipients' home environment. However, they were not authorised to intervene, depending instead on referrals to other care providers:

*Car1: We just tend to monitor. When we see extra bottles and things like that, we would report to the office, speak to the family and just see what they think. I mean, fair enough, we go in and look after them, but that's where it stops. If the family is the one that you approach, it's down to them. We haven't really got a leg to stand on when it comes to that.*

However, they had not experienced much success in prompting appropriate intervention through referral:

*Car1: We don't really have much luck with GPs, to be fair. I mean, normally, if you do a referral, you will get a visit, but GPs only really tend to be interested in illnesses. [We tend to pass our concerns onto] the care manager and the district nurse, and to be referred to other people, Social Services, to see what other things*

*can be done. I think when people come up against it, they tend to just pass it from one to the next so they haven't got to deal with it.*

Participating social workers responded to each case holistically, looking to improve the individual's quality of life by whatever means necessary. They saw their approach as a stark contrast to that of health care providers, who rarely responded to potentially harmful alcohol use unless it had led to clear health consequences:

*SW2: Social workers, on the whole, generally, see it as the same thing. It's not necessarily the same from our health colleagues. They're very much, "That is a social issue and therefore we're not going to do anything about it. This is health. This is our sort of we're going to draw a line around what it is that we do."*

*SW4: Yes. Almost stating, "Unless you're yellow, it's not a health issue."  
(Laughter) Yes.*

*SW2: Yes, whereas, we have to, by the nature of our job, look at it as something holistically.*

*SW1: Because once you identify a health issue you just ignore it, you just can't ignore it. You have to explore further and try and help as much as possible. Otherwise, most of the health issues tend to affect social issues as well. So they're interlinked, actually, so it's very hard to separate them.*

Care providers working in general practice acknowledged their role in managing older care recipients' alcohol use. However, there were differences in how alcohol-related discussion was systematised within their work that meant allied health professionals, such as nurses and health care assistants, worked more to address older patients' alcohol use through screening and brief intervention than did general practitioners; as care providers participating in Focus Group 3 discussed:

*HCA2: I think we ask [about alcohol use] because it's part of our sequence and it's part of what we have to ask there. It's engrained - every contact you're saying, "Can we just ask you about your smoking, your drinking," you know?*

*GP4: It's not something that flags up though on our systems is it unless it's become an official problem or something. I think you can go back and you can see your consultations, you can see if they've said drink 50 units or whatever. It's not*

*all that obvious if we're seeing them for something else unless we actually look for it. It's not something that flags up.*

General practitioners had fewer prompts to address older care recipients' alcohol use, and less dedicated time within their consultations than did allied health professionals; but recognised their colleagues' roles in addressing alcohol use.

Care providers took different roles and were supported by different resources in working to address alcohol-related harm amongst the older age group.

### ***Incompatibility of illness with drinking***

Participants broadly viewed acute illnesses to be incompatible with drinking. When experiencing ill health, a number described having curtailed their alcohol use, often without prompting from care providers. Following his heart attack, Malcolm had greatly reduced his alcohol intake until he was considered to have recovered:

*Malcolm: Immediately after my heart attack, once the angiogram proved it - but even before the angiogram, erm, I was - er, I felt so ill. Erm, I had the under-tongue spray, and 999, if you're anywhere ring 999, it'll save your life. Erm, it was that - so, obviously, my life went on - my traditional routine went into suspended animation, until... my health... erm, until the experts, the cardiologists gave me the all clear and said continue on the rest of your life. But I'm probably more conscious now, which probably explains why, at that regimental reunion I go to in April, I'm the first to leave, because - because, before my heart attack, I wasn't the first to leave. [...] That stopped.*

*BKB: Aha. So the heart attack's changed how you see your health and you look after yourself more since that.*

*Malcolm: Yes, very much so.*

*BKB: Aha. And this stopping drinking while you were waiting for the results and things, was that - were you told to do that?*

*Malcolm: No, I did it.*

*BKB: Off your own back?*

*Malcolm: Yeh.*

*BKB: So what was your reasoning behind that? Was that just you wanted to do everything you could to be as happy as possible?*

*Malcolm: I wanted to stay alive.*

*BKB: So behind that wanting to stay alive and how that changed your alcohol, did - so you think that alcohol has a negative effect on your health?*

*Malcolm: No. I just - because I was on quite heavy medication, I thought, "Right, back off." [...] And -the alarm bells had rung. I didn't need to be told, it was a – it was a deliberate act by me. I was putting up, I was putting up the guard. I was - defending myself. I was defending my body. And because I was on medication, I thought, "I'm not going to – I'm not going to take anything into my body which I think could negate that medication." I want to stay – erm, it was my urge to live.*

Such conditions meant older adults saw their health as vulnerable, and potential health risks were considered to be more relevant. In light of this vulnerability, Malcolm resumed his drinking at what he considered to be a responsible level to minimise risks associated with his alcohol use.

### ***6.7.3. Relatable cases of harm from drinking***

Cases of harm through drinking experienced by others were conveyed as a tangible source of knowledge of alcohol-related health risks by participants where these 'others' were seen to have a similar relationship with alcohol and similar personal circumstances to their own. These cases were therefore personally relatable. Relatable cases of others' experiences attached to their alcohol use influenced older adults' perception of any risks associated with alcohol, motivating restriction or maintenance of their alcohol use.

Examples of the effect of drinking upon individuals' health often described positive effects. These positive, relatable cases may have been drawn upon by participants to position their own drinking as responsible and favourable. However, negative relatable cases were also discussed, and some participants described having been motivated by such relatable cases to change the way they used alcohol.

A number of older adults remarked upon the alcohol use of centenarians, demonstrating a goal as these individuals reached a great age. Their views varied depending on the stories

that participating older adults had heard about their drinking practices; for example Stanley noted there were few trends in their health-related behaviours:

*Stanley: There's plenty of centenarians who drink like fish, which suggests that maybe it didn't have an awfully bad effect on them. Of course, maybe it's that they avoided infections as a result, but then if you looked at all the centenarians around, at their lifestyles, there's no pattern in that.*

This understanding underpinned his fatalistic view about the effect of his behaviour upon his longevity. In contrast, Malcolm had heard about centenarians consuming night caps, and had consequently incorporated this practice into his own alcohol use in an effort to protect his health.

A number of participants had relatives with problematic relationships with alcohol. Their vivid memories of the catastrophic effects of drinking upon their relatives' behaviour and health appeared to colour their views of alcohol, as relatives were seen to be relatable in disposition. Most of these individuals were wary of drinking and restricted their alcohol intake. For example, Julia conveyed a negative perspective of alcohol across the course of the interview, which, it emerged, was caused by her experiences of her father's drinking:

*Julia: My father used to drink a lot and I think that was the sort of the sight of the kind of lifestyle, and that's kind of not left me, and I think that would be a significant reason why I don't drink. [...] You know, you're talking about sort of the 50s and the 60s and how it sort of affected you, the home life, and stuff like that.*

*BKB: His behaviour?*

*Julia: Yes, so that's not - never left me. So, I think that has had a significant effect on whether I would drink or not drink.*

*BKB: And what affect did that have on him across his life course?*

*Julia: He died when he was - well, he smoked as well. I'm trying to think how old he would have been. Erm - eighty, nine... sixties, probably my age, he had cancer and that was affected by smoking and drinking, so it shortened his life. He died, well he was 79 when he died, but he stopped drinking. He didn't stop smoking but he stopped drinking, but it did show in his life, I suppose, to my mother, who is still with us and she's 91. So, he went when he was about 79.*



Julia's experiences of the negative effects of drinking had caused her to distance herself from alcohol. Negative exposures earlier in life could therefore have a lasting influence on older adults' attitudes to drinking. However, where the individual was perceived to be qualitatively different, participants dissociated themselves from associated risks. For example, Janice perceived that her father's excessive drinking was driven by a disposition she did not possess. This experience had little effect upon her own use of alcohol.

Care providers involved in intervening to address older people's alcohol use (as detailed in Table Apx T- 1) discussed the challenges of navigating older care recipients' perceptions of risk associated with relatable cases within their narratives. Those with most experience in discussing alcohol with older care recipients, such as pharmacists and GP7 (who frequently consulted regarding mental health, to which the patients' alcohol use was often relevant) had developed responsive strategies, drawing upon relevant relatable cases to effectively convey risks attached to their patients' alcohol use. GP7 highlighted older patients' personal susceptibility to risk when treating issues relating to alcohol-related bereavement:

*GP7: As a GP, you need some backup, to make it work. [...] It can be, probably, fairly brutal if a member of the family has suffered from something that is lifestyle related. I'd normally say, "Do you know what the silver lining is in here? Somebody should have told Fred 10 years ago not to do that, and he might still be here or he might not be in hospital. What does that tell you about how you're living?" I'm fairly tough on that one. The GP intervention on its own has a certain amount of value, but if you can follow it up with other intervention.*

This strategy served to motivate reduced alcohol intake amongst his older patients.

#### ***6.7.4. Perceived relevance of health state to quality of life and longevity***

Disease and death were an accepted and expected part of the later stage of life for older adults and care providers. This view could lead to either an increased wariness of risk and consciousness of how their behaviour might affect their health, or apathy regarding riskier practices.

Some older adults were motivated to restrict their alcohol use when they viewed that their drinking might affect their health state, and when they perceived personal control over their own health and longevity. This view was evident amongst middle class participants, where

health consciousness was a valued attribute and they perceived agency over their own health state. Those whose illness had affected their quality of life were also keen to maintain their remaining abilities. Many accepted that their remaining years were limited. They felt that it was important to ensure their quality of life was not impeded by ill health caused by their behaviour. Men taking part in Focus Group 2 demonstrated this, as they talked of being more wary about their alcohol use:

*BKB: I think we've sort of talked about whether health is particularly important in later life. Would that be right?*

*Billy: You're more conscious of it! (laughter)*

*Jack: Well, when I think, again, it goes back to what Billy was saying about quality-of-life. One knows that one's quality-of-life is going to be severely diminished if one suffers from ill health. And overweight is obviously a component of that.*

*Billy: You are conscious of the fact, obviously, that your life is coming to an end. Is going to be far closer.*

*Jack: You are in the final furlong, so to speak.*

*Billy: Well that's right. You end up being more conscious therefore of I better not do this, I better not do that, or whatever, because of that stage. Than you would do, obviously, when you are younger.*

Health care providers involved in intervening to address alcohol use within their work (as detailed in Table Apx T- 1) recognised that their older care recipients were often in touch with their increased susceptibility to disease and motivated to restrict their alcohol intake. GP1 related this increased awareness to their increasingly poor health status, and recognition of their vulnerability to disease and death:

*BKB: Do you think older people give more consideration to their drinking than other age groups at all?*

*GP1: I think they're probably more concerned about their health in general, because of those things that I mentioned. As you get older, everyone becomes more aware of their own mortality, and they tend to develop a number of conditions, whether that be high blood pressure or whatever it is. As part of that,*

*people are probably slightly more aware of all the things that could be impacting into that.*

*BKB: Yes, and alcohol would become part of that.*

*GP1: Yes, so alcohol becomes something that, whereas beforehand – and I think it's the same with lots of things – I think younger people just think they're invincible and, "Yes, whatever, I can drink whatever I want," or, "I can smoke, but I'm not going to do it when I'm older," or, "It doesn't matter if I don't do any exercise and I eat unhealthy food." Then it kind of gets to an age where suddenly you're like, "Oh, actually I do need to think about all these things, because I've developed X, I've developed Y."*

The risks attached to drinking represented more of a concern when working with older care recipients; particularly for care providers with higher levels of training regarding alcohol-related health risks (as detailed in Table Apx T- 1). Pharmacists, particularly, demonstrated expertise regarding specific risks of alcohol use for older people. Additive risks of drinking, in combination with conditions and other risks associated with old age, meant alcohol-related intervention amongst older patients was a particular focus for Ph2:

*Ph2: Yes, well, there's the potential to increase the risk of cancer. Which, I suppose, effects at any age, but if they've already got other risks and also heart disease and risk of stroke and heart attack, cardiovascular disease. If they've got other risks from that, then alcohol might increase the risk so it's an additive risk for older people with their existing risks. The potential to have a fall as well. Because younger people, if they go out on a night out, have too much to drink, fall over, maybe get a couple of bruises and that will be the end of it. But if someone older drinks some alcohol, trips and breaks a hip, that can be very dangerous. So, there's other risks with older people that wouldn't apply to younger people. So, I think the care that we think about with patients, is more important in older people who drink alcohol, in a way that might cause them to have an accident or have other risks.*

Similarly, GP1 was responsive to her older care recipients' individual condition and medicine use in gauging when alcohol use may be problematic; incorporating her recognition of potential heightened risks of drinking in later life:

*GP1: You want to look at what their other comorbidities, their other health problems were, and I guess as people get older that's likely to be a longer list. They're likely to be on more medication and have more other health problems, so that might impact on... Some medications might impact on what you're advising them around alcohol and safe limits. Also, if they have already got lots of risk factors for cardiovascular disease, for example, or they've already got lots of risk factors for a cancer or whatever, then you might alter the way you consult, I guess, in that way.*

Health care providers worked to communicate these increased risks to their older care recipients within their practice, where recognised and relevant to the topic of consultation.

Where old age brought health conditions that affected quality of life, older adults did not feel that they had control over their own health states. These individuals were not motivated to attempt to prevent harm to their health through restricted drinking, and instead focussed on the positive roles of alcohol in their lives. Valerie felt that restricting her alcohol intake to avoid low energy would be pointless, as she experienced fatigue regardless of her drinking. Serena described a sense of hopelessness surrounding her health when she had life-limiting symptoms with no diagnosis to guide appropriate treatment. Although she felt uncomfortable about drinking whilst unwell, she did not perceive that reducing her intake would change her health outcomes.

Many care providers experienced in intervention for alcohol remarked on their oldest care recipients' apathy towards reducing their alcohol intake, who were resigned to their limited remaining years and felt drinking contributed to enjoying these. The general practice focus group discussed how this was difficult to address within their practice:

*DN2: I think older patients sometimes go, "Well, I'm 89."*

*HCA2: Well, that's a part of it, isn't it?*

*DN2: "You know, I haven't got long left. I enjoy it."*

*HCA2: It's hard to argue with, isn't it?*

*DN2: Yes, so it's hard to say anything really to that person.*

*BKB: Do people agree with that?*

*GP4: Yes, the very elderly, you think, "Yes.". I think if they've got that far doing that then good luck to them. I think it's the 65-year-olds, 70-years old who are nearly retiring and are hoping for a nice active retirement. You think, "Well actually, you need to try and do something a bit different to make sure you get that."*

*HCA2: Get that long retirement.*

Care providers frequently shared this sentiment, focusing instead upon the potential benefits of drinking for care recipients' quality of life in their remaining years.

Care providers' expectation of disease amongst their patients with age meant that they often failed to explore potentially harmful alcohol use as a potential cause for health concerns where discussion of alcohol was not systematised within their work (as detailed in Table Apx T- 1). GP1 explained that she responded only to explicit indicators of harmful alcohol use:

*GP1: If someone came... It's interesting because, actually, I maybe am - maybe I don't do this as much as I should, because if older people come in, which is quite a common presentation, saying they feel a bit giddy, or a bit unsteady, or a bit dizzy, or say they've had a trip or a fall, I go through... There's quite a big list of things you would go to, to see whether it's related to their blood pressure, or middle ear and things, or general frailty. I don't necessarily always ask about alcohol, I have to say.*

*BKB: But it sometimes comes up in that discussion, but not as a priority.*

*GP1: Yes, it would come up, I think, but I think there would probably have to be other cues from the patient, or other things in the history from the notes, or something else that's made me think, "Maybe I should ask about alcohol here." Maybe you have a bit of an assumption that your old granny that's falling over, sort of, "No, it can't be because of alcohol."*

## **6.8. Chapter Summary**

This chapter presented the findings of the fieldwork study exploring older adults' and primary care providers' perspectives of factors shaping drinking in later life, and how they are influenced. Twenty-four older adults and 35 primary care providers participated. The developed conceptualisation of factors shaping late-life drinking was discussed in terms of

four main themes: 1) the socially-situated nature of older people's drinking practices; 2) established and disrupted drinking routines; 3) roles of drinking in late-life socialisation, leisure and wellbeing; and 4) tangibility of health risk from alcohol use. Older people's drinking practices were primarily shaped by their socially learned understanding of appropriate drinking. This was grounded in norms and expectations for alcohol use relevant to their social identity. Drinking practices were embedded within older adults' day-to-day routines. Common late-life transitions could serve to disrupt these routines, and therefore how the individual used alcohol on a regular basis. Alcohol often played roles in older adults' social and leisure activities, which could contribute to their social and emotional wellbeing. Tangible and personally-relevant information on risks attached to drinking affected older adults' perspective of their alcohol use. Implications of and approaches to addressing the factors perceived to shape late-life drinking within primary care were detailed and discussed.

## Chapter 7. Discussion

### 7.1. Chapter Introduction

Two main approaches were taken to addressing the aims of this thesis. Firstly, a systematic review and thematic syntheses of qualitative studies examined perspectives of drinking in later life. Secondly, a qualitative study explored factors shaping older adults' alcohol use. For each component, the views of older adults and care providers were examined. Findings from these components were developed and presented separately. All elements are drawn together here to consider contributions of this body of work to the existing understanding of older people's alcohol use. Applicable social and psychological theory and wider relevant literature are drawn upon in this discussion. I then consider how the factors that shape older people's alcohol use might be addressed in primary care, and more widely in society. Strengths and limitations of this research are examined. Finally, I draw conclusions from my work, and outline implications.

### 7.2. Summary and Interpretation of Key Findings

#### *7.2.1. Appropriate drinking as a social discourse*

External social structures, such as social norms and expectations, were the principal factors influencing older adults' alcohol use (concepts introduced in [Section 2.4.2](#)). These contributed to a socialised understanding of 'appropriate' drinking, and a sense of how older people wanted to be seen to behave. The social and implicit nature of older adults' alcohol-related decisions is not unique to this age group. Qualitative studies of motives for alcohol use have described similar findings across the life course (103). However, this finding has a number of implications for how older adults' drinking can be understood. The dominant discourse of research into late-life alcohol use highlights the increased risks to health with age (52). This may lead to the expectation that health would be a major consideration in older adults' alcohol-related decisions. However, it was implicit social, rather than health, concerns that were the major motivator for restricted alcohol intake in later life. Older adults are often unfamiliar with evidence or guidelines to promote lower-risk alcohol use (23). However, lifelong interactions with social norms and expectations generated an implicit understanding of 'appropriate' drinking that removed the need for other external recommendations.

Specific factors attached to the experience and identity of being an older adult influenced perceptions of drinking. Responsibility was a valued attribute in later life, and one that older

adults worked to project to others in the ways they described their alcohol use. This tendency to engage in or present their alcohol use in a way that was considered to be responsible and 'appropriate' represented an 'age norm' for the older age group (a concept introduced in [Section 2.5.1](#)). A previous study of late-life drinking (included within my review) suggested that this sense of responsibility may protect the individual from aligning with friends' heavier alcohol use (169). Given the grounding of older adults' individual views of 'appropriate' and 'responsible' alcohol use within social norms, it seems unlikely that this is the case. Instead, older adults' investment in their responsible self-image may act as a barrier to recognising risks attached to their drinking. My findings demonstrated that older adults' 'responsible' drinking practices did not necessarily reflect low-risk alcohol use. Declining responsibilities through retirement and children leaving home meant key constraints on older adults' drinking were lost. This experience has been highlighted previously as a contributory factor for late-onset alcohol misuse, as fewer activities and requirements for their time increased opportunity for drinking (245).

The contrast between older adults' typical 'responsible' drinking practices and popular images of risky drinking created a strong 'other' group (a concept introduced in [Section 2.4.3](#)). The process of 'othering' affected older adults' perception of risks associated with their drinking. Messages regarding alcohol-related health risks were perceived to be less relevant to their own 'unproblematic' alcohol use than groups such as 'alcoholics' or younger 'binge drinkers', who possessed a need to drink or used alcohol to become intoxicated. The former, often less responsible self, provided an additional benchmark for positioning risk that was acquired in later life. Recent media coverage has highlighted the increasing harms faced by the older population through their alcohol use, and decreasing alcohol misuse amongst younger people. Such information may decrease the strength of this 'other' group for older adults, and may bring them more in touch with the risks associated with their own alcohol use.

Ill health was a common experience that changed older adults' alcohol use. My review indicated that alcohol-related health risks were unlikely to represent a concern to older people unless health became salient through experience of serious illness. This understanding fits with evidence from wider literature. Findings from Holdsworth and colleagues' analysis of data from the English Longitudinal Study of Ageing demonstrated that ill health represents a context where changes in alcohol intake are most likely (25). The



authors explained these changes as a response to medical advice, experienced interactions with medication or reduced ability to engage in social occasions that may incorporate drinking. My fieldwork suggests that the experience of illness may also prompt reduced alcohol intake through changes in how the self is viewed, and respective social rules guiding their behaviour (introduced in [Section 2.4.2](#)) given associated perceptions of vulnerability.

The experience of growing older was itself associated with a sense of vulnerability. This stemmed from older adults' recognition of their increased susceptibility to disease and death in later life. As a result, many placed greater weight on the effects of their lifestyle upon their body. Perceived vulnerability attached to the experience of old age motivated reduced alcohol use amongst older adults engaging in problematic drinking practices in previous qualitative work (246). This 'future time perspective' differentiates older adults' health-related considerations from those of younger age groups. Young people are thought to place little importance on protecting their future health through regulated behaviour (247). However, as I have demonstrated in this thesis, perceptions of vulnerability may lead to reduced alcohol intake only if the individual believes that they have the power to modify health outcomes with their own behaviour (248). For some older adults, symptoms may not be easily managed; and for many within the fieldwork study, physical decline and death were perceived as inevitable. This experience may lead individuals to a sense of hopelessness or fatalism about their health state, so that modifying behaviour is perceived as futile. Individual experiences of the ageing process, and the effects on the body in particular, shape older adults' perceptions of and response to risks attached to their alcohol use.

### *A social discourse of appropriate drinking: Implications for care practice*

Discordance between normative drinking practices and health recommendations for alcohol use had implications for discussion in care settings. Where care providers' and older care recipients' understanding of appropriate alcohol use differed, discussion of alcohol could be challenging. Older adults' understanding of their own alcohol use was contradicted by the guideline-led discourse often utilised in care settings that may lead to their drinking being categorised as risky. This created a sense of dissonance for older adults. Resultant tensions may explain care providers' reluctance to initiate discussion about alcohol. Fears of alienating patients by broaching the sensitive topic have been highlighted as a barrier to detection and intervention for alcohol misuse across age groups in care settings (59, 232).

Care providers, as individuals subject to social influences, also possessed their own understanding of 'appropriate drinking'. By recognising that drinking was the norm, they were uncertain as to whether alcohol use represented a valid concern to address in their practice; particularly where alcohol-related discussion was not systematised within their practice (as detailed in Table Apx T- 1). Similar findings have been demonstrated in other qualitative studies of alcohol-related practice in the North East of England. Local norms for excessive drinking meant potentially risky levels of alcohol use were not addressed by care providers (230, 249). Increased risks of drinking at normalised levels in later life (15) may mean the influence of norms for excessive drinking on care providers' perceptions of risk could result in greater harm amongst older people. Care providers also held a social construction of problematic drinkers. This led to preconceptions for people likely to drink to excess. Their perceptions of risk associated with older adults' alcohol use paled in contrast to the harmful drinking of stigmatised groups, such as younger 'binge' drinkers. In combination with low levels of awareness of specific risks attached to drinking with age evident amongst providers less educated in alcohol-related practice within the fieldwork study, this may contribute to low levels of detection of older adults' potentially harmful alcohol use (44).

Care providers expressed negative assumptions about the value of intervening with older people's alcohol use, given the established nature of their drinking practices. This led to uncertainty as to how to approach the issue for those less equipped with intervention skills. Some care providers consequently lacked confidence for broaching the topic of alcohol. Low self-efficacy for alcohol-related discussion has been recognised as a barrier to discussion of alcohol with older care recipients (54). Older adults' drinking practices were typically maintained through integration within their day-to-day routines. However, it was evident that changes in their alcohol use occurred over time. Some care providers were reflective and responsive to this feature of older adults' alcohol use, and worked to incorporate reduced alcohol intake into older care recipients' routines; particularly where they were experienced in intervention, and alcohol-related discussion was systematised within their work. Older adults could be supported to reduce intake per session, and number of sessions across the week.

### *Social and cultural identity and context*

Older adults' sense of social identity and context shaped the development and form of drinking practices, through specific societal expectations that defined appropriate drinking

(discussed in [Section 2.4.2](#)). Participants' alignment to these social expectations led to socio-demographic and country-specific patterns of alcohol use. Gendered and class-based expectations for alcohol use were present in older adults' narratives, and were associated with differences in the way they used alcohol. Alcohol use amongst older women was more restricted than amongst men, as older men felt able and expected to drink in a broader range of contexts. Compared to women, their overall alcohol intake and number of drinks consumed on individual occasions were often higher. This finding reflects gendered trends seen across cultures amongst older drinkers, where men consistently consume greater quantities of alcohol than women (24, 28-30). Previous research has reported a reverse social gradient in alcohol intake in later life (29). My work demonstrated that different socio-economic groups were prone to different drinking practices. Drinking to become intoxicated was more commonly described amongst more socio-economically deprived individuals in my study. The socio-economically advantaged more often exceeded weekly alcohol use guidelines with intake accrued through daily drinking practices rather than high intensity drinking occasions. As such, both groups engaged in risky uses of alcohol. The reverse social gradient for alcohol intake should therefore not be interpreted to infer that socio-economically advantaged groups are at higher risk from their drinking. This is particularly true given strong evidence suggesting that the more socio-economically deprived are most susceptible to harm from drinking (250). My work demonstrated that both groups may be at risk through their drinking, but these risks stem from different practices, with different implications.

Country-specific influences on drinking norms and expectations amongst older populations were also highlighted within my cross-cultural review. In particular, lower-level drinking and abstinence described in Sweden, Norway and Finland were rooted in their historic temperance movement. Such country-specific influences were observed in quantitative analyses of national survey data, where drinking practices varied greatly amongst the older age group between different higher income countries (24). The findings of this thesis emphasise that the older population is a heterogeneous group in terms of identity and patterns of alcohol use. Older drinkers should not be treated as one amorphous group given different social expectations shape individual drinking practices.

Care providers' perceptions were also subject to socio-cultural influences, contributing to preconceptions for older adults' alcohol use. For example, in Sweden and Norway, care

providers were less open to the possibility that excess drinking may be a problem for older care recipients in my review. This was because older adults within these countries tended to idealise lower-level drinking and abstinence. Care providers' alcohol use screening and brief intervention is guided by their preconceptions for characteristics of individuals likely to engage in risky alcohol use (251). Stereotypical perspectives about which sections of the population were risky drinkers often reflected social trends for groups likely to use alcohol at higher levels. As such, care providers' preconceptions raise awareness of aspects of care recipients' social identity that may make them more likely to drink excessively, facilitating detection of potentially harmful alcohol use (59, 252, 253). However, many examples were discussed within this thesis where alcohol use was not explored where it may have been an issue because the care recipient did not fit the expected profile; particularly where such preconceptions were not challenged through close work with the older population. Intervention led by preconceptions may consequently act as a barrier to identification and support of some older adults' problematic drinking.

The local environment created additional, structural constraints upon older adults' alcohol intake. The influence of the physical environment on access to alcohol was highlighted in some studies included within the review. Limited availability of alcohol within the local area was a barrier to alcohol use. This finding was evident in studies conducted in some Scandinavian countries, where access to alcohol is restricted (254). Transitions associated with ageing, from changes in financial status to mobility, may also limit access to alcohol within the local environment. Within the UK, my fieldwork suggested that the economic and environmental context facilitated access to alcohol. My participants were drawn from diverse socio-economic circumstances, across urban and rural areas, and some had poor mobility. Yet, all spoke of alcohol as available, affordable and easy to access. Holdsworth and colleagues highlighted the current socio-economic context as a facilitator for unrestricted and regular patterns of consumption when reflecting upon their analysis of socio-demographic factors affecting older adults' alcohol intake in England (25). Findings of this thesis highlight the contextual variability of social constraints upon older adults' alcohol use.

The influence of social and environmental structures on older adults' alcohol use situates individual choices within the wider context of society, creating a pre-conscious logic to how older people use alcohol (explained in [Section 2.4.2](#)). The nature of older people's alcohol-related decisions is therefore discordant with the philosophy of self-determination and

individual choice that lies at the heart of current approaches to health promotion and public health (103). This individual-level understanding of alcohol-related decisions was reflected in the practice described by care providers. My review indicated that this created challenges within their work. Their view that older adults' drinking practices reflected individual, conscious choice meant practitioners questioned their roles and responsibilities in intervening with excessive intake. Future approaches to prevention of harm from unhealthy behaviour are set to sustain this view of alcohol-related decisions. In a recent speech introducing the NHS's Long Term Plan for disease prevention, the current health secretary emphasised the importance of individuals taking responsibility for their health through choosing to engage in a healthier lifestyle (255):

*“Prevention is [...] about ensuring people take greater responsibility for managing their own health. It's about people choosing to look after themselves better, staying active and stopping smoking [...] making better choices by limiting alcohol, sugar, salt and fat. [...] but focusing on the responsibilities of patients isn't about penalising people. It's about helping them make better choices, giving them all the support we can, because we know taking the tough decisions is never easy.”*

This view references the influences of social structures as barriers to engaging in low-risk behaviour. However, the main emphasis is on the conscious nature of lifestyle decisions that may represent a health risk. Evidence from the broader public health literature suggests that approaches to the prevention of alcohol-related harm are unlikely to be successful if they are focussed solely on individual behaviour change (103). Wider determinants of health-related behaviours must be recognised and addressed to enable people to make positive changes.

### ***Cohort-specific and transitory drinking practices***

Differences between birth cohorts of older adults were evident in patterns for drinking practices, and related perceptions. Former manifestations of societal expectations for alcohol use had been internalised across the life course. These were integrated with current social norms and societal expectations for appropriate drinking to determine older adults' drinking practices. This finding supports Holdsworth and colleagues' hypothesis that older adults' alcohol use likely reflects a hybrid of practices learned in younger adulthood and maintained or developed across the lifespan (25). Within my work, perceptions of appropriate drinking appeared to have transitioned since earlier in life to the drinking

practices older adults now worked to align with. Societal expectations for restricted intake in public settings amongst women had softened across participants' adult life, aligning more with those for men. Such changes in expectations for alcohol use were reflected in 'migrating' drinking practices described by older adults. As cohorts aged, their alcohol use changed to align with new social expectations. Gender convergence in social expectations for alcohol use and consequent alcohol intake was evident within my fieldwork and some studies included within the review. Such convergence is associated with increasing gender empowerment in some countries (256). However, gender inequalities in alcohol use still remained amongst the older age group, reflecting sustained influence of historic norms and expectations. My review demonstrated similar shifts amongst older adults in Sweden, Norway and Finland, where older people described how their alcohol intake had increased. Norms and expectations shaping alcohol use had progressed as society moved beyond the historic temperance movement.

Practices learned earlier in life continued to influence older adults' alcohol use as they aged. Lower levels of alcohol use amongst the older age group are typically assumed to indicate age-related declines in alcohol intake. However, this likely reflects cohort-based trends, where older groups idealise more restricted alcohol intake. This is not a new idea, and reflects conclusions drawn by studies examining older adults' alcohol use across multiple countries (46, 190).

Cohort effects also appeared to explain ageing out of some drinking practices. Some uses of alcohol were recalled by the oldest old as an unsustainable practice of previous generations. This was the case for drinking to self-medicate physical ailments amongst those in the fieldwork sample. By contrast, the oldest old still engaged in this practice in some studies included within my review. Similarly, although some review participants reported using alcohol for protective effects for their health, this finding was not reflected within my fieldwork. This disparity may be due to differences in study time-frames and cultural context, spanning different and changing discourses. Fieldwork data were collected following the release of updated low risk alcohol use guidelines and related media coverage. Both challenged the evidence for health benefits associated with drinking. Medicinal uses of alcohol appeared to have evolved towards promoting wellbeing through alcohol's roles in socialisation and leisure time. This may represent a function of alcohol amongst the most recent cohort of older adults. This use was evidenced amongst British mid-life stage adults in

2012 (105); a group that has since aged into later life. Cultural factors likely also influenced discrepancies between fieldwork and review findings for medicinal uses of alcohol. Analyses of survey data demonstrate such uses amongst the older age group in Finland (47), but not within the UK (257).

Changes in norms and expectations for drinking over time have implications for care practice. Perceptions of alcohol as a sensitive subject affected discussion of alcohol use, particularly in studies conducted in Sweden and Norway. However, recent qualitative studies of factors affecting alcohol-related discussions in primary care illustrate how care providers' recognition of increasing cultural acceptability of alcohol use is making these discussions easier (230, 232, 258).

### *7.2.2. Late life and alcohol-related risk perception*

My fieldwork study highlighted the differential impacts of a range of knowledge sources on older adults' perceptions of risk attached to their alcohol use. Experience of tangible evidence of harm associated with drinking was important in older adults' recognition of alcohol-related health risks. Older adults expected that excessive drinking would be accompanied by the experience of associated, indicative symptoms. This expectation may be problematic, given the complex relationship between alcohol use and experiences of physical health. As was demonstrated within the fieldwork study, older adults who are at risk of harm through their drinking do not always experience symptoms (259). Beyond the experience of symptoms associated with excessive drinking, for some older adults reaching old age was taken to indicate that their lifestyle was healthy and sustainable, justifying their continuing pattern of alcohol use.

My fieldwork study indicated that older adults' attribution of alcohol as a potential cause of any symptoms they experienced was important in triggering thoughts about modifying their drinking. Attributing behaviour as a potential cause of symptoms is important in recognising behaviour change as an appropriate response to a health threat (260). Leventhal's common-sense model of self-regulation of health suggests that concrete experiences of symptoms, where attributed to risky behaviour, are more likely to prompt behaviour change than other risk communications. Experiences of concrete manifestations of harms are processed as a danger, instigating fear. This prompts the individual to produce action plans to mitigate the health threat (260). Care providers are an important influence on individuals' attribution of

causes for their symptoms, where they are consulted by care recipients for diagnosis and management. Here they can raise attention to symptoms and highlight alcohol as an influential factor, guiding an appropriate response through reduced alcohol intake (260). A qualitative study of older adults' perspectives of alcohol use, published following completion of my review, highlighted how care providers' advice (that reduced alcohol intake was an appropriate response) was fundamental in instigating reduced consumption (261). It is crucial that care providers recognise alcohol as a potential relevant cause of care recipients' health concerns. However, as was demonstrated within my fieldwork study, age-related processes may be preferentially attributed as a cause of symptoms in later life; particularly where exploration of alcohol use is not systematised within providers' work. This is due to the expectation of deteriorating physical function with age; described as the 'age-illness heuristic' (262). Health concerns associated with alcohol misuse within the older population, such as accidents, insomnia, confusion and self-neglect are easily misattributed to the ageing process. This heuristic process represents a barrier to alcohol-related discussion and intervention with older care recipients (54).

Alcohol use screening tools and indicative blood test results were recognised by both older adults and care providers as a tangible source of evidence that alcohol may be harmful. Amongst older care recipients, this facilitated contemplation of reduced drinking. Medical evidence suggesting alcohol to be harming health was reported by older adults as a motivator for reduced intake in a survey study of older adults engaging in risky drinking practices (49). However, the screening tools commonly used to convey health risks in a tangible format are not designed for use with older adults, and have low validity in detecting risks attached to alcohol use amongst the older age group (54). The Alcohol Use Disorders Identification Test (AUDIT) is the gold-standard screening tool employed by care providers to assess risk. This tool does not acknowledge the interaction of alcohol with medications, slower biological metabolism associated with ageing, existing illnesses or frailty, which make 'moderate' levels of intake problematic in later life (23). Many older adults participating in the fieldwork study conveyed health risks in their alcohol use that were not reflected in their AUDIT score, such as use prior to driving and in combination with conditions and medications that make drinking more harmful.

Older adults' indirect experience of harm resulting from alcohol use also represented a tangible knowledge source. My fieldwork study demonstrated how older adults drew upon



others' experiences of alcohol-related harm given similar personal circumstances in establishing their perceived risk from drinking. The experiences of 'relatable others' contribute to a lay epidemiology; where the individual's perceived risk of harm is gauged through links made between their behaviour and consequences they have experienced (263). Health messages based upon epidemiological studies rely upon wide-scale behaviour change, leading to overall improvements in population health. However, on an individual level, small differences in a behaviour are unlikely to manifest in noticeable differences in experiences of physical health. Consequently, people commonly do not acknowledge any consequences of their behaviour for their own health. This phenomenon is evidenced in other populations. Within Laing's study of pregnant women's perceptions of alcohol use during pregnancy, risks conveyed regarding drinking when pregnant were mitigated through the women's experiences of others' use with no apparent negative consequence (264).

General public health messages appeared to be disregarded by older adults as an indicator of risk associated with drinking. Several processes may explain this. Firstly, as previously discussed, the risks associated with alcohol use were deflected to 'othered' groups known to use alcohol in a harmful manner. Secondly, theories of self-regulation suggest that generic health messages represent a different, abstract source of knowledge; in contrast to an individual's own experiences and the experiences of relatable others. Processing such health messages involves conscious thought about conceptual knowledge, which involves more cognitive effort and is less automatic (265). Finally, the abundance, and apparent contradictory nature of health messages may have delegitimised them as a knowledge source. This phenomenon is described in Crawford's writing about risk rituals:

*"The regulatory and litigious disputes of the last 30 years, with their conflicting expert testimony about what is safe or unsafe, leave many feeling baffled; and the continually shifting state of knowledge ('one day they tell you it's safe, the next day it may kill you!') adds to the bewilderment. [...] People are left wondering about the efficacy of medical advice: as the map of danger is filled in, safe passage appears all the more difficult; but as the map of safe passage becomes illegible, people do not know what to believe or how to act in order to be safe"*  
(pg.511, (266))

The constant stream of seemingly conflicting health messages available to the public decreases the value of these messages as a source of information about health risk. Within

this study, it was evident that this deluge was even greater. Older adults had experienced many years of different health messages, alcohol-related and otherwise. Guidelines for 'safe' and 'lower risk' drinking have also changed over time. In 1995, they encompassed a view that alcohol had protective effects for cardiovascular health. The most recent manifestation reverted to former guidance, having understood the emphasis of health benefits as politically-motivated (1).

My qualitative study identified the circumstances in which alcohol-related health risks become a concern that in turn may lead to behaviour change. The key point is when symptoms that affect an older adult's quality of life are specifically attributed to their alcohol use. Suggestions to reduce engagement in a potentially enjoyable activity may be disregarded if the individual does not perceive they would benefit, as indicated in survey data on risky older drinkers' alcohol use over time (49). In the context of later life, primary care practitioners may be involved in managing multiple individual health issues. Some of these issues will affect the patient more than others, with differing relevance to their life goals.

Like older adults, care providers expected that older care recipients' alcohol misuse would present with recognisable signs. They relied on these indicators to prompt a discussion about alcohol consumption. This reflects a targeted approach, termed 'pragmatic case finding' in a qualitative exploration of general practitioners' approaches in Norway (253). Within my fieldwork, alcohol-related discussion was often integrated within consultations alongside weight and hypertension. Here, alcohol may play a role in the development and/or management of a condition. However, many signs that prompted alcohol-related discussion were associated with alcohol dependence. Care providers' focus upon these signs may reflect the absence of any indicators at lower levels of drinking. It may also reflect the perceived legitimacy of dependent drinking as a medical condition in its own right. Findings from analyses of survey data support this idea. Amongst English primary care patients, risky alcohol use is less likely to be identified than alcohol dependence (267). Taken together, these findings support the idea that care providers view their role in intervening with patients' alcohol use as valid only when they perceive their drinking is directly affecting patients' health. This reflects a disease-focussed approach to care, where resources are directed towards those already unwell, rather than to preventing disease occurrence (268).

My fieldwork study suggested that prevention of alcohol-related harm became a low priority in the face of ever increasing workloads within the UK.

It is likely that care providers' and recipients' risk perceptions have implications for discussion of alcohol use with patients of any age. Opportunities for preventive discussion may be further compromised by the number of health concerns in later life, and their prioritisation in care practice. The increased contact time associated with typically higher numbers of health concerns in later life may be viewed as a facilitator to alcohol-related discussion within primary care (62). However, it was evident within this work that the complex health needs of many older adults meant multiple issues must be addressed in consultation. Consequently, preventive discussions may not be prioritised in care settings such as general practice, where an array of care needs are encompassed within providers' working remit.

### *7.2.3. Roles of drinking in later life*

Social and emotional wellbeing were important in older adults' considerations of the effects of alcohol on their lives. My work highlighted the positive contributions of drinking to older adults' social and mental wellbeing. Drinking was an integral part of many older adults' social lives. The ritualised roles of alcohol in social occasions are not unique to the older age group, and have also been described amongst working age adults (112) and young people (94). However, my findings demonstrated that reduced social connectivity in later life could affect alcohol intake due to its functions in social contexts. Disengaging from social 'fields' such as work and sport could mean that older people had fewer opportunities for social interaction. A high proportion of remaining opportunities involved alcohol. Socialisation represents a major reason for drinking in later life, reported by three quarters of older drinkers within the UK (23). However, my work also demonstrated that where drinking companions were lost, reduced social opportunity could lead to reduced or ceased alcohol use. This finding is reflected in UK survey data of older adults' drinking (269). Similarly, my work suggested that efforts to reduce alcohol could have a negative impact on older adults' relationships where they did not engage in alternative opportunities.

For some sections of the population, drinking is particularly integral to socialising in later life. Within American and Australian retirement communities studied in papers included in my review, most socialisation took place in on-site bars. However, the presence of alcohol in

supported living or care home settings was not discussed by UK residents participating in my study. Within this work, men's socialisation was more centred around alcohol use than women's, particularly when the individual lost their partner. The intrinsic roles of alcohol in men's social engagement may explain findings indicating that older men's, but not older women's, drinking increases following widowhood (270). My fieldwork suggested that drinking may be involved in rebuilding social networks in such circumstances.

Alcohol has a symbolic role in distinguishing leisure time from time allocated to less pleasurable activities or tasks. This was described within my work, but may also be observed across age groups (113). However, this transformative function of drinking played a particular role in later life where formal structures had been lost through retirement and disengagement from other day-to-day responsibilities. My findings suggested that an additional role of alcohol, in creating a state of pleasure, developed with age. Many participants discussed a symbolic association between drinking and happy experiences, in which alcohol had been involved across the life course. This has previously been described in terms of 'expectancy' (18), where older adults are motivated to engage in alcohol use through expectation of positive outcomes. This positive reward cycle is a process in behavioural pattern forming, which is thought to be involved in the development of alcohol dependence (271). However, drinking motivated by such associations was seen broadly within the fieldwork sample of non-dependent drinkers. At least for the older age group, this experience is unlikely to be specific to the development of a dependent relationship with alcohol. Similarly, the role of alcohol in creating a state of relaxation in later life has previously been associated with the development of alcohol misuse amongst older adults in American and Danish populations (46, 245). Again, this use of alcohol was demonstrated broadly within the fieldwork sample, suggesting the discrepancy may reflect cultural differences in social expectations for appropriate drinking. Roles of alcohol that may be suggestive of problematic drinking contributed positively to the lives of many older adults within the findings of this work.

Older adults' celebration of the positive contributions of alcohol to their quality of life was a dominant narrative within this thesis. For some older adults involved in the fieldwork study, the important contributions of alcohol towards their social and emotional wellbeing were prioritised ahead of any health concerns. This finding reflects an 'all things considered' view of health-related behaviour, typical of lay epidemiology. Rewards associated with engaging

in risky behaviours may outweigh any health benefits that could result from avoiding them (248).

The positive effects of alcohol use for older adults' social and emotional wellbeing may contribute towards explaining J-curve relationships between alcohol intake and health outcomes; in addition to characteristics of abstaining groups that make them more likely to experience harm (described within [Section 1.2.1](#)). It is possible that alcohol's roles in social opportunities also contribute to protective effects, through altering the individual's social circumstances that are conducive to experiences of loneliness - known to be harmful to health (272). My fieldwork suggested that alcohol promotes social connectivity through its involvement in social activity and rituals, and through its disinhibitive functions (explained within [Section 6.6](#)). This may explain cross-sectional evidence from the American Healthy Living As You Age study suggests that people who drink more often are less likely to be lonely (272). However, this finding could also be linked to the fact that lonely older adults drink less because they are engaging in fewer social contexts where alcohol might be consumed – the direction of this relationship is not clear-cut. Further caution should be advised in interpreting the relationship between loneliness and alcohol suggested by my study. Social connectedness (as opposed to isolation) does not necessarily mean an individual is not lonely. Whilst loneliness and social isolation are associated, they are not equitable concepts. People with infrequent social interactions (socially isolated) are not necessarily lonely (dissatisfied with their level and quality of social contact); and people with active social lives can be lonely (229). For example, an individual may experience loneliness because they are missing the company of their wife following widowhood; and interactions with other individuals may not temper this feeling. Whilst my fieldwork demonstrates that engaging in alcohol use can increase the frequency and quality of older adults' social interactions, it does not mean that these interactions will fit with the older person's desires for socialisation, and as such does not eliminate the potential for experiencing loneliness. Further, whilst alcohol may facilitate the individual to enter a social setting, barriers associated with old age, such as hearing impairments or a sense of overwhelm stemming from the very circumstances that may lead to dissatisfaction with social interactions (such as widowhood) may leave the individual unable to participate meaningfully (273). These issues, in addition to broader social, cultural and socio-economic influences upon experiences of loneliness, with unclear pathways (229), paint a complicated picture of experiences of

loneliness, and the potential roles of alcohol in mitigating this. To add to this complexity, although more frequent alcohol use may be associated with social connectedness, loneliness is also a commonly cited reason for heavier drinking in later life (23). Findings reported within this thesis suggesting mechanisms involved in the relationship between alcohol use and experiences of loneliness are likely just a part of a broader and complex picture.

Care providers conveyed a bleaker view of later life, and roles of alcohol in coping with negative experience. However, they recognised the valuable contributions of alcohol to older care recipients' wider wellbeing. The complexities of alcohol use as an issue for care provision were vivid within both review and fieldwork findings, and had implications for practice. Drinking was not viewed as a clear-cut health risk, raising question regarding the ethics of working to motivate any level of disengagement from drinking activities where intervention to address alcohol use was not systematised within providers' practice.

Roles of alcohol in coping with late-life stressors were demonstrated within the narratives of older adults participating within the fieldwork study. This reflects findings from British survey data, demonstrating that use of alcohol in managing stress is a common motivator for drinking amongst the older age group (257). My work provided a novel understanding of this function of alcohol for older adults. Drinking represented a form of escape through its roles in social opportunities and accessing pleasure, providing distraction and respite from negative affect. As was demonstrated within my sample, baseline data from the Drink Wise Age Well programme suggest that such reactive uses of alcohol are associated with risky levels of intake (23). Coping with late-life stressors is a commonly attributed cause for late-onset alcohol misuse amongst older populations (245). Use of alcohol as a coping mechanism may therefore be a damaging response, and, as was demonstrated within my fieldwork, could even be associated with a deterioration in older adults' emotional state.

#### ***7.2.4. Rethinking transitions in understanding changes in older adults' alcohol use***

My findings highlighted complexities in the effects of common late-life transitions on alcohol use, beyond simple trends for overall intake. Late life transitions altered the individual's personal circumstances and drinking routines. Resources, or 'capital', that enable older people to act in a particular way could be affected (concepts introduced in [Section 2.4.2](#)). Their engagement with different social 'fields' could also be altered, in which different social rules guide different drinking practices. Lifestyle change most often occurred organically in

response to such changes in life circumstances. However, there were few trends in the influence that these changes had upon the individual's overall alcohol intake. Variation depended upon the older person's social resources and influences, perceived control over health and upon the roles that alcohol came to fulfil in new day-to-day routines. This finding corroborates the multi-directional effects of late-life transitions on alcohol intake demonstrated within a qualitative study of older adults' perspectives of drinking in later life (261). Survey data similarly demonstrate a complex relationship between late-life transitions and alcohol use. There are few consistent trends in the effect of any particular life transition upon older adults' alcohol intake. For example, there is no clear pattern for effects of retirement upon older adults' intake within existing literature (25). My work demonstrated how retirement could have varying influences on alcohol use. Through disengaging from the workplace, social connections were lost, and drinking opportunities could be reduced. Retirement could also increase engagement in social 'fields' where drinking is appropriate, increasing intake. Similarly, analysis of data from the English Longitudinal Study of Ageing demonstrated that bereavement was associated with both increases and decreases in intake (172). Late life transitory events should not be viewed simplistically as a risk factor for alcohol misuse amongst the older age group. As evidenced within this thesis, a multitude of factors determine the influence of these experiences upon older adults' drinking.

#### *7.2.5. Understanding this work through theories of ageing*

Some intricacies in the factors found to shape older people's alcohol use can be understood in the context of a life course perspective, and theories of the third age (introduced in [Section 2.5](#)).

The body of work presented within this thesis highlighted influences of individual experiences of alcohol across the life course upon late life drinking practices; through family values learned early in life, experiences of others' alcohol use, and changes in social expectations for 'appropriate' drinking practices, and how these are incorporated into older adults' understanding of how to act. Although longitudinal evidence indicates that transitions may be most influential for alcohol use trajectories across the life course (120), my findings suggest that social contexts from earlier in an individual's life are still influential for their alcohol use as an older adult. Additionally, this work demonstrated that although change in older people's alcohol use occurred in the context of life transitions, the impact of transitions upon older people's drinking practices is complex and varied (discussed in [Section](#)

7.2.4). Life transitions influenced intake not only through effects upon opportunities for consuming alcohol, but also the roles alcohol plays within available social opportunities, and in distinguishing leisure space. Cohort effects were also evident within this work, as experiences on a birth group-level across the life course influenced patterns of alcohol use and related perceptions within older populations (as examined in Section 7.2.1).

Individual experiences of alcohol across the life course created a context for how older adults understood their current drinking practices and associated risks; positioning their alcohol use as responsible (discussed in Section 7.2.1). Accrued experience of alcohol also meant older adults viewed themselves to be experts in their own alcohol use, and how to drinking 'appropriately'. Experiences of contradicting messages about alcohol across the life course created a sense of perspective regarding the legitimacy of recent claims for health benefits associated with drinking (discussed in Section 7.2.2). As such, perceived health benefits associated with alcohol use did not have such significant influence on older adults' alcohol use as has been previously suggested in studies of contextual influences on motivations for drinking amongst current cohorts of older adults (129). Personal experiences of alcohol accrued across the life course in the context of enjoyable activities created a new function of alcohol in later phases of life, in accessing pleasure (discussed in Section 7.2.3).

It was evident that older adults in the fieldwork sample prioritised quality of life in their decisions and behaviour regarding alcohol use. Whilst this finding was true regardless of the individual's life stage, theories of the third and fourth age suggest that underlying motivations may differ. Expectations that the third age is a period for leisure and enjoyment (274) may explain older adults' use of alcohol as an enjoyable social and leisure activity during this life stage. However, recognition that decline comes with the next phase of life creates a dilemma for older adults in the third age (130), as people within this life stage are known to be motivated to prolong their remaining healthy years through taking protective measures in their behaviour (275). This was demonstrated within my fieldwork, where those with some control over their health (who would classify as 'third age') were motivated to sustain their physical and cognitive abilities, and the freedoms these offered, through lower risk alcohol use (discussed in Section 7.2.2). However, my fieldwork highlighted a number of barriers to older adults' recognition of risks associated with their drinking, relating to their awareness of specific risks attached to alcohol use with age, how they positioned their alcohol use and identified with 'risky' drinking (discussed in Sections 7.2.1 and 7.2.2). As



such, social expectations for 'appropriate' drinking, and motivations to enjoy this period for as long as it lasts were dominant in older adults' decisions regarding their drinking for members of the sample in the 'third age'. For members of the sample in the 'fourth age', through experiencing decline and decrepitude, efforts to prevent further decline and death were considered to be futile; explaining why these individuals were most concerned with maximising their quality of life where deteriorating ability presented a barrier to other activities that may be enjoyable. Expectations of functional decline during this life stage (87) also create a barrier for older adults, and their care providers, in recognising negative effects of alcohol upon their current health state and quality of life. Through recognising the inevitability of disease and death for their oldest care recipients, care providers stopped prioritising prevention. My fieldwork highlighted barriers for older adults in the fourth age in recognising potential negative effects of alcohol for their quality of life, and to health as a motivator for limited alcohol use. As such, changes in outlook regarding health risks attached to alcohol use, associated with transitions through phases of later life (127), help explain older adults' motivations underpinning how they use alcohol.

As theories of the third age might suggest, declining responsibilities in later life associated with role transitions (retirement, children leaving home) meant key constraints on older adults' drinking were lost (discussed in [Section 7.2.1](#)). The centrality of alcohol to the social and leisure activities of current cohorts of older people has tracked across their life course (128). However, opportunity and freedom associated with loss of responsibilities in later life (discussed in [Sections 7.2.1](#) and [7.2.4](#)) did not explain the increasing roles of alcohol in older adults' social and leisure activity with age. Marginalisation from social and leisure opportunity was evident in narratives across the fieldwork sample irrespective of individuals' life stage. The effects of marginalisation upon late life socialisation and leisure activity are typically associated with the fourth age, due to barriers to engagement attached to declining physical and mental ability (276). Environmental deprivation meant there were limited social and leisure activities for older adults aside from alcohol; particularly for those living in rural or socio-economically deprived areas, at a time when lost responsibilities meant there was more free time to fill. The roles and contributions of alcohol increased within older adults' lives, as drinking remained an accessible pleasure (discussed in [Section 7.2.1](#)). Physical decline marginalised older adults further from these alternative social opportunities in their

final phase of life; while they were still able to leave the house and engage in drinking contexts.

#### ***7.2.6. Considering the roles of primary care providers in supporting healthy alcohol-related decisions amongst older adults***

Care providers' perceptions of their professional remit determined which alcohol-related issues were judged to be a health concern that was relevant to their practice. This defined the circumstances under which action was taken, and care providers' approach to intervention or discussion. Prioritisation of health risks or social benefits was also determined by care providers' perceived remit. Within primary care, where the majority of practitioners concerned themselves with promoting good health, this often resulted in health-focussed care. The multi-disciplinary nature of preventive work in care practice means care providers have varying perceived roles and resources to support alcohol-related discussion. This led to a clear pattern of deflected responsibility for addressing alcohol use within the review. This finding is not unique to work with the older age group, and has been evidenced in other qualitative studies of care providers' work with risky drinking (277, 278). However, older adults are exposed to different care providers with different care remits, and have competing health concerns; particularly when experiencing decline associated with the final phase of life. This may mean that the older age group receives inconsistent support from care providers to work towards healthy alcohol use.

### **7.3. Implications for Policy and Practice**

This thesis considers how factors shaping late-life drinking might be influenced. As such, my work is rich with ideas for approaches to address older adults' alcohol use within public health and legislative policy, and health and social care practice; particularly within primary care settings.

Many current approaches to risk communication and intervention about alcohol emphasise health risks and benefits (52). This contrasts with the social discourse that shapes the way older people use alcohol that was evidenced within my work. Social reasoning and norms that affect the way individuals drink should be important targets for developing interventions. Societal-level factors, such as those described within this thesis, may not be easily addressed. However, primary care settings offer an opportunity to explore some of these factors, and associated perspectives, on an individual basis. Restrictive legislation may also serve to constrain older people's alcohol consumption.

Older adults' alignment with 'responsible' alcohol use meant they were not receptive to typical warnings for health risks attached to excessive drinking. Health messages may be more effective by conveying risks associated with the drinking practices that older adults identify as similar to their own.

Sustained social influences on older people's alcohol use represent a cause for concern. Risky drinking practices, such as frequent excess and binge drinking, are common within the most recent cohort of older adults (23, 34). Without intervention, these are likely to be maintained within the older age group (33). Changes in societal expectations, described by older adults within the review and fieldwork studies, were linked with less restricted drinking practices and higher alcohol intake. Intricacies of factors shaping future cohorts of older adults will likely differ in the UK from those demonstrated within my fieldwork, as an increasing retirement age compresses the period of freedom that characterises the third age. Work-related constraints will likely be sustained for future cohorts of the 'older age group' as defined chronologically within this thesis (see [Section 1.2.2](#)). The roles of alcohol are also becoming less intrinsic to the social and leisure activity of current cohorts of young adults (279) who will age to become the future older population. Future approaches must be responsive to cohort-based patterns of alcohol use in current and future populations of older adults, as well as the developing view of appropriate drinking within that culture. They should also look to target risky practices associated with particular socio-demographic and cultural groups, as discussed within this thesis.

Primary care settings provide a context where older adults' daily drinking routines can be explored for associated risks (280). Simply exploring one's routinised practices can support older people's recognition of excesses in their drinking. This exercise can lead to contemplation of change, lowering the odds of risky alcohol use (281). Older adults may require further support from their care providers to plan to reduce their overall consumption within their routines. My fieldwork suggested that care providers systematically involved in screening and intervention, with higher levels of training to recognise alcohol-related health risks and intervene, are best equipped to provide such support; including practice nurses, pharmacists and social workers. Many providers involved in addressing older adults' alcohol use lacked the training or experience necessary to enable them in discussing alcohol use, assessing older adults' risk from their drinking and in providing appropriate support in interactions with older care recipients; particularly dentists

and domiciliary care providers. Even those with higher levels of training, such as providers working in general practice, lacked knowledge of specific risks attached to drinking as an older person; which implicated how they gauged where intervention may be appropriate. It is important that all care providers involved in addressing older people's alcohol use receive appropriate training to support them in their role. Tools screening for risk-indicators specific to alcohol use in later life, such as the Comorbidity Alcohol Risk Evaluation Tool (CARET), may also be useful as a guide for care providers in identifying potentially problematic use (32). Care providers must recognise older adults' capacity to change their drinking practices and how best to support them. Communication skills are important to facilitate navigation of discordant understandings of risky drinking, and motivate change. Within my fieldwork, such skills appeared to be learned or developed through higher levels of training or experience in systematically discussing alcohol with older care recipients.

The benefits of restricting alcohol use for aspects of their health that affected quality of life were most influential in prompting older adults to contemplate changing their intake. Positive framing of behaviour change in terms of such potential benefits to the individual are likely to be most effective in promoting reduced alcohol intake. Findings of conversation analysis of risk communications in primary care settings suggest that such 'gains-based' health messages are most impactful in instigating behaviour change. Health promotion highlighting benefits of a healthier lifestyle to the individual are more likely to lead to change than communicating potential consequences of the behaviour (282).

My findings also suggest that, in opposition to the current health-focussed approach to older adults' drinking (52), a broader view of alcohol use might be more reflective of older adults' experiences. The comprehensive effects of alcohol for older adults' wellbeing should be considered, rather than simply focussing upon health risks and negative roles. The importance of alcohol in older people's lives may mean any strategies looking to reduce older adults' intake have limited success (112). Replacing alcohol's roles in rituals with other practices can support reduced use, without negative implications for their relationships and social connectivity. For example, non-alcoholic or low alcohol content beverages provide a feasible alternative when the sense of luxury attached to alcohol is important (112). This thesis demonstrated how behaviours integrated within rituals were replaced organically when a behaviour was deliberately ceased; as was described by the oldest old with the replacement of smoking with drinking. Older adults must be supported to replace the roles

of alcohol with healthy alternatives. Hot beverages, which fulfilled similar functions to alcohol, may offer one such alternative. This replacement has been incorporated within diversionary interventions within the Drink Wise Age Well Resilience programme. Trade-ins of practices can be managed within primary care settings to support older care recipients to engage in healthy lifestyles. Roles of rituals within older adults' wellbeing could also be reduced through diversionary interventions, such as provision of alternative social and leisure opportunities. Social prescribing of such interventions may be a legitimate approach to reducing the roles of alcohol in older people's lives, empowering them to make healthy changes to their alcohol use. This strategy can improve the individual's social connectivity and confidence (283). My fieldwork suggested resources for provision of these opportunities were limited. However, opportunities for social prescription are set to increase within the UK, due to the roles of this strategy in forthcoming disease prevention and loneliness initiatives (255, 284). Individual difficulties in access and engagement with alternative opportunities, associated with declining physical function and environmental deprivation, must be considered in prescribing social activity to older adults. Where disinhibition is an important factor in the roles of alcohol through providing confidence and escape, different strategies for intervention are required. Approaches such as support with social skills and self-management to overcome depression, grief and loneliness are successful in reducing alcohol use amongst older adults through addressing the functions of drinking (15, 63).

This thesis highlighted key contributions that can be made within primary care to support older adults to make healthy decisions regarding their alcohol use. Primary care is predominantly conducted face-to-face, and rapport may be built through interactions with patients. This provides a basis for personalised evaluation and communication of risks associated with alcohol use. Such initiatives are already incorporated within primary care in alcohol use screening and brief intervention programmes (63). A recent systematic review of evidence for the effectiveness of interventions aiming to address older adults' alcohol use suggested that personalised approaches may be most effective (285). Continuity of care within primary care settings can facilitate continued alcohol-related discussion to motivate and support older adults to make changes in their drinking (232). However, differences between providers in typical frequency of interactions with individual care recipients demonstrated within providers' narratives in my fieldwork suggest that scope for continuity and rapport building is inconsistent across primary care. Dentists and health care assistants

saw older individuals less frequently than other providers; and although the older age group are known to engage in high usage of primary care, frequency varied between patients on an individual basis within general practice depending on their health state (61). Primary care settings also provide opportunities to evaluate and respond to older people's individual perspectives and circumstances in alcohol-related discussion. Roles of alcohol in their lives, their individual understanding of appropriate alcohol use, health priorities and the effects of transitory events upon alcohol use may all be explored, so that support can be tailored to benefit their overall quality of life. Within my fieldwork, providers had greater recognition of these influences upon older care recipients' alcohol use through experience in working with the older age group, gained through systematised alcohol-related work and years in practice. With this developed understanding, dedicated time and appropriate resources, primary care providers worked to respond to individual factors shaping their older care recipients' drinking, representing a valuable resource in addressing potentially harmful alcohol use amongst the older age group.

A number of significant barriers highlighted within this thesis may impede the role of primary care in supporting older people with their drinking. Time constraints, limited options for intervention, the influence of care providers' preconceptions upon their approach to care, perceived roles in addressing potentially harmful alcohol use and discordance in views of alcohol all affected responses to drinking amongst the older age group. Specific barriers to addressing older adults' alcohol use differed between providers. Limited systematic discussion of alcohol, and multiple health concerns to address, meant time constraints were a dominant issue in general practice. Domiciliary care providers relied on referral to address their care recipients' alcohol use, ill-equipped to address any concerns through their own interventions. Dentists perceived little responsibility for addressing older people's alcohol use, assuming other providers were conducting this work. Barriers must be addressed to ensure older adults receive appropriate support to meet their needs. Resolutions must be responsive to specific issues affecting the work of particular providers.

To date, general practice has led intervention for alcohol use (64). Within the UK, current workforce shortages and time pressures constrain how general practices are able to respond to patients' alcohol use. My findings indicate that other care providers such as pharmacists possess the expertise and time to lead in addressing older care recipients' alcohol use. Pharmacists participating in my fieldwork demonstrated extensive knowledge about risks

attached to alcohol use beyond that of other providers through their training; particularly the major risks associated with drinking in later life, such as effects of alcohol in combination with medical conditions or medications. Alcohol-related discussion was a protected element of lengthy interactions with older care recipients within their Healthy Living Pharmacies. Although older adults' complex care needs may mean alcohol is not raised in consultations, these needs can also bring older adults in touch with a broader range of primary care providers. As already highlighted, not all providers are equipped with appropriate skills and resources to support them in their work to address older people's alcohol use. Developing different care providers' roles and resources will be important within the current climate of the UK, where the role of primary care in prevention of harm attributed to lifestyle factors is to be emphasised in upcoming strategies (255). Strategies developed in recent years by the Drink Wise Age Well group to support older adults with their drinking could be incorporated within future approaches.

#### **7.4. Strengths of This Research**

##### ***7.4.1. Approach to this work***

My focus on factors that shape non-dependent alcohol use in later life means my work is appropriate for informing the development of strategies to benefit the majority of older drinkers who could potentially be experiencing harm, or at least increased health risk, from their alcohol use (15).

The balanced view of late-life drinking that I have taken represents a unique approach to understanding factors that determine older people's drinking practices. This provides an alternative perspective to the dominant health risk-focussed discourse. Perceptions of potential health risks and benefits that may or may not be considered by the individual were examined, as well as external influences and the positive roles of alcohol in older people's lives. Individual-level and wider social determinants were explored. My perspective offers an important contribution to the knowledge-base on the prevention of harm from drinking amongst the older population; as highlighted in a recent editorial prompted by outputs from this thesis (52, 286). In view of this evidence, strategies can be developed that target determinants of older people's drinking, whilst recognising and working with the potential positive roles of alcohol in older people's lives.

My qualitative approach provided a deeper understanding of the realities of drinking in later life, to advise the development of effective interventions (52). Practitioners' perspectives offered a practical understanding of how factors shaping late-life drinking might be addressed in practice. Focussing upon perspectives of those working in primary care meant findings were relevant to the care setting where most alcohol-related intervention occurs (15). My study drew upon care providers from multiple disciplines working to address alcohol-related harm in primary care. This enabled examination of the different roles and contributions of these care providers, and associated perspectives. Triangulating these different views produced findings that indicate practical recommendations relevant to care provision and health policy.

The critical realist orientation that guided my approach to this work meant that underpinning mechanisms and factors determining older adults' drinking practices were identified and explored. These can be addressed within approaches to health and social care policy and practice. This progressed understanding beyond the descriptions of older adults' drinking practices offered by the existing body of qualitative evidence.

Relevant social theory was explored, led by issues raised during my data collection and development of my analysis. This meant that my understanding of factors shaping older adults' alcohol use was grounded within the experiences of older adults and the practical knowledge supplied by care providers. Concepts from health psychology and social theory helped progress understanding of individual-level and wider social determinants of older adults' drinking that arose within data. Biographical disruption theory (introduced in [Section 2.4.1](#)) illuminated how typical late-life transitions could disrupt older adults' day-to-day routines, leading to changes in their alcohol use. Bourdieu's Theory of Practice (introduced in [Section 2.4.2](#)) provided insight into the grounding of older people's alcohol-related decisions in social factors. Application of this theory led me to understand late-life drinking practices in terms of 'habitus', and the influence of social expectations for their implicit understanding of appropriate alcohol use. 'Othering' (introduced in [Section 2.4.3](#)) provided a frame within which social comparisons in older adults' narratives were understood in terms of positioning relative risk. Rituals (introduced in [Section 2.4.4](#)) explained the additional meaning of alcohol to older adults' experiences of socialisation and leisure, beyond its properties as a disinhibitor. Life course theory situated older adults' drinking practices in the context of a life course trajectory, highlighting the influence of changing social context and



life transitions upon drinking practices in later life (Sections [2.5.1](#) and [7.2.5](#)). Theories of the third age aided understanding of late life alcohol use in terms of the impact of physical function and decline for social engagement, and specific outlooks regarding preventive behaviour and expectations associated with the third and fourth age (Sections [2.5.2](#) and [7.2.5](#)). Cognitive dissonance theory supplied an explanation for tension experienced in discussion with participants, given discordance between lay and public health perspectives of appropriate drinking. Finally, the common-sense model of self-regulation of health was drawn upon within this discussion, illuminating the different contributions of abstract and concrete understanding of risks from drinking in terms of perceptual processes.

#### ***7.4.2. Review methods***

I took a rigorous approach to systematic review methodology. Dual-screening and translation of foreign language material ensured that findings represented all literature available in the area. Translations enabled the inclusion of studies from a broader range of higher income countries. Studies identified for the review presented thick descriptions, enabling conceptual development. Inclusion of studies of populations from a range of different countries and social circumstances meant social patterns were identified. By looking across different cultural contexts, presented findings should be applicable beyond individual study populations, and provide a breadth of understanding of older people's drinking. Perspectives from different health and social care disciplines and care settings were incorporated in the care provider synthesis. Issues identified may require global attention. The review drew on findings from data collected from a range of cultural and care contexts. These data illuminated the influence of country-specific contextual factors, such as cultural identity, upon older people's drinking practices and care provider's approach to alcohol-related care. Finally, this review created a picture of the existing understanding of factors shaping older people's alcohol use. I was able to design my fieldwork and analyse generated data in view of this understanding to further my insight into the topic.

#### ***7.4.3. Fieldwork methods***

Patient and public involvement and exploration of preceding literature contributed to successful recruitment, meaningful data collection and enhanced analysis of fieldwork data. This ensured understanding of the topic was progressed through this work. Involving patients and the public in the fieldwork study design, formulating multiple recruitment pathways and a flexible approach to participation led to high interest in this study. As a

result, I was able to sample purposively for a range of individual-level factors thought to affect late-life alcohol use. Discussion of loneliness and its influence on drinking was possible within my fieldwork, where it had not been reported in any previous studies of older adults' drinking. This may have reflected the stigma associated with loneliness creating a barrier to discussion within these studies. Further, samples predominantly recruited from social groups, meaning participants were less likely to be socially isolated; which can contribute to experiences of loneliness. My study aimed to include potentially isolated older adults by recruiting from beyond social groups. This meant that the mechanisms underpinning the link between alcohol use and loneliness and isolation could be explored in data collection. I made strong efforts to establish rapport, and was rewarded with in-depth discussion and disclosure on sensitive topics. These included guilt surrounding alcohol use that was perceived to be socially inappropriate, and the influence of loneliness and mental illness upon drinking.

Focus groups provided a context where social phenomena could be observed, such as individuals' portrayal of their drinking as socially appropriate. This helped me to understand the socially-situated nature of older people's drinking practices. Recording extensive data on participant characteristics meant it was possible to make inferences about how different individual-level factors affect older adults' alcohol use; such as age, social class, gender, health and marital status. The timeline approach incorporated within interviews ensured my understanding was contextualised within the individual's life course. This enabled me to understand cohort-based factors, and factors specific to experiences of later life. My approach to recruitment of care providers (via my own professional network and the regional Clinical Research Network) meant that not all participants had a specific interest in alcohol use. My findings were therefore reflective of issues faced in usual care practice; but benefited from insights and approaches of those with a special interest.

## **7.5. Limitations of This Research**

### ***7.5.1. Applicability of findings***

My findings are limited to explaining factors shaping non-dependent drinking in later life. The factors identified may shed light on some mechanisms involved in the development of dependent drinking, and how these factors may be addressed in preventive efforts; as highlighted within this discussion. However, it was not the aim of this study to explore factors involved in the experience of alcohol dependence. Dependent drinking in later life

requires specific exploration, such as that supplied by Emiliussen and colleagues' articles from their qualitative study (245, 246, 287). Specific approaches to intervention are necessary, such as those developed by the Drink Wise Age Well group (23).

The findings of this thesis may be partly grounded in inaccurate accounts from study participants, due to reliance upon self-report attached to the generation of data from individual accounts. The significance of drinking practices for the individual's self-image suggests it is likely that older adults provided socially desirable accounts, responding in a way they perceived I may view favourably. However, I was clear about my balanced perspective, acknowledging the potential positive contributions of alcohol to their lives. Some participants did discuss their engagement in what they perceived to be socially undesirable uses of alcohol. Their narratives were examined critically, and contributed to the developed conceptualisation. Any socially desirable accounts likely reflect the ways in which older care recipients present their drinking in encounters with care professionals. Findings are therefore clinically-relevant.

The influence of contextual factors understood through my qualitative approach are current, but likely to change over time. Rich fieldwork data collected for the purpose of addressing the aims of this study were essential for developing a conceptualisation of factors shaping drinking in later life. However, findings are bound to the study context. The fieldwork study and all studies included within the review were conducted in countries with historical temperance movements, where alcohol is addressed in health policy (254). Some findings may not be generalizable to all higher income countries given the influence of these movements upon drinking and alcohol-related care practices, as described within this thesis.

Finally, although my findings examine how care providers work to address the factors shaping older adults' drinking within their practice, it must be emphasised that the approaches discussed are not necessarily effective in bringing about any change.

### *7.5.2. Review data*

Pooling of cross-cultural findings may mean that country-specific drinking norms receive less emphasis in my review. It is important that the development of strategies to address older adults' alcohol use are guided by local norms for drinking practices.

Bringing together findings from multiple countries means the review draws on issues from differing health and social care systems. Most higher-income countries face pressures on their care services (80). However, specific pressures, and how services function in the face of them, are individual to the care system. Included studies also explore views from different time points across a long period. The findings span changes in alcohol-related policy and practice that have affected priorities and approaches in alcohol-related care. Developing strategies to support older adults with their alcohol use must be responsive to issues that may affect care providers' efforts in that care system at that time.

How representative findings were of different populations was dependent upon samples of included studies. Study populations may have narrowed the socio-demographic characteristics represented within findings. Within the care provider synthesis, the dominant focus of included studies was on the perspectives of domiciliary care providers. This may have meant issues relevant to social care practice were highlighted. However, this review drew on perspectives of a range of health and social care providers. Issues reported were demonstrated across these groups unless otherwise stated.

Thematic syntheses were limited by the quality of reporting in primary studies. The synthesis of studies reporting care providers' perspectives was restricted by thinner published descriptions of themes. This meant that patterns attached to care discipline and other provider-related variables were difficult to distinguish. Studies reporting older adults' perspectives offered thicker descriptions, enabling identification of social patterns in their drinking practices. However, some studies described the analytical approach better than others. It was not always possible to evaluate the reliability of study findings to conduct a critical analysis.

Patients and the public were not involved in the review study, as their potential advisory roles were still being agreed whilst the review was underway. However, the study advisory group reflected on the findings of the review and their own life experience and concerns in shaping the design of the fieldwork study, influencing the overall findings of this thesis.

Since completion of the systematic review, five articles were produced that meet inclusion criteria. Two reported older adults' perspectives (88, 261); and three reported care providers' perspectives (206, 288, 289). The review is therefore no longer encompassing of all available literature. However, a full update of review findings was not considered

necessary, as the content of these additional articles contributes little to further understanding. The few additional insights, highlighted as follows, were understood within the findings of the fieldwork study. Dare and colleagues' article (288) provided pharmacists' perspectives, which were not represented in the synthesis. However, their views aligned with my narrative. The influence of provider-specific factors upon their views, such as available time resources and remit, were consistent with those discussed within my fieldwork. Nicholson and colleagues' article (88) described the effects of late-life transitions on alcohol use through disruption of day-to-day routines. This perspective was mirrored and elaborated upon within my fieldwork. Finally, Gavens and colleagues (261) provided some insight into perceptions of risk attached to late-life drinking. The understanding presented was simplistic relative to that provided by my fieldwork. Key ideas reflected those developed within this thesis; such as the influence of abstract versus tangible knowledge sources. Additional evidence is therefore corroborative of my findings.

### *7.5.3. Fieldwork data*

The characteristics of my fieldwork sample has implications for the applicability of reported findings.

All participants were either lower- or increasing-risk drinkers as scored by the Alcohol Use Disorders Identification Test (AUDIT). This may reflect the recruitment strategy of my study. Explicitly excluding those screened as potentially dependent drinkers may have deterred those engaging in riskier drinking practices. Findings are unlikely to explain drinking at higher risk levels. However, many participants engaged in risky alcohol use, and factors shaping their drinking were explored in analysis. Self-selecting to participate in a study about non-dependent alcohol use may also have meant participants were comfortable in discussing their drinking. This may have implicated my developed understanding of sensitivity in alcohol-related discussion. However, the sample captured those lacking insight into risks attached to their drinking. A number of others used the interview to work through concerns that their alcohol use may be problematic.

Data from interviews and focus groups with care providers was rich with discussion of heavy and dependent alcohol use in later life, despite my efforts across the course of the interview process to retain focus upon discussion of non-dependent alcohol use. Material regarding their understanding of older adults' non-dependent drinking was limited. As discussed in

Section 7.2.2, most alcohol-related discussion occurred in the context of heavier and dependent alcohol use. Experiences in practice that care providers spoke from predominantly involved addressing such consequential alcohol use, where drinking had a recognised negative impact for the individual physically, mentally or socially, as GP2 explained:

*GP2: The problem is that the ones that I often see that have always drunk to a level, the ones that stick in my mind are the ones that have been becoming more dependent, and the ones that actually present more to general practice. It's difficult to see the non-dependent one in that group, because all the ones that I can think when I think back, of the ones who have always drunk all their life, maybe not to a dependent level through their life, but then have ended up dependent as they got older. They definitely - there's this group who, alcohol has always been their life. But if you're thinking about people who are non-dependent, [it is] difficult, because again, they don't always necessarily present. Or maybe I'm not asking the question of them to say definitely.*

This may explain why care providers conveyed a more negative view of older people's drinking; in contrast to older adults, who were speaking from experiences of less problematic alcohol use, and highlighted the positive effects of alcohol (as discussed in Section 7.2.3). Those more focussed upon alcohol within their work, either through systematised discussion in practice or through specific interests in addressing alcohol use, recognised and discussed the potential positive roles of alcohol in older people's lives. Participating pharmacists particularly conveyed deep insights into factors shaping older people's non-dependent drinking, including such positive roles. They drew from experiences gained through dedicated time discussing older care recipients' alcohol use, regardless of the individuals' level of intake or perceived consequences.

The majority of participants were in good health, which may reduce the relevance of findings to those experiencing poorer health. Poorer health can act as a barrier to participating in research studies through issues with mobility and energy levels. It is usual that older adults recruited for studies are well (213). This may explain why no older adults aged over 90 years were recruited, as physical health often declines with age (18). In addition, those in poorer health are more likely to abstain from drinking (10). These individuals may have chosen not to take part in a study about a behaviour they no longer engaged in. However, a number of

participants discussed issues with health and mobility and implications for their alcohol use. My findings encompass these perspectives.

My understanding of factors shaping late-life drinking drew on culturally and ethnically diverse studies through review work. In contrast, the conceptualisation developed from my fieldwork analysis is based on data collected from my majority white, British participants. The fieldwork sample lacked ethnic diversity, despite specific efforts being made during recruitment to engage minority ethnic groups. The applicability of the developed conceptualisation to more ethnically diverse populations may therefore be limited. However, the sample reflected demographics of the North of England (290). Recruitment issues may have reflected specific social expectations amongst minority-ethnic groups, implicating the likelihood that they engage in alcohol use; as well as sensitivities attached to alcohol-related discussion (291). Factors affecting late-life drinking amongst ethnic minority groups require specific exploration, with involvement of these groups in study design to promote engagement.

The implicit, practical logic that was understood to shape older people's drinking practices means that individual accounts may not have been the most appropriate format in which to study this topic. Actors have little awareness of the practical logic underpinning their behaviour (292), and may struggle to explain why they act as they do. This was evident in data collection, as participants did not articulate why they used alcohol as they did with ease. The implicit nature of their drinking practices meant a number of participants expressed having explicitly considered their alcohol use for the first time within the context of the study. For example, the timeline exercise provided a medium for Serena to recognise a pattern within her behaviour:

*Serena: Looking at it, it's good doing this because, really, everything was associated to happiness. Maybe with that thought, if I drank, it would make me happy.*

Questioning prompted participants to consider the reasoning behind their perspectives, as occurred within this excerpt with Julia:

*BKB: Without knowing the guidelines, how did you know this [that Julia was a lower-level drinker as she had suggested] yourself?*

*Julia: That I was a low-level drinker? Probably - you're right, well probably just - probably just looking at everyone else, I think. Because you know when you go out, because – oh I dunno, you know, if you stay sober, almost, over the years you can see what people are drinking – erm, and you can see, you know, in your family or anyone else. You know that they're having quite a few drinks, you're not, so there's that, so I think you just always know that; you just know what kind of drinker you are.*

Through probing and exploration of their accounts, this implicit logic and pre-conscious influence of 'habitus' became evident and contributed to my understanding (terms introduced in [Section 2.4.2](#)). Triangulating the perspectives of older adults with those of care providers working to evaluate and address their alcohol use added an additional insight that aided understanding of these social influences.

The influence of particular aspects of an individual's social identity were highlighted within the analysis. Participants varying in age, sex and socio-economic status enabled exploration of these factors. Sexuality represents an additional socio-demographic factor that can influence how people use alcohol (293). However, this was not explored as the study advisory group did not identify sexuality as a priority topic to guide sampling and data collection.

By seeking maximum variation for a number of characteristics known to affect alcohol use in later life, my fieldwork sample of older adults was highly heterogeneous. It is difficult to discern patterns in behaviour and causal factors when studying such heterogeneous groups. In such circumstances, behaviour can be examined and understood in terms of underlying processes and mechanisms (127); which was the approach taken within this study (as discussed in [Section 7.4.1](#)). Although intricacies in older people's perspectives regarding alcohol were explored and highlighted within my analysis and findings, identified factors, and how I reported these shape older people's alcohol use, should not be assumed to be applicable to all. Particularly of note are age-related differences in alcohol use, and related perceptions across the older age group. Sensitivities to alcohol associated with the ageing process (introduced in [Section 1.2.1](#)) and increasing rates of harm from alcohol use across the older age population (33) necessitated attention to factors shaping alcohol use across the older age group as a whole. I sampled from a broad age range to study late life alcohol use, as I looked to explore age as an individual-level factor affecting older people's



perspectives and use. However, this meant that my study population spanned a 25 year period. There are different trends for drinking practices between cohorts of older adults within this age range (33, 34, 39), and my study highlighted differences in underpinning factors shaping older people's alcohol use across these cohorts (discussed in [Section 7.2.1](#)). Although some intricacies were highlighted within reported findings and explored within this discussion, it is likely that further age- and stage-specific factors influence older people's alcohol use across later life, beyond those reported in this thesis. These must be explored and recognised in understanding alcohol use across this broad age group, and in developing specific and responsive interventions.

Including care providers with different roles in addressing alcohol gave insights into how factors shaping older adults' alcohol use can be addressed within the primary care system. Although this heterogeneity meant that issues and approaches specific to particular care providers could be examined through contrast between provider groups, it meant that these could not be understood in depth.

The measures of socio-economic status utilised to indicate social class within this fieldwork were limited. Social class is a complex concept, encompassing numerous material and cultural elements. Different approaches to measuring class are reflective of specific elements (294). Individual- and area-level measures were both utilised as a gauge of social class in my fieldwork. Individual-level indicators, such as occupation, income or educational attainment, can be used to infer class position. They capture a person's financial resources and provide a reflection of their 'cultural capital', which contributes to class identity (95). Amongst the older age group, these measures must be adapted, as retirement, pension and generational norms for education implicate these indicators (294). Former occupation was therefore utilised to infer individual's social class. However, this measure is less reflective of women's class status, due to more restrictive norms for occupation amongst older cohorts (294). Area measures, which were also adopted, reflect the aggregate socio-economic properties of the individual's postcode. Measures provide an indicator of the level of deprivation or affluence within their local environment. This captures the resources the individual has access to, such as shops and transport links (295).

The class-based indicators encompassed by these measures were all found to be relevant to older people's access to and use of alcohol. However, these indicators do not directly reflect

the social and cultural activities that the individual engages within. These contribute to personal identification with class (292), which my fieldwork identified as a factor affecting alcohol use. The reflection of class provided by participants' demographic data were not encompassing of all relevant aspects of the concept. However, participants were often explicit about their class identity within discussion, and implications for their drinking practices. This contributed towards the analysis of fieldwork data, and how the influence of social class was understood.

## 7.6. Further Research

Interventions to address the factors that shape older adults' alcohol use can be developed for evaluation in view of the understanding provided within my work. The findings presented here will be used to advise, and be incorporated into the developing Drink Wise Age Well programme during my placement with the Glasgow branch following submission of this thesis. The potential for use of appropriate risk assessment and communication tools to support discussion of alcohol use with older care recipients in primary care could be explored. The effects of social prescribing upon older care recipients' alcohol use should be included in evaluations of this strategy, given its emphasis in initiatives to address loneliness and for disease prevention within the UK. Theories highlighted within this thesis offer insights into how factors shaping older adults' alcohol use might be appropriately addressed in developed theory-driven interventions. Theory of practice and the common-sense model of self-regulation of health advise appropriate targets for and approaches to intervention.

The positive contributions of alcohol use to older adults' social and emotional wellbeing should be explored in further understanding J-curve relationships between alcohol intake and health outcomes. This work could help legitimise the roles of alcohol in older people's lives in understanding and responses to late-life drinking. Further qualitative work examining the roles of alcohol in the lives of older adults with risk factors for loneliness, and mechanisms for protective or causative roles in experiences of loneliness, would help clarify the link between alcohol use and loneliness in later life. Longitudinal studies of cohort data exploring links between alcohol use, loneliness and associated risk factors over time could also contribute to this understanding.

Further research should look to understand how specific health and psychosocial factors shape older people's alcohol use in minority populations and other countries and cultures,

so that future strategies are responsive. The influence of sexuality, poor health and alcohol dependence upon how older people use alcohol must also be understood. Multimorbidity and frailty are common experiences in later life; however my study sample was in good health relative to the older population as whole. The influence of these health states upon alcohol use, and engagement with and response to any developed interventions, is important to understand further in future work. Further research should continue to map trends in the drinking practices of ageing cohorts. Strategies can then be adapted to support groups at risk of harmful alcohol use and current influences upon drinking.

Many strategies to address factors shaping older care recipients' drinking practices were described by participating care providers. However, the utility and effectiveness of these strategies is not yet understood. Audio-recorded discussions of alcohol use with older care recipients in primary care settings could be examined to understand effective and ineffective or harmful communication strategies. Primary care providers' individual strategies are a valuable resource, and could be utilised by consulting this group in a co-produced intervention for evaluation.

Within fieldwork data, it was evident that structural factors affected care providers' capacity to provide interventions that addressed alcohol use amongst older care recipients. Although some of these factors were touched upon within analysis, examining these in-depth was beyond the scope of this thesis. However, data are currently being examined with the assistance of an interning medical student to understand facilitators and barriers to addressing older adults' alcohol misuse within primary care settings.

## **7.7. Conclusions**

This study aimed to conceptualise the many factors shaping older people's drinking, and explore how these factors are influenced. Qualitative methodology was employed to address this aim, drawing upon older adults' and care providers' perspectives from available evidence and in-depth fieldwork conducted in the North of England.

Older people's drinking practices were shaped by norms and discourses for appropriate drinking within their social environment. Many factors influencing how older people used alcohol were not distinct to the older age group; such as perceptual processes involved in attributing risk to alcohol use, and the roles of alcohol in social and leisure activities. These factors are nonetheless important in understanding late-life drinking. Specific considerations

associated with common experiences and values in later life affected the nature of older adults' alcohol use. Drinking could become firmly established in day-to-day routines, and central to social and leisure experiences. Decreased engagement in alternative opportunities meant drinking was involved in an increased proportion of older adults' activities.

Associations between drinking and happy memories accrued across the life course meant alcohol use developed additional roles in accessing pleasure in later life. Older adults were likely to aspire to responsible drinking practices. Experiences of reduced tolerance to alcohol with age could lead to constrained use. However, risky drinking practices were still evident. Perceptual processes and discourses on risks attached to older people's drinking relative to other groups meant increased risks associated with alcohol use in later life were often overlooked. Environmental constraints affected older adults' alcohol use through limiting access; particularly where mobility issues attached to physical decline created an additional barrier. Within the UK, the physical and social environment facilitated and normalised drinking amongst older adults.

This work challenges the current understanding of late-life alcohol use. Older adults' motivations for drinking were framed broadly in terms of quality of life, rather than specifically around the effect of alcohol on health. Positive contributions of drinking to social and emotional wellbeing were highlighted. The influence of social norms and expectations upon late-life drinking practices were also emphasised within this work. A more holistic view of older adults' drinking would be beneficial in guiding future approaches, acknowledging the psychosocial benefits and social context of their alcohol use. This may have implications for when care providers choose to act on any associated health risks.

This work has several implications for strategies and approaches to supporting older people to make healthy choices in their alcohol use. Practitioners' and public health interventions must engage with older adults' lay understanding of health-related behaviour and risk. The older age population should be approached as a heterogeneous group, responding to individual differences in alcohol use, and roles and risks attached to drinking. Health communications must appeal to the responsible identity of potentially risky older drinkers. Older adults' broader social identity and circumstances should be recognised. Approaches must also be responsive to the nature of drinking practices, and acknowledge older adults' individual health priorities and the contributions of drinking to their quality of life. My work suggests that primary care providers can support older people to recognise risks and develop

healthier drinking routines, but require appropriate resources and knowledge. Complex interventions, addressing factors at individual, social, cultural and environmental levels, will be required to address alcohol-related harm amongst older populations.

# Appendix A - Published Work

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## QUALITATIVE RESEARCH

### Drinking in later life: a systematic review and thematic synthesis of qualitative studies exploring older people's perceptions and experiences

BETHANY KATE BAREHAM, EILEEN KANER, LIAM PATRICK SPENCER, BARBARA HANRATTY

Institute of Health and Society, Newcastle University The Baddiley-Clark Building, Richardson Road, Newcastle upon Tyne, NE2  
4AX, UK

Address correspondence to: B. K. Bareham. Tel: 0191 208 2056; Fax: 0191 208 1121. Email: [bkbareham@ncl.ac.uk](mailto:bkbareham@ncl.ac.uk)

#### Abstract

**Background:** alcohol presents risks to the health of older adults at levels that may have been 'safer' earlier in life. Moderate drinking is associated with some health benefits, and can play a positive role in older people's social lives. To support healthy ageing, we must understand older people's views with regards to their drinking. This study aims to synthesise qualitative evidence exploring the perceptions and experiences of alcohol use by adults aged 50 years and over.

**Methods:** a pre-specified search strategy was applied to Medline, PsychINFO, Scopus, Applied Social Sciences Index and Abstracts and Cumulative Index to Nursing and Allied Health Literature databases from starting dates. Grey literature, relevant journals, references and citations of included articles were searched. Two independent reviewers sifted articles and assessed study quality. Principles of thematic analysis were applied to synthesise the findings from included studies.

**Results:** of 2,056 unique articles identified, 25 articles met inclusion criteria. Four themes explained study findings: routines and rituals of older people's drinking; self-image as a responsible drinker; perceptions of alcohol and the ageing body; and older people's access to alcohol. Differences between gender, countries and social patterns are highlighted.

**Conclusions:** older people perceive themselves as controlled and responsible drinkers. They may not recognise risks associated with alcohol, but appreciate its role in sustaining social and leisure activities important to health and well-being in later life. These are important considerations for intervention development. Drinking is routinised across the life course and may be difficult to change in retirement.

**Keywords:** alcohol, older people, perceptions, qualitative thematic synthesis, systematic review

#### Introduction

Alcohol consumption is causally-linked to over 60 disease-conditions, many of which are common in older age, including cardiovascular disease, dementia and various cancers [1]. Drinking up to 14 units of alcohol per week, spread evenly over three or more days is considered to be lower-risk for developing these diseases [2]. However, physiological tolerance for alcohol decreases with age [3–6], increasing risks attached to using alcohol at levels that would have been

'safer' at earlier stages in life [7, 8]. Many older adults also live with multiple health conditions and take a range of prescribed medications to manage them. Some of these conditions and medications can be affected by alcohol use [9]. Older adults are therefore likely to be effected more by alcohol, and must take extra care with their drinking [2].

Alcohol misuse is a particular issue in higher income countries, including amongst older people, where relatively greater income supports the purchase of alcohol [10, 11]. Consequently, within these countries public health campaigns

and clinical practice have targeted later life alcohol misuse [11]. Older adults have not responded to these campaigns, maintaining levels of risky drinking where the rest of the population has reduced their intake and associated risks [4, 12–14]. Across higher income countries, up to 45% of older people who drink do so at levels which may be harmful to their health [10]. Older adults are facing increasing health issues linked to their drinking [15–18], and these numbers will continue to grow as the population ages [19]. However, most older adults experiencing harm from their drinking would not view themselves as problematic drinkers [7], as despite drinking more frequently than younger age groups, older people tend to drink to less dramatic excess, where risks are less visible [12, 20, 21]. Policy makers and health and social care workers fail to recognise alcohol-related harm amongst the older age group as a consequence [22]. Social patterns in older people's drinking illuminate at-risk groups; for example, hazardous older drinkers are more likely to be male [10, 23–25] and less socioeconomically deprived [24]. Patterns of drinking can also vary between different countries [10, 23]. Particular ethnicities such as Europeans (particularly Irish) and Maori's are more likely to drink at risky levels [10, 25, 26] as cultural and religious prescriptions shape attitudes towards alcohol [27–29].

Alcohol can play a positive role in many older people's social lives [16, 30–33], and there may be some health benefits at lower-levels of intake [34–40]. Qualitative studies provide the most appropriate approach to enhancing our understanding of older people's reasons behind their drinking practices. This study aims to identify and synthesise qualitative data on older people's views and experiences of drinking in later life to explore reasons for, and factors shaping, older people's drinking in higher income countries. Recognising these reasons and exploring how socio-demographic factors shape older people's alcohol use in higher income countries will ensure that public health policy makers and clinical practitioners, within the UK and more widely, are able to respond to the reasons behind older people's drinking and target appropriate groups.

## Methods

### Search strategy

Five bibliographic databases were searched from start date to March 2016 (Medline (1946), PsychINFO (1806), Scopus (1960), Cumulative Index to Nursing and Allied Health Literature (CINAHL, 1984) and Applied Social Sciences Index and Abstracts (ASSIA, 1987)). Database-specific headings and key words were developed relating to the concepts 'older adults', 'drinking', 'qualitative' and 'perceptions and experiences'. The search terms for this review were developed applying the Joanna Briggs Institute's recommendations for qualitative systematic reviews [41]. For Medline, key words were mapped to related medical subject headings (MeSH), which were exploded, focussed, and combined appropriately,

alongside key words. This produced a search strategy optimised for sensitivity (tested for inclusion of known relevant articles) and specificity. The following grey literature sources were searched, applying key terms: NHS evidence, Open Grey and Dissertation Abstracts International. The full search strategy applied to each database within this review is available through our Prospero registration [42]. The reference list and citations of included articles were searched for further eligible articles.

### Eligibility criteria

- Published studies and theses in any language presenting qualitative analysis. No time limits were applied other than those imposed by the limits of the database. Reviews and case studies were excluded.
- Studies with a focus on the views of older adults, defined for the purpose of this review as aged 50 years and over. This is the earliest age frame specified by studies focussing on later life.
- Studies reporting perceptions and experiences of alcohol consumption in later life.
- Studies focusing on the views of individuals living in higher income countries.
- Studies specifically focused on individuals who were known to be dependent were excluded as such treatment populations are strongly encouraged to abstain from drinking.
- Studies where alcohol use could not be distinguished from other substance use were excluded.

### Data extraction and quality assessment

Following electronic de-duplication of articles, two independent reviewers screened papers for relevance based on titles and abstracts. Full text versions of selected papers were then assessed for inclusion within this review. Discrepancies were discussed and resolved, or referred to a third team member. Non-English titles/abstracts were translated online to assess eligibility. The findings of non-English full text papers were translated by individuals bilingual in the language and English. Authors were contacted when articles were irretrievable online.

Details of the study setting, participants, methods and study data were extracted from articles selected for inclusion. Study quality was assessed by two independent reviewers using Saini and Schlonsky's Qualitative Research Quality Checklist [43]. Studies were not excluded on the basis of quality appraisal, as poor reporting is not necessarily indicative of poorly conducted research [43]. However, assessing quality prevents unreliable results from influencing the review findings [44]. Key limitations and comments on richness of presented findings are detailed for each study in Table 1 (see Table 3 in Appendix 1, available at *Age and Ageing* online for full summary of appraisal) and summarised within our study descriptions to give a sense of the limitations and richness of data available in this field.

Table 1. Brief descriptive summaries of included studies with key limitations identified in quality appraisal

Article and country	Aims	Sample	Data collection methods and analysis	Author-identified key themes	Key limitations and comment on fitfulness from quality appraisal
Abrahamson [66] (a) Sweden and Finland Abrahamson <i>et al.</i> [48] (b), Sweden	(a) To investigate how old people—who during their lives have experienced the displacement of drinking's moral border from sobriety to moderate drinking—are presenting themselves, and their values, and attitudes towards alcohol (b) To examine changes in women's relationship to alcohol during the 1960s	(a) $n = 32$ , Age = 78–94, Drinking status = sober or moderate (b) $n = 25$ , Age = 61–94 years, Drinking status = light or moderate.	Written responses to autobiographical questions (a) Qualitative thematic analysis (b) Narrative construction and thematic motives	(a) Sober repertoire; Moderation repertoire (b) Scene and co-agents; Scene and counter-agents; Choice of the protagonist; Alcohol as agency	(a) Lack of transparency in reporting of study design and methods; lack of exploration of study limitations and biases; thick description with reference to trends and contextual details. (b) Inconsistent transparency in reporting; thick description in places with some contextual details and trends presented. Lack of transparency in reporting thick description in places with some contextual details presented and many exemplary quotes
Aitken [59], New Zealand	To understand the meanings of alcohol use for older people who use alcohol and to understand older people's reasons for drinking and identify the discourses they draw on to construct their alcohol use.	$n = 18$ , Age = 53–74 years, Drinking status = responsible and potentially hazardous drinkers.	Semi-structured interviews, Discourse analysis	A 'social life' discourse; A 'thinking to relax' discourse; The 'health issue' discourse; A 'problem' discourse	No exploration of author biases presented; thick description rich with contextual detail, characteristics and trends.
Bilfinger <i>et al.</i> [2012] [60], Sweden	Examines how older adults reason their relationship with alcohol and how they see the boundaries between what is acceptable and unacceptable drinking.	$n = 20$ , Age = 61–70 years, Drinking status: not reported.	Focus groups, Hermeneutic interpretation analysis	How the participants described the role of alcohol in their adulthood; How participants described their first experience with alcohol; The participants' definition of their current alcohol consumption; The boundary between acceptable and unacceptable alcohol use; Other people's means of dealing with alcohol	Lack of transparency in reporting thinner description with some details presented of sample and context linked to study findings.
Bobrova <i>et al.</i> [67], Russia	Investigated gender differences in drinking patterns and the reasons behind them among men and women in the Russian city of Novosibirsk	$n = 44$ , Age = 48–63 years, Drinking status = abstainers, occasional drinkers, frequent drinkers and heavy drinkers.	Semi-structured interviews, Framework approach and inductive and thematic analysis	Traditional drinking patterns; Individual drinking patterns; Perceived reasons behind the gender differences in drinking	Lack of transparency in reporting thick description of study findings supported with contextual detail.
Burrows <i>et al.</i> [53], the USA	Exploring alcohol use among a subpopulation of older adults in congregate living, specifically a continuing care retirement community	$n = 11$ , Age = 68–90 years, Drinking status = regular drinkers	In-depth interviews, Thematic analysis	Drinking as habit/routine; Peers as catalysts for increased consumption; Alcohol use and congregate living.	Inconsistent transparency in reporting; thick description of study findings exploring differences between contexts.
Dare <i>et al.</i> [61], Australia	To explore • What role does alcohol play in older people's lives? • What factors facilitate or constrain alcohol use in different residential settings? • How does setting influence older people's alcohol use?	$n = 44$ , Age = 65–74 years, Drinking status = frequent drinkers, mostly low risk.	In-depth interviews, Thematic analysis	Alcohol and social engagement; Alcohol and relaxation; Alcohol, work, and leisure; Social engagement; Social norms; Self-imposed regulations; Driving; Convenient and regular access to social activities; Driving and setting	Lack of transparency in reporting thick description in places within context of individual characteristics, but no trends presented.
del Pino <i>et al.</i> [49], the USA	To understand unhealthy alcohol use behaviours in socially disadvantaged, middle-aged and older Latino <i>é</i> by laboureaux.	$n = 14$ , Age = 50–64 years, Drinking status = occasional and frequent binge drinkers.	Semi-structured interviews, Grounded theory	Perceived consequences of unhealthy alcohol use on physical and mental health; The impact of unhealthy alcohol use on family relationships; The family as a key factor in efforts to change behaviour	Lack of transparency in reporting thick description in places within context of individual characteristics, but no trends presented.

Continued



Table 1. Continued

Article and country	Aims	Sample	Data collection methods and analysis	Authors-identified key themes	Key limitations and comment on richness from quality appraisal
Edgar <i>et al.</i> [80], the UK	<p>Investigate how the process of retiring and ageing shapes alcohol use and its role in the lives of retired people</p> <ul style="list-style-type: none"> <li>Explore the meaning and uses of alcohol in retirement</li> <li>Explore the lives of older people more broadly, including social networks, interests and family life</li> <li>Capture the intersections of gender, age and socioeconomic status in shaping the experience of retirement and how it relates to alcohol use.</li> </ul> <p>This was achieved by including men and women, three specific age groups, and those from areas categorised as 'more deprived' and 'less deprived', according to the Scottish Index of Multiple Deprivation (SIMD)</p> <ul style="list-style-type: none"> <li>Consider service and policy implications flowing from an enhanced understanding of alcohol use in later years.</li> </ul>	<p><math>n = 40</math>, Age = 55–81 years, Drinking status = current or non-drinkers.</p>	<p>Semi-structured interviews, Thematic analysis</p>	<p>Routes into retirement; drinking routines; "keeping busy"; work and leisure in retirement; adapting to changing social networks; processes offering protection; adapting drinking routines</p>	<p>Inconsistent transparency in reporting thick description of findings presented, supported by contextual detail with trends conveyed.</p>
Gell <i>et al.</i> [81], the UK	<p>To explore</p> <ul style="list-style-type: none"> <li>What purpose(s) does drinking serve for older adults?</li> <li>What kind of knowledge do older adults have of the relationship between health and alcohol consumption?</li> <li>Why do older adults change (or maintain) their alcohol consumption over time?</li> <li>What mechanisms lead to a change or maintenance of alcohol consumption behaviour in older adults after change in health?</li> </ul> <p>To analyse the relationship third-age people have with alcohol; how does long life experience affect drinking habits and what are those habits actually like in the everyday life of older adults?</p>	<p><math>n = 19</math>, Age = 59–80 years, Drinking status = abstainers, low-level drinkers, mid-level drinkers or high-level drinkers.</p>	<p>Semi-structured interviews, Thematic and framework analysis</p>	<p>Current alcohol consumption among interview participants; Changes in alcohol consumption among interview participants; Psychological capability; Reflective motivation; Automatic motivation; Physical opportunity; Social opportunity</p>	<p>Thick description of findings; quotes at times appeared to be used out of original context to support the points made.</p>
Harmi and Hautamaki [82], Finland	<p>To analyse the relationship third-age people have with alcohol; how does long life experience affect drinking habits and what are those habits actually like in the everyday life of older adults?</p>	<p><math>n = 31</math>, Age = 60–75 years, Drinking status = current or ex-consumers of alcohol.</p>	<p>Biographical and semi-structured interviews, Content and biographical analysis</p>	<p>Different kinds of drinking career; The ideal of moderation; Ageing, generation and period of time</p>	<p>Study limitations were not considered in reporting thick description of study findings with contextual detail provided; quotes at times appeared to be used out of original context to support the points made.</p>

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Johannessen <i>et al.</i> [64], Norway	To investigate older peoples' experiences with and reflections on the use and misuse of alcohol and psychotropic drugs among older people	<i>n</i> = 16, Age = 65–92 years, Drinking status = experience with drinking but no known history of misuse.	Narrative interviews, Phenomenological-hermeneutic analysis	To be a part of a culture in change; To explain use and misuse	Potential biases of research team were not explored; thin description of study findings with no discussion of sample characteristics or trends in the data.
Joseph [54], Canada	To examine the alcohol-related leisure practices of a group of older Afro-Caribbean men in Canada and the ways alcohol consumption at outdoor grounds plays an integral role in the reproduction of club members' gender as well as their homeland cultures, age, class and national identities	<i>n</i> = not reported due to study design, Age = 44–74 years, Drinking status = leisurely drinkers.	Observations and interviews, Inductive analysis	Drunkness as a mask of physical degeneration; Drunkenness as temporal escape from femininity and family. Alcohol brands as class and (trans)nationality markers	Insufficient reporting of study limitations; thick description of study findings presented with rich contextual detail.
Kim [55], Canada	To explore the drinking behaviour of older Korean immigrants	<i>n</i> = 19, Age = 62–83 years, Drinking status = mostly (63%) drank more than once a week.	Semi-structured focus groups, Thematic analysis	Reasons for drinking among men versus women; Health and alcohol; Signs of problem drinking; drinking in immigrant life; Reasons for a change in drinking behaviour; Religion	Potential biases of research team were not explored; thick description of study findings with trends explored and rich contextual detail provided.
Rezek <i>et al.</i> [65], the USA	To provide insight into the processes that underlie the alcohol trajectories of mid- to late-life men's and women's heavy alcohol use identified in the quantitative results	<i>n</i> = 88, Age = 40–89 years, Drinking status = self-reported heavy alcohol users.	In-depth interviews, Inductive analysis	The gendered context of (re)marriage; The gendered context of divorce	Inconsistent transparency in reporting; potential biases of research team were not explored; thick description of study findings; thin description of study findings presented with rich contextual detail and exploration of trends.
Sharp [56], the USA	To understand the communication between community-based older adults and their physicians regarding their alcohol use	<i>n</i> = 11, Age = 79 years (mean), Drinking status = frequent drinkers.	Semi-structured interviews, Interpretive phenomenological analysis	Factors that hinder alcohol conversations; Characteristics that promote positive patient-doctor relationships	Under whether the sample was appropriate for the purpose of the study as most participants had never discussed alcohol use with their physician; thin description of study findings with no supporting excerpts or exploration of trends.
Stanojevic-jerkovic <i>et al.</i> [70], Slovenia	To describe drinking patterns in older people, to identify the most common risk factors and protective factors for hazardous or harmful drinking, older people's empowerment for resisting social pressure to drink and their knowledge about low-risk drinking limits	<i>n</i> = 20, Age = 65–89 years, Drinking status = current drinkers, abstainers or occasional drinkers.	Focus groups, Thematic analysis	Factors that stimulate drinking; Factors hindering drinking; Factors that for some people encourage drinking, for others hinder it; Behaviour in a drinking company; Seeking for help; Familiarity with the recommendations for low-risk drinking; Further findings	Potential biases of research team were not explored; thick description of study findings with rich contextual detail and some exploration of trends.
Tolvanen [72], Finland	To examine the ways in which older people in Finland talk about their use of alcohol. It also aims to shed light on the meaning of alcohol use in the context of social ageing	<i>n</i> = 40, Age = 60–89 years, Drinking status: not reported.	Structured interviews, Discourse and conversation analysis	Alcohol use as discussed by older people; Who is the 'one' who drinks?	Insufficient transparency in reporting; questionable suitability of data for qualitative analysis; thick description of findings with contextual trends presented.
Tolvanen and Jylha [62], Finland	To explore how alcohol use was constructed in life story interviews with people aged 90 or over	<i>n</i> = 181, Age = 90+ years, Drinking status = abstainers and current drinkers.	Semi-structured/life story interviews, Discourse analysis	I and others; The use of alcohol as a moral issue; Men's and women's drinking; Alcohol as a man's destiny and a threat to the happiness of homes; Alcohol use as part of social interactions; Alcohol use as a health issue	Inconsistent transparency in reporting; limitations and potential biases of research team were not explored; thick description of findings in places with trends presumed; limited discussion of findings in relation to participant characteristics.

5

Continued

Table 1. Continued

Article and country	Aims	Sample	Data collection methods and analysis	Author-identified key findings	Key limitations and comment on richness from quality appraisal
Vaz De Almeida <i>et al.</i> (63), Europe Germany, Italy, Poland, Portugal, Spain, Sweden and the UK	To explore social and cultural aspects of alcohol consumption in a sample of older people living in their own homes, in eight different European countries	$n = 644$ , Age = 65–74 years, Drinking status = non-dependent.	Semi-structured interviews, Grounded theory	Alcohol consumption narratives of older people; Gender differences in the narratives; Specific cultural differences between the eight countries	Inconsistent transparency in reporting; reported methods of analysis did not appear compatible with data collected; thinner exploration of data with some descriptive themes; quotes lacked depth where presented. Inconsistent transparency in reporting; insufficient explanation of limitations and biases; thick description of findings with some trends presented.
Ward <i>et al.</i> (87), the UK	To generate a wider evidence base by exploring the circumstances in which older people drink, the meaning that drinking alcohol has for them and its impact, acknowledging that this can be a pleasurable and positive experience, as well as something that can have adverse health, financial, personal and interpersonal impacts	$n = 21$ , Age = mid 50s to late 80s (years), Drinking status = regular drinkers who may or may not have a problem with their level of alcohol consumption.	Semi-structured interviews and focus groups, Thematic analysis	Drinking practices and styles; What affects drinking styles; Seeking help	Potential biases of research team were not explored; thinner description of findings with inconsistent provision of contextual data.
Wadding and Armstrong (88), Australia and Sweden	To identify attitudes that might influence drink-driving tendency among this group of women and further show how these attitudes vary across countries	$n = 30$ , Age = 52 years (mean), Drinking status = low-risk or risky drinkers	Semi-structured interviews, Thematic analysis	Findings were not organised under theme headings	Potential biases of research team were not explored; thinner description of findings with inconsistent provision of contextual data.
Wilson <i>et al.</i> (71) (a), Houghton <i>et al.</i> (69) (b), Houghton <i>et al.</i> (68) (c), the UK	(a) To elucidate the views of older individuals aged over 50 years about alcohol consumption, health and well-being, to inform future targeted prevention in this group (b) To gain an in-depth understanding of experiences of, and attitudes towards, support for alcohol-related health issues in people aged 50 and over (c) Explored concurrent alcohol and medication use, as well as the use of alcohol for medicinal purposes, in a sample of individuals in mid to later life	$n = 51$ , Age = 51–95, Drinking status = abstainers, occasional drinkers, moderate drinkers, heavy drinkers, recovering dependent drinkers and dependent drinkers.	In-depth interviews and semi-structured focus groups, Grounded theory and discursive analysis	(a) Alcohol identities; Health and changing drinking behaviour; gendered patterns of drinking (b) Drinking in mid to later life; Devolving to change; Experiences of primary care; Experience of detoxification and rehabilitation; Experience of counselling and therapy (c) Drinking and using medication regardless of consequences; Health professionals being unaware of alcohol use; Reducing or stopping alcohol consumption because of medication; using alcohol to self-medicate; differences related to gender and age	(a) Potential biases of research team were not explored; thick description on findings with trends presented and rich contextual detail. (b) Inconsistent transparency in reporting; thick description of findings with trends presented and rich contextual detail. (c) Inconsistent transparency in reporting; thick description of detail with rich contextual detail.

## Drinking in later life: a systematic review and thematic synthesis

### Data synthesis

A thematic synthesis of included studies was conducted (see Figure A1 in Appendix 1, available at *Age and Ageing* online). The methods for synthesis were based upon Braun and Clarke's principles of thematic analysis, commonly applied to primary qualitative data [45]. The review team familiarised themselves with the findings of each study during full text screening and immersion through repeated reading. During this phase, the lead author listed ideas and potential codes from the primary study findings. The compiled codes were comparable to second- and third-order constructs described in meta-ethnography. Second-order constructs are interpretations and themes derived from the primary data, specified by the authors of included studies. Third-order constructs are ideas and interpretations identified by the review team which further explain findings within and across the primary studies [46]. Recurring codes, explaining findings across the studies, were developed by the review team into a candidate framework of themes which explained the views of older people surrounding their drinking. NVivo (version 11) was used for data management, which involved storing included study findings, and coding these according to the developed framework. The lead reviewer recorded analytical notes during this process, detailing explanations and patterns within each theme. The developed thematic framework was then further refined to ensure that it reflected the views and experiences

conveyed across the included studies, and defined to form the theme descriptions which are presented as our findings. Excerpts from the included studies were identified to present as examples of the review findings. Throughout this process, developing themes were discussed amongst the research team and Gusfield's sociological work on drinking rituals [47] informed data interpretations.

### Results

#### Literature search and study descriptions

Twenty-five papers, reporting 21 unique studies were included (see Figure 1). The synthesis of findings involved over 1,500 older adults, aged 50–90 years upwards (see Table 1 for summary of study details). Most studies included men and women. One study had all female participants [48]. Authors variably reported other characteristics including socio-economic status (four studies) [49–52], ethnicity (seven studies) [49, 53–58], health status (four studies) [49, 51, 52, 59], work status (four studies) [49, 52, 54, 60], living context (seven studies) [52, 53, 57, 59, 61–63], marital status (eight studies) [52, 53, 55–58, 64, 65], religion (one study) [55] and sexuality (one study) [57] (detailed in Table 3 Appendix 1, available at *Age and Ageing* online where reported). All studies included participants with a range of drinking behaviours including abstainers (10 studies) [50–52, 62, 66–71],

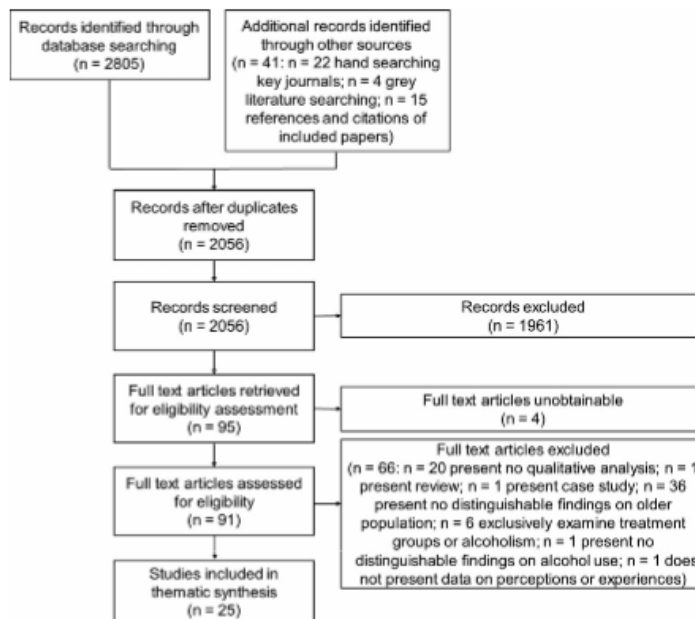


Figure 1. PRISMA flow diagram depicting the flow and number of studies identified and then excluded at each stage during identification of papers for inclusion in this review.

occasional drinkers (six studies) [48, 51, 67–69, 71], moderate drinkers (20 studies) [48, 50–53, 55–59, 61, 62, 64, 66–71] and heavy drinkers (10 studies) [49, 51, 54, 58, 59, 65, 67–69, 71]. Five studies included some people who may have been dependent on alcohol, but these were a minority of participants [49, 65, 68, 69, 71]. Studies were from 16 countries. Six studies were conducted in the UK [50, 51, 57, 68, 69, 71], four in the USA [49, 53, 56, 65], Finland [52, 62, 66, 72] and Sweden [48, 58, 60, 66], two in Canada [54, 55] and Australia [58, 61]. Single studies included participants from New Zealand [59], Russia [67], Norway [64] and Slovenia [70]. Three studies were conducted across several European countries [63, 64, 66]. Three studies specifically focussed on settled migrant groups [49, 54, 55]. Where reported, most samples were recruited either purposively (six studies) [50, 51, 61, 68, 69, 71] or opportunistically (10 studies) [49, 52, 55–58, 60, 65, 67]. Ten studies also employed snowball sampling [49, 60, 52, 55, 56, 58, 60, 68, 69, 71]. Data were collected through in-depth/semi-structured interviews, focus groups, written autobiographical responses and ethnographic observation. A range of theories and approaches were applied to qualitative analyses, including grounded theory, discourse analysis, conversation analysis and thematic analysis. The main quality limitations related to a lack of transparency in reporting and triangulation or exploration of potential biases.

### Themes

Supporting quotes are presented in Table 2. The sex and age of participants are provided where available.

#### *Routines and rituals*

Across their life-course, older adults reported developing specific routines related to their drinking as leisure practices. Descriptions of their drinking were bound to certain contexts [48, 50–57, 59–72], such as with meals or in company. Some drinking seemed to hold additional symbolic meaning and was more 'ritualistic' as opposed to just regular or repeated (routinised) activity. Thus, whilst drinking was engrained within many social occasions [48, 50–55, 57, 59–63, 66–68, 70–72], it could also become a meaningful part of spending time with friends and family members [50–53, 56, 57, 59, 60, 63, 65, 66, 71, 72]. Drinking routines helped older people 'stay in touch' in their relationships (for example, quote 1i) [48, 50–55, 57, 59–62, 66, 67, 69, 71, 72]. For some, the social role of alcohol increased due to the effect of transitions such as retirement or bereavement in later life, which could lead to an increased frequency of drinking occasions [50, 57, 60, 61, 69]. Some heavier drinkers felt it would be difficult to spend time with friends or family without alcohol [51, 55, 69], although situations were also described where a change in drinking habits could adversely affect their social opportunities (quote 1ii).

Drinking was seen as supporting relaxation during spare time (for example, quote 1iii) [51–53, 57, 59–61, 63, 67, 69, 71] which was generally viewed as more plentiful following

retirement. This increase in spare time sometimes led to an increase in the number of contexts and activities where alcohol was consumed (quote 1iv) [50, 57, 60, 61, 69]. Drinking could act to maintain structure in older people's lives, which may have been lost in retirement, symbolising distinct leisure time and creating a clear daily routine [50, 61, 67]. For a small number, the loss of external structure associated with retirement and children leaving home could lead to heavier drinking [50].

Routines and/or rituals in older adults' drinking practices were shaped by social norms and expectations [48–55, 57–61, 63–67, 69–72]. For example, the central role of alcohol was highlighted in retirement communities, where social occasions were based in drinking settings [53, 61]. Most older adults reported that they had reduced their previous overall intake of alcohol with age [48, 51, 52, 59, 63]. However, risky or unhealthy patterns of drinking were described as normal for older adults in some cultures, such as Mexican, Caribbean, Nordic and Russian cultures, particularly amongst men [49, 54, 63, 67]. Women more often described increasing their drinking in later life from previously lower levels [50, 52, 63, 69]. Whilst gender differences in norms and expectation of drinking were present, some described more equal expectations, suggesting these differences were reducing (quote 1v). Scandinavian and Finnish participants described how their lower levels of drinking were shaped by historic temperance movements [52, 62, 64, 66, 72], particularly amongst women, who were expected to drink less than men. Cultural norms also altered the drinking habits of migrants, where older adults report integrating the new culture with that of their home country [54, 55]. This served either to restrict previously risky drinking habits, or encourage riskier practices in groups whose home country consumed less alcohol.

#### *Self-image as a responsible drinker*

Most older adults saw themselves as controlled, responsible and considered in their drinking behaviour (quote 2i) [48, 50–53, 55–60, 62, 66, 68, 71, 72]. This represented their perception of what the image of an older drinker should be, for example quote 2ii. Their experience with drinking across the life course was perceived to make them wiser about drinking [48, 50–52, 59, 60, 64, 66, 70, 71]. Older people presented an idealised view of moderate, low-risk styles of drinking [48, 50–53, 55–57, 59–68, 71, 72]. Idealisation of abstinence or low-level drinking was more likely amongst the oldest individuals, particularly in Scandinavian countries [48, 50, 62, 63].

Drinking was described around these ideals, and justifications of drinking emphasised positive experiences with alcohol [48, 50–52, 54, 55, 57, 60–63, 66–68, 71]. Many participants described their drinking as appropriate to the context [48, 50–55, 57–63, 65–68, 71, 72], and usually aligned to their companions [48, 51–53, 56, 57, 59–63, 65, 70–72]. Social context could sometimes justify drinking to excess [48, 50–53, 57, 59–62, 65, 67, 70, 71]. Whilst alignment of drinking with social peers usually restricted

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Table 2. Supporting quotes for the key themes presented

Theme:	Supporting quotes:
(1) Routines and rituals	<p>(i) Drinking routines could help older people stay in touch in their relationships:  <i>'Boonie and I still enjoy a scotch in the evening... and the way we start off, we have a little bit of scotch. And actually that goes way back. That was when we were both working, we'd come home and have scotch. So it's a pattern that we've used to. And we usually then just sit and chat and talk about what's happening the next day.'</i> female [53].</p> <p>(ii) Change in drinking habits could adversely affect older people's social opportunities:  <i>'The same group, every Friday without fail. There was eight of us and well, there's seven go now because I don't go up [since I stopped drinking] and they've said to me, 'oh, come up, we miss the, sort of, banter and all that sort of thing...' but, yeah, as I say, I miss the company more than I miss the drink.'</i> [50].</p> <p>(iii) Routinised drinking practices could hold symbolic meaning, and were a ritual in relaxation during spare time:  <i>'You know the end of the day – in the evening on the weekend I think it's time to relax and I find that glass of wine is part of that ritual of starting to enjoy the evening.'</i> Female, [59].</p> <p>(iv) The number of drinking contexts could increase with increasing spare time associated with retirement:  <i>'I think possibly it's tempting to drink more when you retire... I go out more for lunch and go out more with friends because I've got time to do it, so possibly linked to that yes [I drink more]'</i> [50].</p> <p>(v) Women's suggestions of more equal expectations between genders with regards to drinking:  <i>'[F2] I think a lot of the men go out a lot more. The older men do still drink. Because that's their only entertainment really, isn't it? I would say middle aged men –' [F5] I don't think it's just men. I think ladies can drink just as much as men.' [F2] I'm talking about going out for a drink though, you know: Do you think the older ladies do?' [F5] Oh yeah, I would say so.' Female focus group [71].</i></p>
(2) Self-image as a responsible drinker	<p>(i) Older adults present themselves as controlled and responsible drinkers, idealising moderation and perceiving themselves to be at low risk of harm from their drinking:  <i>'Drunk? No, I haven't really been for a while. I have to say that for the past ten years I've managed so that I've never been in that bad a way, that I've always known what I've been doing. Haven't been out of my senses, like, when you get to bed, you ask which country, what time and where are we. It's all been so well. I mean, as I've gotten older I've also gotten wiser and know when to stop. Learnt how to know how to stay in control.'</i> [52].</p> <p>(ii) Older adults' image of what an older drinker should be:  <i>'As a pensioner one drinks a bit more often but less at each occasion. You don't have any pressures, it's not as rushed to go to bed. You have more opportunity to eat nice food but it isn't about getting drunk anymore.'</i> Male, [60].</p> <p>(iii) More problematic older drinkers concealed their higher consumption by drinking in private, avoiding pressures to align their drinking:  <i>'I do not enjoy going out and meeting people, sitting in pubs and shouting at the top of my voice. When I come home, this is my haven, I want to be here... say I had my friend come over, and she's very moderate, she drinks like a little... you know. So I feel embarrassed then. So I'd rather drink on my own.'</i> Female [57].</p> <p>(iv) Reduced responsibilities in later life could enable increased opportunity for alcohol consumption:  <i>'I don't really consider the fact that you shouldn't be drinking midday, that you shouldn't be drinking late at night, that you shouldn't be drinking when 'this and that'. I don't mean to imply that I drink a lot, but I do drink, I will drink when I feel like drinking... It changed after I turned 40ish. But now that I am retired I have even more freedom, when you're working you can't have a glass of wine with lunch. But now I can'</i> Female [60].</p> <p>(v) Self-imposed limits and rules maintained controlled drinking patterns:  <i>'I don't like drinking during the day, and would only have the odd drink during the day. Once I have a drink, I would tend to keep drinking. I don't normally drink before 6 pm. Those are my internal rules, it limits the alcohol intake. I don't feel right after drinking during the day, which is why I tend not to.'</i> Female [61].</p> <p>(vi) Rules and limits to restrict drinking were also employed by heavier drinkers:  <i>'I'm probably the one in the group to drink the most. Not outrageously, but when you say winchou; dear god I have a glass from my winchou every night! Sometimes I'll think, one bottle that should be enough for a couple of days. Just to re-focus myself and make me think a little. It's not at the state where I would run to the neighbours and steal from their cellar. But I can think; this isn't good! It is something – dependent they call it. It is extremely rare that I'll end up intoxicated, I think. But still I can feel like the dependency is there... I always take the car when I go anywhere now, for that reason alone. So that I don't have to...''</i> Female [60].</p>
(3) Alcohol and the ageing body	<p>(i) Some believed that not drinking could be negative for health, because alcohol was perceived to be protective to health:  <i>'So being a teetotaler can be hazardous to your health too! I'm in the middle of the road with what the experts seem to say that is a healthy level of consumption, if there is such a thing, keep it down to a drink a day and I'll not do it every day, seem to be the feeling. A small amount of alcohol does have some benefits.'</i> Male [59].</p> <p>(ii) Perceived health benefits of particular drinks served to justify older people's drinking:  <i>'My consultant told me that whiskey was only 2<sup>nd</sup> to red wine for heart disease, and if it's good enough for him it's good enough for me [during cardiac rehabilitation].'</i> Male [51].</p> <p>(iii) Some used alcohol to help with physical ailments:  <i>'It is said that whiskey is healthy. In any case, for me, it is soothing for my stomach and can sometimes act as a medicine'</i> [66].</p> <p>(iv) Alcohol use could be relied upon to cope with stressors or mental health issues in later life:  <i>'Well, [my partner] couldn't have any [alcohol] in the last six months [of his life]. I drank, coz I was so anxious. It's easy to say that one is using because of this and that, but at times I was so distressed that alcohol made me feel better in that situation. And the worse [my partner] got in hospital – I, when I got back from the hospital and had a little alcohol, I could get some sleep and it helped. I sort of relaxed. I was just so anxious about it, I got used to it back then. I should have guessed back then that it wouldn't end well. But I didn't think of it like that back then. You can't know beforehand that that's how it's going to turn out.'</i> Female, aged 62 years [52].</p>

*Continued*

Table 2. Continued

Theme:	Supporting quotes:
	(v) Intoxication could be seen as one of life's remaining pleasures, leading heavier drinkers to maintain their drinking: 'I'd like to cut it down altogether, but even the last time – I cannot be going away and just sitting on my own. I don't smoke, I don't have nowt else and that's the only pleasure I've got – drinking.' Male, aged 61 years [69].
	(vi) Some older people justified maintaining their drinking by identifying alternative explanations for health issues: 'I started to think about what I was consuming that might be, erm... having an effect. And the obvious one is drink, but I didn't want to stop having a drink. But I honed in on citrus... and I thought I wonder, you know, people had said to me there was a connection between citrus fruit, and I wasn't eating a great amount of fruit, the occasional apple, banana whatever, so I stopped and, dare I say it, touch wood... I haven't had gout since... It's a popular explanation for gout, people say oh you're drinking too much red wine or something... that's a throwaway remark that everybody seems to make and I ignored it because I found the solution was there for me and with no adverse effects.' Male [51].
	(vii) Heavier drinking was justified through the lack of noticeable effects on the individual's health: 'I'm 55, I'm perfectly fit, I don't run about beating everyone up, I'm not incontinent, I'm perfectly healthy, I get a check for my stroke, which coincidentally, they check my bloods, they check my liver, check my pancreas, check my kidneys you know, everything's fine, so how is half a dozen pints doing any irreparable damage?' Male, aged 56 years [71].
(4) Access to alcohol	(i) Drink driving legislation could constrain older people's drinking: 'If I know I have to drive, I will just have a light beer, or sometimes I will just go without altogether. I find that easier because you don't have to worry about whether you have gone over the limit. Driving has killed a lot of social drinking, particularly living down here (an outer metropolitan suburb). If I'm in Perth, I very seldom drink, if at all. It is a long drive and I'm not only worried about RBT (random breath testing). But I don't want to feel sleepy. It's the driving mainly that would affect whether or not I will have a drink.' Male [61].
	(ii) Some binged on alcohol when the money was available: 'I drink usually when I receive the pension – it is a small holiday. We buy food and I drink chokushku (a quarter of a litre of vodka), 250 g Beer I drink about once a week. It is sold in big plastic bottles, 1.5 l each. So, I usually finish it during the evening watching TV' Male, aged 69 years [67].

drinking, it could also increase consumption in the company of heavy-drinking friends [52, 56, 60, 61, 65, 67, 70, 72]. A failure to align with companions' drinking could cause relationship problems—particularly with partners or family, but also within wider social groups [49, 50, 57, 65, 66, 69, 70]. Those with more problematic alcohol use consequently reported drinking more heavily in private, to conceal their higher consumption (quote 2iii) [51, 56, 57, 61, 69].

Drinking was seen to be acceptable, provided day-to-day responsibilities remained fulfilled. Many personal responsibilities judged to be incompatible with drinking were lost in later life, through retirement [50, 52, 57, 60, 61] or reduced parental responsibilities [51, 54, 57, 60, 66]. These changes enabled increased alcohol consumption (quote 2iv). However, some older adults acquired new responsibilities during retirement which restricted drinking, including voluntary work, or caring for a sick partner [50, 51, 60, 69]. Conversely, drinking could act as a form of escapism from responsibilities as demonstrated in Joseph's Caribbean-Canadian cricketer community, where family responsibilities were passed on to partners, as drunkenness ensued [54].

Controlled and responsible drinking was often maintained through self-imposed limits or rules (for example, quote 2v) [51–53, 55, 56, 58–63, 66–68, 70, 71]. Heavier drinkers also applied rules and limits to restrict their drinking (quote 2vi). These self-made restrictions played a large part in exerting control and reducing alcohol consumption in later life. Drinking habits in later life were also shaped by stigmatisation of certain drinking styles [48, 50, 52, 54, 55, 57–63, 66–68, 70–72]. Inappropriate drunkenness, alcoholism, drinking

alone, drink-driving and women's drinking were all judged to be unacceptable. Older adults avoided identifying with these behaviours [48, 50, 52, 54, 55, 57–63, 66–68, 70–72].

There was a general perception that 'problematic' and 'normal' drinking behaviours were separate entities [51, 59, 60, 63, 71]. Problematic drinking was associated with a lack of control, need, and risk [51, 52, 59, 60, 71]. Most older adults identified themselves as 'normal' drinkers, framing their consumption as responsible and acceptable compared with problematic use [50, 57–60, 62, 63, 71, 72]. However, this perception meant that many did not reflect upon the increased risks attached to drinking as an older person. Those recognising issues with their drinking did so through identification with the problematic drinking discourse [49, 51, 52, 60, 65, 68, 71].

#### Alcohol and the ageing body

Older people recognised the positive and negative effects that alcohol could have on their bodies as they aged [48–57, 59–72]. Alcohol was valued for its ability to create feelings of pleasure [50, 52, 53, 57, 59–61, 63, 66, 67, 69, 71] and relaxation [50–53, 57, 59–61, 66, 67, 69, 71], which were perceived as an important part of enjoying later life. Alcohol was also believed to have positive effects for health and well-being in older age [49–51, 53–55, 57, 59, 61, 63, 66, 67]. Many viewed alcohol as protective to health [56, 59], particularly when taken in moderation [55, 59, 62]. This led some to believe that not drinking could be negative for health (quote 3i). The health benefits of red wine and whiskey were emphasised [51,

55, 57, 59, 61, 63, 66, 69], but this appeared to be a means of justifying preferences, rather than encouraging a change in use (quote 3ii). The perceived positive effects of drinking led many to view alcohol as a form of medicine [48–51, 53–55, 57, 59, 62–64, 66, 67, 70, 72], particularly in Scandinavian countries. Reported medicinal uses were wide ranging. Aside from preventing numerous diseases, alcohol was seen to cure many physical ailments such as digestive problems, colds and pain (for example, quote 3iii) [48, 51, 54, 55, 62–64, 66–68, 70, 71]. At times, alcohol was used in place of medications [50, 51, 68], as a sleeping aid [51–53, 55, 57, 59, 63, 66, 68, 72], or to promote mental health [48–53, 55, 57, 59, 61, 66–68]; particularly amongst women. Alcohol use could, however, become heavy when relied upon to cope with stressors or mental illness in later life (quote 3iv) [48, 51, 52, 57, 65]. Some recognised that using alcohol in this way could negatively impact mental health [49, 51, 57, 59, 68, 71].

Other negative effects of alcohol were recognised [48, 50, 51, 53, 59, 62, 63, 66, 69, 71, 72]. Older adults were especially aware of short-term consequences associated with intoxication, such as hangovers, accidents and blackouts [48–50, 52, 59, 63, 68, 69, 71]. Longer-term damage was recognised as a potential consequence of drinking [49–51, 54, 57, 59, 62, 69, 71], usually associated with heavier intake. Authors noted that these negative consequences were usually discussed by older adults after prompting, rather than spontaneously described [59, 71]. Many older people were aware of the dangers of drinking whilst taking medication [48, 50, 51, 56, 57, 59, 63, 64, 68, 71, 72]. However some participants, particularly heavier drinkers, described drinking alongside or with medications [51, 59, 64, 68].

In later life, most participants reflected that health was a major priority [51, 59]. The ageing body was felt to be more fragile, requiring greater care than before. Some saw the ability to drink in later life as a sign of good health and resilience [54, 55]. Many adjusted their drinking because of the perceived effects of alcohol on health [50–52, 57, 59, 62–64, 68–72]—particularly men, who had often consumed at higher levels earlier in life [51, 55, 68]. A small number described maintaining their alcohol intake, despite concerns for their health [48–51, 54, 57, 68–71]. Heavier drinkers continued to drink heavily as they saw intoxication to be one of life's remaining pleasures (quote 3v) [55, 57, 69]. Some looked for other explanations for their problems, justifying continued drinking (quote 3vi). Whether alcohol use was reconsidered in later life was determined by the salience of health issues [49–51, 57, 59, 64, 71]. Experiencing negative impact of alcohol on health, either directly or through others' experiences, led to changes in alcohol use. Others justified their heavier drinking habits through the lack of noticeable effect on their health (quotes 3vii).

#### Access to alcohol

Financial and environmental factors were strong influences on access to alcohol, and how much was consumed [50–53, 55, 57–61, 63, 64, 66, 67, 69, 70, 72]. The accessibility of shops and drinking establishments shaped levels of drinking

[51–53, 57, 61, 69, 72]. Mobility issues could complicate access to alcohol [51, 57, 69, 72]. However, drinking could also be facilitated through visits from heavy-drinking friends [57, 69]. In retirement villages, the availability of alcohol in social areas increased residents' drinking [53, 61]. Those living in residential care homes with restrictive alcohol policies could have drinking curtailed [70, 72].

Drink-driving legislation was a major consideration, constraining many older people's drinking (quote 4) [50–53, 55, 57–59, 61, 63]. Restrictions on drink-driving had most impact on socioeconomically advantaged groups, who tended to drink in friends' homes [51]. For individuals living in suburban areas, a lack of public transport could enforce the need to drive [55]. However, in urban settings, safety became a key consideration, restricting time spent drinking outside the home [51].

Financial considerations also shaped older people's drinking [53, 60, 63, 66, 67, 70]. Those with higher disposable incomes increased spending on alcohol and vice-versa [54, 57, 63, 67, 72], although some binged when money was available (quote 4ii). Heavier drinkers prioritised spending on alcohol regardless of income, adjusting their drinking style to fit with the money available [50, 54, 57].

## Discussion

Our review described the multifaceted role of alcohol in older adults' lives. Drinking could help sustain social and leisure activity, which may otherwise diminish through retirement and other transitions relating to the ageing process [16, 20]. The positive and valuable roles of alcohol seen here in older people's lives contrast with the majority of studies of older people's drinking, which focus on risks to health and alcohol use as a coping mechanism for the challenges of ageing [16, 73, 74].

Our review also identified some negative implications of alcohol consumption for older people. Health may be adversely affected if well-established heavy-drinking habits are maintained into later life, or conversely, social lives may diminish if drinking is affected by health concerns. Alcohol consumption alongside health conditions and medication use also carries some risks [9]. Older people may need advice and support to recognise and address potentially adverse interactions [16, 74]. The link between older adults' drinking and loneliness is another common negative view of drinking in later life [16, 73, 76] although no studies within this review directly addressed this issue. This may reflect a sense of stigma associated with isolation and loneliness, or the tendency to recruit from social groups.

Older people typically viewed alcohol risks and harm as belonging to other heavier, more problematic drinkers. This process reflects the sociological concept of 'othering', where the positive, 'healthy' self-identity is protected through contrast with those worse off. 'Othering' may result in a barrier to change for those not recognising alcohol-related risk [77, 78]. People in good health did not consider the risks of their own drinking, as adverse outcomes may have been less



salient compared with those in ill health. This is explained within biographical disruption theory, where good health is assumed unless it is disrupted through the experience of illness [74]. The perception of alcohol as a medicine for minor ailments was prominent in this review. In younger age groups, this is attached to problematic drinking [80–82], but amongst older people it cuts across all levels of consumption.

Social patterns of alcohol consumption reflect cultural trends in population drinking [83]. This suggests that reduced drinking in later life may be a product of cohort or period effects rather than a result of ageing [84]. Riskier drinking styles were demonstrated amongst some settled migrant groups through integration of drinking habits from the old and new countries [85]. However, maintenance of distinct drinking behaviours could also be a way of holding onto cultural or earlier life identity which could carry through into retirement communities [30, 86]. Gendered patterns are complicated and whilst gender differences are highlighted in certain cultures and often associated with men [10, 87], these differences may have decreased over time as women's drinking becomes normalised. Men were more likely to report reductions in their drinking, whilst some women reported increased consumption in later life [88]. Particular patterns of risky drinking, such as drinking to self-medicate, were more commonly amongst women. Future exploration of the evolution of gender differences in alcohol consumption will be important.

This study is novel and applied a rigorous approach to systematic review methodology. Dual-screening and translation of foreign language material ensure that the findings represent literature currently available in the area. By drawing on qualitative literature, it has been possible to present a deeper insight into the reasons behind and social patterns of older people's drinking than can be gleaned from other types of evidence. Our work drew on multiple qualitative studies and looked across different settings. The findings should be applicable beyond individual study populations, and provide a breadth of understanding of older people's drinking. The inclusion of studies of populations from a range of different countries and social circumstances enabled social patterns to be identified. Our focus on non-treatment groups meant findings are relevant to the majority of the older population—a valuable contribution to our understanding of older people's drinking.

A number of limitations must be acknowledged in interpreting our findings. Qualitative data are based upon participants' responses, and so may convey any inaccuracies associated with recall and possibly socially desirable accounts as alcohol use can be a sensitive issue [89]. Good methodology such as rapport building, probing and authenticity checking can reduce this risk [86]. However, in synthesising findings, we are reliant on the reporting of authors of included studies, and some described their analytical approach better than others. Nevertheless, the patterns we have presented are generally reflected in quantitative studies of older people's drinking [10, 20]. The sampling strategies employed in included studies may also have narrowed the socio-

demographic characteristics represented within our findings. Pooling of cross-cultural data may mean that country-specific drinking norms receive less emphasis in our findings. However, this loss of specificity needs to be balanced against a wide and culturally diverse literature which included both settled and migrant communities across most of the developed world.

In conclusion, our findings emphasise that drinking routines can become firmly established in older people's lives across the life-course. Modifying older people's drinking is likely to be a challenge, as well-established patterns of behaviour can be hard to change. However, some older people may reconsider their drinking when concerned about their health in later life. Consequently, routine health checks or other clinical contacts may represent teachable moments in clinical practice, where older people may be receptive to reconsidering their drinking behaviour when this is relevant to their health. Available data on alcohol consumption suggests that positive engagement with the large section of the older population who consider themselves to be controlled and responsible drinkers may be a more effective approach to prevention than focussing on high risk individuals [16]. In any future interventions, it will also be important to acknowledge the positive role of alcohol in the social lives of older people. New social and leisure opportunities may be needed, to replace those associated with heavy or risky drinking. Furthermore, effective interventions will need to act at individual, social, cultural, and environmental levels since all play a key role in shaping and sustaining later life drinking.

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### Key points

- Alcohol presents risks to older people's health, but also plays important roles in their lives.
  - Alcohol use is routinised in older people's lives, and can be an important part of social occasions.
  - Most older people consider themselves to be responsible drinkers, making them less likely to recognise risks in their drinking.
  - Public health interventions to modify older people's drinking should consider targeting older adults identifying as responsible drinkers.
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### Supplementary data

Supplementary data mentioned in the text are available to subscribers in *Age and Ageing* online.

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**Conflicts of interest**

None.

**References**

Note: The very long list of references supporting this article has meant that only the most important are listed here. The full list of references is available in the Supplementary data.

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## Appendix B - Items Included in Saini and Shlonsky's Qualitative Research Quality Checklist

Items included in Saini and Shlonsky's Qualitative Research Quality Checklist are provided below, with authors' guiding notes for enquiry (152). The relevance of each item for each individual study was considered, before evaluating whether enough information was provided to address that question. Comments were noted for each item carried forward for appraisal, which contributed to the final narrative summary for each included study.

1. Is the purpose and research question clearly stated?
  - Is the topic important, relevant and of interest for the given question?
  - Relevant details are likely to be provided within the abstract and introduction, phrased as a research question or described as general purposes for conducting the study.
2. Is a qualitative approach appropriate to answer the research question?
  - Does this approach answer the question at hand?
  - Is this contribution important to the understanding the topic? How is this reasoned?
3. Is the setting of the study appropriate and specific for exploring the research question?
  - The setting should be described richly to understand where it was conducted, who was involved, the time spent in the setting, and contextual factors of the setting to allow readers to consider the transferability of findings to another setting. Philosophical frameworks may help explain the relevance of the setting within the paper.
4. Is there a prolonged engagement to render the inquirer open to multiple influences?
  - Referring to a) the history of involvement with the groups under study (more allows trust building and comfort for sharing truthful accounts) and b) a lengthy process of data collection that can enhance breadth and nuance of perspective.
  - How long did the interviews last?
  - Were interviewers already familiar with participants?
  - Does the person of interest have their say? Is their input facilitated? (Rather than input of carer etc.)

5. Is there persistent observation in the setting to focus on the issues relevant to the research question?
  - Is there enough information for the reader to assess whether there is sufficient depth of data collection to permit an appreciation of the complexity of the phenomenon?
  - Were the interviewees interviewed at an appropriate time to provide sufficient information on the question? A prolonged time gap since the event in question raises issues of recall. A short time gap may lead to negativity as the event may still feel raw.
6. Is there compatibility between research question, method chosen and research design?
  - The research question should guide the qualitative approach, methods used in the study and overall research design.
7. Is the process of sample selection adequately described and consistent with the research design and research question?
  - The process used to select participants should be clearly described. The method should be explicitly stated, and the rationale should fit with the study question and methods.
  - Terms such as purposive, quote, snowballing, maximum variation, homogenous, critical case, theory-based, extreme case and typical case sampling may be used in descriptions.
  - The sampling strategy used should depend on the purpose and method of the study.
8. Is the sample size and composition justified and appropriate for the stated methods, research design and research question?
9. A small sample size is typical, but should be enough to give firm themes and enable rich analysis of individual cases.
10. The numbers included will depend on the chosen method of study.
11. Consider the study composition. Who was and was not included, and why? Consider factors such as age, gender, ethnicity and relationship status.
12. A lack of detail has implications for how findings can be understood within the synthesis.
13. Are the methods for data collection consistent with the research question?

- Reporting should offer sufficient information regarding the data collection methods, and should describe how these methods were used in the data collection phase.
  - Methods should describe when data collection occurred in relation to the event, where this occurred, and who participated.
14. Are the methods for data collection consistent with the stated methods, research design and research question?
- There are guiding assumptions that can be made within various research designs that are associated with different methods leading to congruency.
15. Is a range of methods used for triangulation?
- Are two or more sources explored in looking to understand the topic of study? Sources may include data collected by different researchers, with different theoretical orientations; use of more than one method for qualitative data collection; multiple coders involved in analysis; interdisciplinary triangulation of interpretations of the data with researchers from different fields.
16. Is there an articulation of who collected the data, when the data was collected, and who analysed the data?
- Transparency of data collection is important due to subjective location of experiences and connections with researcher to process and interpret results.
  - Information regarding who was involved in each phase of the study helps better assess the level of reflective analysis at each stage.
17. Is there an audit trail for data collection? Including tapes, memos and note taking of decisions made in the study.
- This provides a transparent data collection process for others to scrutinize steps taken in the research, and helps to assess where reactivity and biases of the researcher are adequately addressed during the study and the impact on overall findings.
  - Do the authors mention making an audit trail?
  - How do they analyse data? Do they make any comments on the findings?
  - No audit trail has implications for credibility of the article, particularly when methods and frameworks are poorly described.
18. Is there an adequate consideration of ethical issues? Including as informed consent, privacy and confidentiality, and protection from harm

- Ethical considerations should be explained and steps to gaining approval described including. Informed consent, particularly when researching with vulnerable groups, where appropriate considerations should be made.
  - How were confidentiality and privacy ensured and maintained? For example, location of interview, secure files, limits on sharing.
19. Has the researcher identified potential and actual biases (both as a researcher, and in the research design)?
- The narrative should explicate any potential sources of bias, for example initial expectations for study results. This detail strengthens the credibility of these findings.
  - The researchers' roles in design and understanding of their role in production of knowledge should be described. The impact of the research process upon results should be discussed. Biases should be acknowledged and explored through self-awareness, evaluating the potential influence they may bring to the study.
20. Did the researcher(s) use a reflexive journal in the analysis and interpretation?
- This documents bias – recorded prior, during and after data collection.
  - Does the author mention the use of reflexivity or a reflexive journal? Does the author mention any team discussion of bias during the research process?
21. Is the process of data analysis presented with sufficient detail and depth to provide insight into meanings and perceptions of the sample?
- There should be sufficient description provided to allow the reader to assess whether data analysis was based on and was consistent with the method and purpose of the study
  - How was the data coded? Methods for transforming raw data into codes depend on the method used in analysis.
  - Any cross-coder reliability?
22. Are quotes used to match concepts and themes derived from raw data?
- Quotes are part of traditional qualitative analysis. They can be included as evidence of the consistency of the interpretations with the words and phrases expressed by participants, and help further explain and illustrate key messages in the findings. Verbatim comments from participants can provide a deeper understanding of themes.
  - Are quotes provided to illustrate the themes?

- Does quotes provided help support understanding of findings?
23. Do the findings emerge from the experiences of the sample?
- Do findings help the reader understand how themes emerged from the experiences of the participants, or from the influences of the researcher?
  - Do the researchers explore their biases and assumptions in reporting the findings?
  - Do the researchers mention their involvement and opinions in the findings?
  - Are both positive and negative findings reported?
24. Was member checking employed?
- Are any other methods of participant validation included?
25. Does the researcher provide a 'thick description' of the sample and results in order to appraise transferability?
- Is the sample carefully described, using quotes from the participants to support conclusions?
  - Is there sufficient detail about the sample/context, and is this linked to study findings?

# Appendix C - Protocol for Systematic Review as Registered in PROSPERO

**PROSPERO**  
International prospective register of systematic reviews



A systematic review of qualitative studies exploring older adults and health and social care practitioners' perceptions and experiences of alcohol consumption in later life

*Bethany Bareham, Eileen Kaner, Barbara Hanratty*

## Citation

Bethany Bareham, Eileen Kaner, Barbara Hanratty. A systematic review of qualitative studies exploring older adults and health and social care practitioners' perceptions and experiences of alcohol consumption in later life. PROSPERO 2016 CRD42016039005 Available from:

[http://www.crd.york.ac.uk/PROSPERO/display\\_record.php?ID=CRD42016039005](http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42016039005)

## Review question

What are the perceptions and experiences of drinking in later life?

What are the perceptions and experiences of drinking in later life for older adults?

What are the perceptions and experiences of drinking in later life for health and social care professionals?

## Searches

We searched the following electronic bibliographic databases: MEDLINE, CINAHL, ASSIA, PsycINFO, Scopus, NHS evidence, Open grey and Dissertation Abstracts International.

The search strategy will include only terms relating to older adults, alcohol consumption and perceptions/experiences/qualitative research. The terms will be combined with the HEDGES filter for qualitative studies (as recommended in the CRD guidelines for systematic review). The search terms will be adapted for use with each bibliographic database, with relevant database-specific headings included in the search strategy.

The citations and references of all included studies will be scanned for any further papers which may be relevant to this review. Google Scholar and relevant journals will also be searched using combinations of the keywords developed in the search strategy.

The searches will be re-run just before the final analysis and further studies retrieved for inclusion.

Additional information about the search strategy can be found in the attached PDF document.

## Search strategy

[http://www.crd.york.ac.uk/PROSPEROFILES/39005\\_STRATEGY\\_20160411.pdf](http://www.crd.york.ac.uk/PROSPEROFILES/39005_STRATEGY_20160411.pdf)

## Types of study to be included

The review will include qualitative studies reporting primarily narrative data concerned with older adults' or health and social care professionals' perceptions or experiences of alcohol consumption among older adults. This will comprise ethnographies, one-to-one interview studies, focus group work and survey studies with analyses of responses to open questions.

## Condition or domain being studied

Alcohol use in later life, which has been causally linked to over sixty disease conditions.

## Participants/population

Inclusion:

Older adults (over 50 - encompassing the retirement window);

Residents of higher income countries;

Can include patients with a long term condition relating to alcohol consumption.

Exclusion:

Focus on adults or children (under 50 years of age);

Focus on patients with alcohol dependence.



**Intervention(s), exposure(s)**

This qualitative review does not focus on interventions (outcome-focused research).

**Comparator(s)/control**

Not applicable.

**Primary outcome(s)**

Qualitative (rich narrative) accounts of perceptions and experiences of alcohol consumption in older adults; particularly focused on both the risks and benefits of alcohol use in later life encompassing health and social functions for older drinkers and also practitioners who may deliver health and/or social care to them.

**Secondary outcome(s)**

None.

*Timing and effect measures*

Not applicable.

**Data extraction (selection and coding)**

Studies will be assessed for quality based primarily on their relevance. A standard quality assessment tool will be selected to appraise the quality of the articles, however no exclusions will be made on this basis. The data will be sifted by two independent researchers with discrepancies discussed. Data extraction will be performed primarily by the lead researcher but will be verified within the supervisory team.

**Risk of bias (quality) assessment**

Due to the qualitative nature of the studies to be included within this review, an assessment of risk of bias would be neither possible nor appropriate. Studies will be assessed for inclusion initially by relevance to the research question. A standard qualitative quality assessment tool will then be applied, although this will not be used as a basis for exclusion.

**Strategy for data synthesis**

The data for synthesis will include both data from individual participants quoted within the article, and data where authors make interpretations and generalisations within the text. Data will be synthesised through metaethnography. Third order concepts will be constructed from primary and secondary concepts gathered from the review articles. If the data is not appropriate for metaethnography, a thematic synthesis will be conducted. Irrespective of the method selected, similarities and differences between the framing and types of concepts included within the different articles will be considered based on differences in the contexts of each item of research. These will include differences in the type of participant (older adult or health and social care professional; age of participants; drinking status of participants), the definition of later life used and the location. Due to the qualitative nature of this work, explorations of heterogeneity and sensitivity will not be appropriate.

**Analysis of subgroups or subsets**

There will be no planned analysis of subgroups or subsets, however group-based patterns within and between studies in perceptions of alcohol consumption will be noted. These may relate to whether participants are older or younger old, their gender and also their culture.

**Contact details for further information**

Bethany Bareham  
b.k.bareham@ncl.ac.uk

**Organisational affiliation of the review**

Newcastle University Institute of Health and Society  
<http://www.ncl.ac.uk/ihs/>

**Review team members and their organisational affiliations**

**PROSPERO**  
International prospective register of systematic reviews



Miss Bethany Bareham. Newcastle University Institute of Health and Society  
Professor Eileen Kaner. Newcastle University Institute of Health and Society  
Professor Barbara Hanratty. Newcastle University Institute of Health and Society

**Anticipated or actual start date**

21 March 2016

**Anticipated completion date**

01 October 2016

**Funding sources/sponsors**

National Institute for Health Research School for Primary Care Research trainee scholarship

**Conflicts of interest**

None known

**Language**

English

**Country**

England

**Stage of review**

Review\_Ongoing

**Subject index terms status**

Subject indexing assigned by CRD

**Subject index terms**

Adult; Aged, Aged, 80 and over; Alcohol Drinking; Attitude of Health Personnel; Health Personnel; Humans; Social Perception; Social Workers

**Date of registration in PROSPERO**

11 May 2016

**Date of publication of this version**

11 May 2016

**Details of any existing review of the same topic by the same authors**

**Stage of review at time of this submission**

<b>Stage</b>	<b>Started</b>	<b>Completed</b>
Preliminary searches	No	Yes
Piloting of the study selection process	No	Yes
Formal screening of search results against eligibility criteria	Yes	No
Data extraction	No	No
Risk of bias (quality) assessment	No	No
Data analysis	No	No

**Versions**

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11 May 2016

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PROSPERO

This information has been provided by the named contact for this review. CRD has accepted this information in good faith and registered the review in PROSPERO. CRD bears no responsibility or liability for the content of this registration record, any associated files or external websites.

## Appendix D - Full systematic review searches as applied to each database

Table Apx D-1 - Search strategy for systematic review, including keywords and database-specific terms

Theme:	Keywords:	MeSH terms:	CINAHL headings	PsychInfo headings	ASSIA headings	Scopus
Older Adult:	"older adult*" OR "older age*" OR "old age*" OR "old person*" OR "old people*" OR "older person*" OR "older people*" OR retire* OR retiring OR ageing OR aging OR elder OR elderly OR "nursing home*" OR geriatric OR geriatrics OR senior OR veteran* OR "older individual*" OR "later life" OR	*RETIREMENT; *ADULT; *AGED; *MIDDLE AGED; *AGE FACTORS; *AGING	*AGED; *MIDDLE AGED; *RETIREMENT; *AGING; *AGE FACTORS; *NURSING HOMES; *NURSING HOME PATIENTS; *GERIATRICS; *VETERANS	AGING; GERIATRIC PATIENTS; GERONTOLOGY; GERIATRICS; ELDER CARE; RETIREMENT; RETIREMENT COMMUNITIES; NURSING HOMES; MILITARY VETERANS	OLDER PEOPLE; ELDERLY PEOPLE; RETIREMENT; RETIREMENT HOMES; AGEING; SENIOR; VETERANS	<i>In title:</i> "older adult*" OR "older age*" OR "older person*" OR "older people*" OR retire* OR retiring OR ageing OR elder OR elderly OR "nursing home*" OR geriatric OR

Theme:	Keywords:	MeSH terms:	CINAHL headings	PsychInfo headings	ASSIA headings	Scopus
	"older drinker*" OR "older client*"					geriatrics OR senior OR veteran* OR "older individual*" OR "later life" OR "older drinker*" OR "older client*" OR *old* OR aged
Professional:	Professional OR profession OR "health personnel" OR nurse OR nurses OR nursing OR physician OR physicians OR	PHYSICIANS; SOCIAL WORKERS; SOCIAL WORK; PATIENTS; PRIMARY HEALTH CARE				

Theme:	Keywords:	MeSH terms:	CINAHL headings	PsychInfo headings	ASSIA headings	Scopus
	practitioner OR practitioners OR doctor OR doctors OR "social work*" OR geriatrician OR geriatricians OR geront* OR GP OR patient OR "primary health care" OR "health service" OR "health services"					
Alcohol Consumption :	(alcohol* adj3 (drink*)) OR abstinence OR abstainer OR abstainers OR "tee- total" OR	*DRINKING BEHAVIOR; *ALCOHOLISM; *ALCOHOL INTOXICATION; *ALCOHOL- RELATED	*ALCOHOL DRINKING; *DRINKING BEHAVIOR; *ALCOHOL- RELATED DISORDERS;	ALCOHOL DRINKING PATTERNS; DRINKING BEHAVIOR; ALCOHOLISM; BINGE DRINKING;	ALCOHOL CONSUMPTION; ALCOHOLIC BEVERAGES; PROBLEM DRINKERS; ABSTINENCE;	<b><i>In title:</i></b> Drink OR drinks OR drinking OR drinker OR abstinence OR abstainer OR abstainers OR

Theme:	Keywords:	MeSH terms:	CINAHL headings	PsychInfo headings	ASSIA headings	Scopus
	"alcoholic*" OR alcohol OR sobriety	DISORDERS; *ALCOHOLIC BEVERAGES	*ALCOHOLICS; *ALCOHOLIC BEVERAGES; *ALCOHOLICS ANONYMOUS	ALCOHOLIC BEVERAGES; DRUG USAGE; SOBRIETY	SUBSTANCE ABUSE; BINGE USE; DRUG ABUSE; DRUG ABUSERS; ALCOHOL ABUSE; SUBSTANCE ABUSERS; ALCOHOLICS ANONYMOUS; ALCOHOL RELATED PROBLEMS; SOBRIETY;	"tee-total" OR "alcoholic*" OR alcohol OR sobriety
Perceptions and Experiences:	Perception* OR perceive OR perceived OR perceiving OR perspective OR perspectives OR experience OR	SOCIAL PERCEPTION; DECISION MAKING; JUDGMENT; HEALTH SURVEYS;	HEALTH BELIEFS; PERCEIVED HEALTH; LIFE EXPERIENCES; RISK TAKING BEHAVIOUR; ATTITUDE TO RISK;	ALCOHOL DRINKING ATTITUDES; DRUG USAGE ATTITUDES; HEALTH ATTITUDES;	RISK PERCEPTION; SELFPERCEPTION; PERCEPTIONS; PERSPECTIVES; EXPERIENCES; PERSONAL EXPERIENCES;	<b>Title or abstract:</b>  Perception* OR perceive OR perceived OR perceiving OR perspective OR

Theme:	Keywords:	MeSH terms:	CINAHL headings	PsychInfo headings	ASSIA headings	Scopus
	experiences OR	SOCIAL	ATTITUDE TO	HEALTH	NEGATIVE	perspectives
	view OR views OR	STIGMA;	HEALTH; COST	KNOWLEDGE;	EXPERIENCES; LIFE	OR experience
	risk OR risks OR	STEREOTYPING	BENEFIT ANALYSIS;	HEALTH	EXPERIENCES;	OR experiences
	risky OR benefit OR	; BEHAVIOR;	<b>BIOGRAPHIES;</b>	BEHAVIOR; SELF	MEMORABLE	OR view OR
	benefits OR	SOCIAL	ATTITUDE; SOCIAL	PERCEPTION;	EXPERIENCES;	views OR risk
	biograph* OR	BEHAVIOR;	VALUES; CULTURAL	SOCIAL	EMOTIONAL	OR risks OR
	autobiograph* OR	ATTITUDE;	VALUES; LIFE	PERCEPTION;	EXPERIENCES; DAILY	risky OR
	attitude* OR values	ATTITUDE OF	HISTORIES; LIFE	SOCIAL BEHAVIOR;	EXPERIENCES;	benefit OR
	OR "life story" OR	HEALTH	STYLE; HABITS;	LABELING;	CROSS CULTURAL	benefits OR
	"life stories" OR	PERSONELL;	JUDGMENT;	STIGMA; SOCIAL	EXPERIENCES;	biograph* OR
	behaviour OR	ATTITUDE TO	DECISION MAKING;	APPROVAL;	AFFECTIVE	autobiograph*
	behavior OR	HEALTH;	DECISION MAKING,	SOCIAL	EXPERIENCES;	OR attitude*
	identit* OR		CLINICAL; DECISION	ACCEPTANCE;	VIEWPOINT;	OR values OR
	attitude* OR belief*		MAKING, PATIENT;	SOCIAL	HEALTH RISKS;	"life story" OR
	OR "life course" OR		STIGMA; SOCIAL	COGNITION;	BEHAVIOUR;	"life stories"
	"course of life" OR		BEHAVIOR; HEALTH	ATTITUDES; AGING	HEALTH	OR behaviour
	habit* OR choice*		BEHAVIOR	(ATTITUDES	BEHAVIOUR;	OR behavior
	OR meaning* OR			TOWARDS); AGED	HEALTH	OR identit* OR
	lifestyle* OR story			(ATTITUDES	COMPROMING	attitude* OR



Theme:	Keywords:	MeSH terms:	CINAHL headings	PsychInfo headings	ASSIA headings	Scopus
	OR stories OR account* OR "life histor*" OR reasons OR reasoning OR expectation*			TOWARDS); SOCIAL NORMS; SOCIAL VALUES; EXPERIENCES; LIFE EXPERIENCES; EXPECTATIONS; WORLD VIEW; VALUES; DECISION MAKING; RISK PERCEPTION; RISK TAKING; BIOGRAPHY; PLANNED BEHAVIOR; HISTORY; AUTOBIOGRAPHY; BEHAVIOR; SOCIAL IDENTITY; HABITS; MEANING;	BEHAVIOUR; MORAL BEHAVIOUR; SOCIAL BEHAVIOUR; BIOGRAPHICAL DATA; BIOGRAPHICAL RESEARCH; BIOGRAPHIES; ATTITUDES; CULTURAL ATTITUDES; NEGATIVE ATTITUDES; PROFESSIONAL ATTITUDES; SOCIAL ATTITUDES; STEREOTYPES; BELIEFS; HEALTH	belief* OR "life course" OR "course of life" OR habit* OR choice* OR meaning* OR lifestyle* OR story OR stories OR account* OR "life histor*" OR reasons OR reasoning OR expectation*

**Theme:**

**Keywords:**

**MeSH terms:**

**CINAHL headings**

**PsychInfo  
headings**

**ASSIA headings**

**Scopus**

LIFESTYLE;

REASONING;

BELIEFS; MORAL

BELIEFS; NEGATIVE

BELIEFS; SOCIAL

BELIEFS; LIFE

COURSE; HABITS;

HEALTHY HABITS;

CHOICE; INFORMED

CHOICE; LIFE

CHOICE; SOCIAL

CHOICE; MEANING;

LIFE MEANING;

SOCIAL MEANING;

LIFESTYLE; STORIES;

SHARED STORIES;

LIFE STORIES; LIFE

HISTORIES;

REASONS;

**EXPECTATIONS**

Theme:	Keywords:	MeSH terms:	CINAHL headings	PsychInfo headings	ASSIA headings	Scopus
Qualitative Research	qualitative OR theme OR "discourse analysis" OR interview* OR "constant comparative" OR thematic OR narration OR "exploratory research" OR "focus group*" OR "content analysis" OR transcript* OR "social construction*" OR "grounded theory" or phenomenolog*	INTERVIEW; FOCUS GROUP QUALITATIVE RESEARCH; BIOGRAPHY	QUALITATIVE STUDIES; PHENOMENOLOGY; THEMATIC ANALYSIS; CONCEPTUAL FRAMEWORK; GROUNDED THEORY; DISCOURSE ANALYSIS; INTERVIEWS; CONSTANT COMPARATIVE METHOD; STORYTELLING; NARRATIVES; EXPLORATORY RESEARCH; FOCUS	NARRATIVES; STORY TELLING; INTERVIEWS; QUALITATIVE RESEARCH; GROUNDED THEORY; DISCOURSE ANALYSIS; CONTENT ANALYSIS; INTERVIEWERS; INTERVIEWING; GROUP DISCUSSION; PHENOMENOLOG Y	AUTOBIOGRAPHICA L INTERVIEWING; STORY TELLING; QUALITATIVE ANALYSIS; QUALITATIVE DATA; QUATITATIVE METHODS, QUALITATIVE RESEARCH; DISCOURSE ANALYSIS; INTERVIEWS; FOCUS GROUP INTERVIEWS; SEMI STRUCTURED INTERVIEWS; STRUCTURED INTERVIEWS;	<i>Title or            abstract:</i> qualitative OR theme OR "discourse analysis" OR interview* OR "constant comparative" OR thematic OR narration OR "exploratory research" OR "focus group*" OR "content analysis" OR transcript* OR

Theme:

Keywords:

MeSH terms:

CINAHL headings

PsychInfo  
headings

ASSIA headings

Scopus

GROUPS; CONTENT  
ANALYSIS; SOCIAL  
CONSTRUCTIONIS  
M

VIDEOTAPED  
INTERVIEWS;  
STRUCTURED  
CLINICAL  
INTERVIEWS;  
NARRATION;  
EXPLORATORY DATA  
ANALYSIS; FOCUS  
GROUPS; CONTENT  
ANALYSIS;  
TRANSCRIPTS;  
SOCIAL  
CONSTRUCTION;  
SOCIAL  
CONSTRUCTIONISM;  
GROUNDED  
THEORY;  
PHENOMENOLOGY

"social  
construction\*"  
OR "grounded  
theory" or  
phenomenolog  
\*

**Theme:**

**Keywords:**

**MeSH terms:**

**CINAHL headings**

**PsychInfo  
headings**

**ASSIA headings**

**Scopus**

**Note:** Highlighting indicates explode; \*HEADING indicates focus

Professionals as a search will not be necessary as these papers will come under the combination of other concepts searched for.

**Databases:**

*Select Humans*

MEDLINE

CINAHL

ASSIA

PsychInfo

Scopus:

AND SUBJAREA ( mult OR medi OR nurs OR vete OR dent OR heal OR mult OR arts OR busi OR deci OR econ OR psyc OR soci )

Grey literature - NHS evidence; Open Grey; Dissertation abstracts international

Searching for all theme headings or keywords in title or abstract:

Medline: 1166 (all known papers found)

PsychInfo: 595 (all known papers found)

CINAHL: 387 (2/3 known papers found)

Scopus: 247 (all known papers found)

ASSIA: 387 (all know papers found)

## Appendix E - Items for data extraction from included studies

- Citation
- Country of study
- Study population (older adults or care providers?)
- Phenomena of interest
- Research aims/objectives/research questions
- Age frame for later life
- Level of consumption discussed
- Reported philosophical orientation
- Study design (i.e. qualitative/mixed methods)
- Details of data collection
- Method of analysis
- Recruitment context and sampling strategy
- Date of data collection
- Interview topic guide
- Sample size
- Age range of participants
- Drinking status of participants
- Other participant characteristics
- Nature of material on drinking in later life (experience, views, care policy, care practice)
- Reported summary of main findings
- Themes presented by the author(s)
- Findings reported on drinking in later life
- Reviewer (additional) identified themes on drinking in later life
- Author explanation/discussion of findings
- Reported study limitations
- Reviewer identified study limitations
- Reported conclusions of the study
- Any conflicts of interested
- Related articles

## Appendix F - Citations of items excluded at full text, and reasons for exclusion

*Table Apx F-1 Citations of items excluded from the systematic review at full text, by reason for exclusion*

Reason	Items excluded on this basis
No qualitative analysis presented	<ol style="list-style-type: none"> <li>1. Akers, R. L., et al. (1989). "Social learning theory and alcohol behavior among the elderly." <u>The Sociological Quarterly</u> <b>30</b>(4): 625-638.</li> <li>2. Bristow, M. F. and A. W. Clare (1992). "Prevalence and characteristics of at-risk drinkers among elderly acute medical in-patients." <u>British Journal of Addiction</u> <b>87</b>(2): 291-294.</li> <li>3. Brown, B. B. (1982). "Professionals' perceptions of drug and alcohol abuse among the elderly." <u>The Gerontologist</u> <b>22</b>(6): 519-525.</li> <li>4. Castillo, B. A., et al. (2008). "Stressful situations in life, use and abuse of alcohol and drugs by elderly in Monterrey, Mexico." <u>Revista Latino-Americana de Enfermagem</u> <b>16 Spec No</b>: 509-515.</li> <li>5. Christopherson, V. A., et al. (1984). "Reasons for drinking among the elderly in rural Arizona." <u>Journal of Studies on Alcohol</u> <b>45</b>(5): 417-423.</li> <li>6. Dupree, L. and S. Zimberg (1984). "Perspectives. Intervention and treatment of elderly alcoholics and problem drinkers. Interview by Millree Williams." <u>Alcohol Health &amp; Research World</u> <b>8</b>(3): 48-52.</li> <li>7. Guidoni, O. V. (2007). "Alcohol consumption patterns of two cohorts of Italian men today and at their moment of maximum consumption." <u>Contemporary Drug Problems: An Interdisciplinary Quarterly</u> <b>34</b>(2): 299-311.</li> <li>8. Gunnarsson, E. (2013). "Alkoholmissbruk och självbestämmande - en kartlaggning av den svenska hemtjänstens förutsättningar att arbeta med äldre personer med alkoholproblem." <u>Nordic Studies on Alcohol and Drugs</u> <b>30</b>(3): 227-242.</li> <li>9. Haberman, P. W. (1976). "BOOK: DRINKING, COMMUNITY AND CIVILIZATION: THE ACCOUNT OF A NEW JERSEY INTERVIEW STUDY. By Harold Fallding. New Brunswick: Rutgers Center of Alcohol Studies, 1974. 90 pp. \$6.00." <u>Social Forces</u> <b>54</b>(3): 724.</li> <li>10. Hanson, M. and I. A. Gutheil (2004). "Motivational strategies with alcohol-involved older adults: implications for social work practice." <u>Social Work</u> <b>49</b>(3): 364-372.</li> <li>11. Jennison, K. M. (1992). "The impact of stressful life events and social support on drinking among older adults: a general population survey." <u>International Journal of Aging &amp; Human Development</u> <b>35</b>(2): 99-123.</li> <li>12. Khan, N., et al. (2006). "Reasons for changing alcohol use among older people in New Zealand." <u>Australasian Journal on Ageing</u> <b>25</b>(2): 97-100.</li> <li>13. Klein, W. C. and C. Jess (2002). "One last pleasure? Alcohol use among elderly people in nursing homes." <u>Health &amp; Social Work</u> <b>27</b>(3): 193-203.</li> <li>14. Laforge, R. G. and S. I. Mignon (1993). "Alcohol use and alcohol problems among the elderly." <u>Rhode Island Medicine</u> <b>76</b>(1): 21-26.</li> <li>15. Menecier, P., et al. (2010). "The attitudes and beliefs of nurses in relation to alcohol abuse in the elderly: Exploratory study in 301 hospital nurses." <u>Alcoologie et Addictologie</u> <b>32</b>(4): 291-298.</li> <li>16. Moscato, A. and I. Varescon (2011). "Les aidantes professionnelles a domicile et les personnes agees en difficulte ave l'alcool: evaluation et reflexions cliniques." <u>Geriatric Et Psychologie Neuropsychiatrie Du Vieillessement</u> <b>9</b>(4): 491-498.</li> <li>17. Neve, R. J. M., et al. (1997). "Drinking careers of older male alcoholics in treatment as compared to younger alcoholics and to older social drinkers." <u>Journal of Studies on Alcohol</u> <b>58</b>(3): 303-311.</li> </ol>

Reason	Items excluded on this basis
	<ol style="list-style-type: none"> <li>18. Peter , M. (2008). "Learn to handle problematic alcohol habits in nursing homes." <u>Sygeplejersken / Danish Journal of Nursing</u> <b>108</b>(22): 42-46 45p.</li> <li>19. Rook, K. S., et al. (1990). "Social control, health risk taking, and psychological distress among the elderly." <u>Psychology &amp; Aging</u> <b>5</b>(3): 327-334.</li> <li>20. Wittig-Wells, D. (2007). "Perceptions of native United States Virgin Island residents regarding older women who drink too much." <u>Journal of Multicultural Nursing and Health</u> <b>13</b>(1): 28-36.</li> </ol> <p><b><u>TOTAL: 20</u></b></p>
Presents a review rather than primary data	<ol style="list-style-type: none"> <li>1. Olsson, L. N. and E. Rosell (2010). Hemtjänstens arbete hos äldre med alkoholproblematik. <u>Sociologi Socionomprogrammet</u>, Hogskolan I Gavle.</li> </ol> <p><b><u>TOTAL: 1</u></b></p>
Presents a case study	<ol style="list-style-type: none"> <li>1. Glasdam, S. and C. Oye (2014). "Alcohol abuse in cancer patients: a shadow side in the oncological field and research." <u>Medicine, Health Care &amp; Philosophy</u> <b>17</b>(3): 437-446.</li> </ol> <p><b><u>TOTAL: 1</u></b></p>
Examines non-higher income country	<ol style="list-style-type: none"> <li>1. Castillo, B. A., et al. (2008). "Stressful situations in life, use and abuse of alcohol and drugs by elderly in Monterrey, Mexico." <u>Revista Latino-Americana de Enfermagem</u> <b>16 Spec No</b>: 509-515.</li> </ol> <p><b><u>TOTAL: 0 (for this reason alone)</u></b></p>
Presents no distinguishable findings on drinking in later life	<ol style="list-style-type: none"> <li>1. Baron-Epel, O., et al. (2014). "Alcohol consumption among Arabs in Israel: A qualitative study." <u>Substance Use &amp; Misuse</u> <b>50</b>(2): 268-273.</li> <li>2. Gronkjaer, M., et al. (2011). "Acceptance and expectance: Cultural norms for alcohol use in Denmark." <u>International Journal of Qualitative Studies on Health and Well-Being</u> <b>6</b>(8461): 1-11.</li> <li>3. Gronkjaer, M., et al. (2013). "Drinking contexts and the legitimacy of alcohol use: Findings from a focus group study on alcohol use in Denmark." <u>Scandinavian Journal of Public Health</u> <b>41</b>: 221-229</li> <li>4. Guidoni, O. V. (2007). "Alcohol consumption patterns of two cohorts of Italian men today and at their moment of maximum consumption." <u>Contemporary Drug Problems: An Interdisciplinary Quarterly</u> <b>34</b>(2): 299-311.</li> <li>5. Hurcombe, R., et al. (2012). "Perspectives on alcohol use in a Traveller community: an exploratory case study." <u>Ethnicity and Inequalities in Health and Social Care</u> <b>5</b>(3): 89-97.</li> <li>6. Keenan, K., et al. (2015). "Social factors influencing Russian male alcohol use over the life course: A qualitative study investigating age based social norms, masculinity, and workplace context." <u>PLoS ONE</u> <b>10</b>(11): 1-15.</li> <li>7. Murphy, A., et al. (2015). "One for all: Workplace social context and drinking among railway workers in Ukraine." <u>Global Public Health</u> <b>10</b>(3): 391-409.</li> <li>8. Quintero, G. (1997). "The discourse on drinking in Navajo society." <u>Dissertation Abstracts International Section A: Humanities and Social Sciences</u> <b>58</b>(4-A): 1352.</li> </ol>



Reason	Items excluded on this basis
	<ol style="list-style-type: none"> <li>9. Quintero, G. (2000). "'The lizard in the green bottle': 'Aging out' of problem drinking among Navajo men." <u><i>Social Science and Medicine</i></u> <b>51</b>(7): 1031-1045.</li> <li>10. Raine, P. M. (1999). Different dimensions: women's perspectives on alcohol and drugs, Lancaster University. <b>PhD</b>.</li> <li>11. Simonen, J., et al. (2014). "Femininities of drinking among Finnish and Swedish women of different ages." <u><i>Addiction Research &amp; Theory</i></u> <b>22</b>(2): 98-108.</li> <li>12. Wight, D. (1987). Hard workers and big spenders facing the bru: Understanding men's employment and consumption in a de-industrialized scottish village, The University of Edinburgh. <b>PhD</b>.</li> <li>13. Wight, D. (1993). <u><i>Workers Not Wasters: Masculine respectability, consumption and employment in Central Scotland</i></u>. Edinburgh, Edinburgh University Press.</li> <li><b>14.</b> Yuan, N. P., et al. (2010). "'Alcohol is something that been with us like a common cold": Community perceptions of American Indian drinking." <u><i>Substance Use and Misuse</i></u> <b>45</b>(12): 1909-1929.</li> <li><b>15.</b> Ho, H. K. (2014). Drinking Bordeaux in the 'new' Hong Kong: Exploring changing identities through alcohol consumption. <u><i>Geography</i></u>, University College London. <b>PhD</b>.</li> </ol> <p><b><u>TOTAL: 14 (for this reason alone)</u></b></p>
Examines treatment groups or alcoholism	<ol style="list-style-type: none"> <li>1. Carlstrom, T. and A. L. Westman (2005). Bemötande av äldre missbrukande vårdtagare inom hemtjänsten. <u><i>Socialhögskolan</i></u>. Lund, Lunds universitet.</li> <li>2. del Pino, H. E., et al. (2016). "Stigma and family relationships of middle-aged gay men in recovery." <u><i>Journal of Gay &amp; Lesbian Social Services: The Quarterly Journal of Community &amp; Clinical Practice</i></u> <b>28</b>(1): 1-19.</li> <li>3. Dupree, L. and S. Zimberg (1984). "Perspectives. Intervention and treatment of elderly alcoholics and problem drinkers. Interview by Millree Williams." <u><i>Alcohol Health &amp; Research World</i></u> <b>8</b>(3): 48-52.</li> <li>4. Moscato, A., et al. (2016). " Les aidantes professionnelles a domicile dans l'accompagnement de personnes agees atteintes de la maladie d'Alzheimer ou presentant des conduites d'alcoolisation : evaluation qualitative et reflexions cliniques." <u><i>Canadian Journal on Aging</i></u> <b>35</b>(1): 79-88.</li> <li>5. Pettinato, M. (2008). "Nobody was out back then: A grounded theory study of midlife and older lesbians with alcohol problems." <u><i>Issues in Mental Health Nursing</i></u> <b>29</b>(6): 619-638.</li> <li>6. Wadd, S. and S. Galvani (2014). "Working with older people with alcohol problems: insight from specialist substance misuse professionals and their service users." <u><i>Social Work Education</i></u> <b>33</b>(5): 656-669.</li> <li><b>7.</b> Wadd, S., et al. (2011). Working with older drinkers, University of Bedfordshire.</li> </ol> <p><b><u>TOTAL: 6 (for this reason alone)</u></b></p>
Presents no distinguishable findings on alcohol use	<ol style="list-style-type: none"> <li>1. Brown, B. B. (1982). "Professionals' perceptions of drug and alcohol abuse among the elderly." <u><i>The Gerontologist</i></u> <b>22</b>(6): 519-525.</li> <li>2. Roe, B., et al. (2010). "Experiences of drug use and ageing: Health, quality of life, relationship and service implications." <u><i>Journal of Advanced Nursing</i></u> <b>66</b>(9): 1968-1979.</li> <li>3. Grundberg, A., et al. (2016). "Home care assistants' perspectives on detecting mental health problems and promoting mental health among community-dwelling seniors with multimorbidity." <u><i>Journal of multidisciplinary healthcare</i></u> <b>9</b>: 83-95.</li> </ol>

Reason	Items excluded on this basis
Findings do not examine perceptions and experiences of alcohol use	<ol style="list-style-type: none"> <li data-bbox="496 282 1345 365">4. Drummond, M. and J. Smith (2006). "Ageing men's understanding of nutrition: Implications for health." <u>Journal of Men's Health &amp; Gender</u> <b>3</b>(1): 56-60.</li> <li data-bbox="496 376 1345 459">5. Lewis, J. P. (2010). "Successful aging through the eyes of Alaska Natives: exploring generational differences among Alaska Natives." <u>Journal of Cross-Cultural Gerontology</u> <b>25</b>(4): 385-396.</li> <li data-bbox="496 470 1345 562">6. Nosa, V. and M. Ofanoa (2009). "The social, cultural and medicinal use of kava for twelve Tongan born men living in Auckland, New Zealand." <u>Pacific Health Dialog</u> <b>15</b>(1): 96-102.</li> </ol> <p data-bbox="448 580 810 607"><b>TOTAL: 5 (for this reason alone)</b></p>
Does not examine health and social care workers' perceptions	<ol style="list-style-type: none"> <li data-bbox="496 663 1345 745">1. McCormick, K. A., et al. (2006). "How primary care providers talk to patients about alcohol: a qualitative study." <u>Journal of General Internal Medicine</u> <b>21</b>(9): 966-972.</li> </ol> <p data-bbox="448 772 555 799"><b>TOTAL: 1</b></p> <ol style="list-style-type: none"> <li data-bbox="496 987 1345 1077">1. Andrews, C. (2008). "An exploratory study of substance abuse among Latino older adults." <u>Journal of Gerontological Social Work</u> <b>51</b>(1/2): 87-108 122p.</li> </ol> <p data-bbox="448 1099 555 1126"><b>TOTAL: 1</b></p>
For items included in the synthesis of studies reporting older adults' perceptions: Does not examine older adults' perceptions	<ol style="list-style-type: none"> <li data-bbox="496 1252 1345 1373">1. Andersson, A. and S. Johansson (2013). May I take a snifter to the herring sandwich at the retirement home? A qualitative study of staffs in eldercare approach to older people's drinking habits. <u>Socialhögskolan</u>, Lunds Universitet.</li> <li data-bbox="496 1384 1345 1467">2. Andersson, A. and M. Bommelin (2013). "Det är klart att de inte blir som de vanliga ärendena vi har": Biståndsbedömares förståelse av äldre personers riskbruk av alkohol. <u>Faculty of Arts and Social Sciences</u> Karlstad University.</li> <li data-bbox="496 1478 1345 1561">3. Andrews, C. (2008). "An exploratory study of substance abuse among Latino older adults." <u>Journal of Gerontological Social Work</u> <b>51</b>(1/2): 87-108 122p.</li> <li data-bbox="496 1572 1345 1630">4. Brown, B. B. (1982). "Professionals' perceptions of drug and alcohol abuse among the elderly." <u>The Gerontologist</u> <b>22</b>(6): 519-525.</li> <li data-bbox="496 1641 1345 1700">5. Claiborne, N., et al. (2010). "Alcohol screening, evaluation, and referral for veterans." <u>Journal of Social Work Practice in the Addictions</u> <b>10</b>(3): 308-326.</li> <li data-bbox="496 1711 1345 1769">6. Carlstrom, T. and A. L. Westman (2005). Bemötande av äldre missbrukande vårdtagare inom hemtjänsten. <u>Socialhögskolan</u>. Lund, Lunds universitet.</li> <li data-bbox="496 1780 1345 1839">7. Darwish, J. and M. Fyrpihl (2015). Alkohol inom äldreomsorgen: Hur hanteras problematiken? <u>Institutionen for socialt arbete</u>, Linneuniversitetet</li> <li data-bbox="496 1850 1345 1948">8. Grundberg, A., et al. (2016). "Home care assistants' perspectives on detecting mental health problems and promoting mental health among community-dwelling seniors with multimorbidity." <u>Journal of multidisciplinary healthcare</u> <b>9</b>: 83-95.</li> <li data-bbox="496 1960 1345 2038">9. Gunnarsson, E. (2010). Vi far klara oss själva - Om hemtjänstens arbete med äldre personer som har missbruksproblem. <u>Institutionen for Socialt Arbete</u>. Stockholms, Sweden, Stockholms Universitet.</li> </ol>

## Reason

## Items excluded on this basis

10. Gunnarsson, E. (2013). "Alkoholmissbruk och självbestämmande - en kartläggning av den svenska hemtjänstens förutsättningar att arbeta med äldre personer med alkoholproblem." Nordic Studies on Alcohol and Drugs **30**(3): 227-242.
11. Gunnarsson, E. and L. B. Karlsson (2013). "Man sluter inte dricka för att man far stadat" - om bistånd, hemtjänst och alkohol. Institutionen för Socialt Arbete - Socialhögskolan. Stockholms, Stockholms Universitet.
12. Herring, R. and B. Thom (1997). "The right to take risks: alcohol and older people." Social Policy & Administration **31**(3): 233-246.
13. Herring, R. and B. Thom (1998). "The role of home carers: findings from a study of alcohol and older people." Health Care in Later Life **3**(3): 199-211 113p.
14. Johannessen, A., et al. (2015). "Use and misuse of alcohol and psychotropic drugs among older people: Is that an issue when services are planned for and implemented?" Scandinavian Journal of Caring Sciences **29**(2): 325-332
15. Johannessen, A., et al. (2015). "Prescribers of psychotropic drugs experiences and reflections on use and misuse of alcohol and psychotropic drugs among older people: A qualitative study." Quality in Primary Care **23**(3): 134-140.
16. Kiernan, M. D., et al. (2015). "Understanding why veterans are reluctant to access help for alcohol problems: Considerations for nurse education." Nurse Education Today.
17. Millard, A. and A. McAuley (2008). "Endpage: Alcohol and the over 65s: Service gaps seen from home care in Scotland." Journal of Social Work Practice in the Addictions **8**(3): 417-420.
18. Moscato, A., et al. (2016). "Les aidantes professionnelles a domicile dans l'accompagnement de personnes agees atteintes de la maladie d'Alzheimer ou presentant des conduites d'alcoolisation : evaluation qualitative et reflexions cliniques." Canadian Journal on Aging **35**(1): 79-88.
19. Serbic, J. and H. Sundbring (2015). Alkoholkonsumtion på äldreboenden: En studie gällande vårdpersonals bemötande av alkoholkonsumtion, JÖNKÖPING UNIVERSITY. Socionomprogrammet.
20. Severin, E. and S. Keller (2016). "DET ÄR ETT VÄLDIGT KÄNSLIGT ÄMNE JUST DET DÄR MED ALKOHOL"- En kvalitativ studie om hemtjänstpersonals arbete med brukare som har alkoholproblem. Institutionen för Socialt Arbete, Goteborgs Universitet. **Scientific Work in Social Work**.
21. Shaw, C. and G. Palattiyil (2008). "Issues of alcohol misuse among older people: attitudes and experiences of social work practitioners." Practice: Social Work in Action **20**(3): 181-193.
22. Wadd, S. and S. Galvani (2014). "Working with older people with alcohol problems: insight from specialist substance misuse professionals and their service users." Social Work Education **33**(5): 656-669.
23. Wadd, S., et al. (2011). Working with older drinkers, University of Bedfordshire.

### **TOTAL: 23**

For items contributing to the synthesis of studies reporting care

1. Abrahamson, M. (2009). "Old people's values and ideals in the public call for writing "Alcohol in my life". " NAT Nordisk alkohol & narkotikatidskrift **26**(5): 439-461.
2. Abrahamson, M. (2012). "Moral norms in older Swedish women's drinking narratives. Enduring patterns and successively new features." NAT Nordisk alkohol & narkotikatidskrift **29**(4): 371-396.

**Reason****Items excluded on this basis**

providers'  
perceptions: Does  
not examine health  
and social care  
workers'  
perceptions

3. Aitken, R. (2015). Alcohol in later life: A qualitative study on alcohol use among older people in New Zealand. *Psychology*, Massey University, Manawatu Campus. **Masters of Science in Psychology**: 109.
4. Billinger, K. (2012). "60 till 70-åringars tal om den egna alkoholkonsumtionen." *Socialvetenskaplig tidskrift* **3-4**: 170-185.
5. Bobrova, N., et al. (2010). "Gender differences in drinking practices in middle aged and older Russians." *Alcohol and Alcoholism* **45**(6): 573-580.
6. Burruss, K., et al. (2014). "Understanding older adults' attitudes and beliefs about drinking: perspectives of residents in congregate living." *Ageing and Society*.
7. Dare, J., et al. (2014). "Social engagement, setting and alcohol use among a sample of older Australians." *Health & Social Care in the Community* **22**(5): 524-532.
8. del Pino, H. E., et al. (2013). "Leveraging family values to decrease unhealthy alcohol use in aging Latino day laborers." *Journal of Immigrant & Minority Health* **15**(5): 1001-1007.
9. del Pino, H. E., et al. (2016). "Stigma and family relationships of middle-aged gay men in recovery." *Journal of Gay & Lesbian Social Services: The Quarterly Journal of Community & Clinical Practice* **28**(1): 1-19.
10. Drummond, M. and J. Smith (2006). "Ageing men's understanding of nutrition: Implications for health." *Journal of Men's Health & Gender* **3**(1): 56-60.
11. Gell, L. (2013). Drinking in older adults: the role of changes in health and other influences on alcohol consumption over time. *School of Health and Related Research*, University of Sheffield.
12. Gronkjaer, M., et al. (2011). "Acceptance and expectance: Cultural norms for alcohol use in Denmark." *International Journal of Qualitative Studies on Health and Well-Being* **6**(8461): 1-11.
13. Gronkjaer, M., et al. (2013). "Drinking contexts and the legitimacy of alcohol use: Findings from a focus group study on alcohol use in Denmark." *Scandinavian Journal of Public Health* **41**: 221-229
14. Haarni, I. and L. Hautamaki (2010). "Life experience and alcohol: 60-75-year-olds' relationship to alcohol in theme interviews." *NAT Nordisk alkohol & narkotikatidskrift* **27**(3): 256-258.
15. Haighton, C., et al. (2016). "A Qualitative Study of Service Provision for Alcohol Related Health Issues in Mid to Later Life." *PLoS ONE [Electronic Resource]* **11**(2): e0148601.
16. Haighton, C., et al. (2018). "'I take my tablets with the whiskey': A qualitative study of alcohol and medication use in mid to later life." *PloS One* **13**(10): e0205956.
17. Johannessen, A., et al. (2015). "Older peoples' narratives of use and misuse of alcohol and psychotropic drugs." *Scandinavian Journal of Caring Sciences* Oct(Pagination): No Pagination Specified.
18. Joseph, J. (2012). "Around the boundary: Alcohol and older Caribbean-Canadian men." *Leisure Studies* **31**(2): 147-163.
19. Keenan, K., et al. (2015). "Social factors influencing Russian male alcohol use over the life course: A qualitative study investigating age based social norms, masculinity, and workplace context." *PLoS ONE* **10**(11): 1-15.
20. Kim, W. (2009). "Drinking culture of elderly Korean immigrants in Canada: a focus group study." *Journal of Cross-Cultural Gerontology* **24**(4): 339-353.
21. Murphy, A., et al. (2015). "One for all: Workplace social context and drinking among railway workers in Ukraine." *Global Public Health* **10**(3): 391-409.
22. Reczek, C., et al. (2016). "Marital Histories and Heavy Alcohol Use among Older Adults." *Journal of Health & Social Behavior* **57**(1): 77-96.

**Reason****Items excluded on this basis**

23. Sharp, L. C. (2011). Older adult patient-doctor communication regarding alcohol use: A qualitative study. Department of Psychology. Colorado, Colorado State University. **Doctor of Philosophy**.
24. Simonen, J., et al. (2014). "Femininities of drinking among Finnish and Swedish women of different ages." Addiction Research & Theory **22**(2): 98-108
25. Stanojević-Jerković, O., et al. (2011). "Indicators of problem drinking in the Slovenian elderly: A qualitative analysis." Zdravstveno Varstvo **50**(4): 249-258.
26. Tolvanen, E. (1998). "I and others: alcohol use among older people as a social and cultural phenomenon." Ageing and Society **18**(5): 563-583.
27. Tolvanen, E. and M. Jylha (2005). "Alcohol in life story interviews with Finnish people aged 90 or over: Stories of gendered morality." Journal of Aging Studies **19**: 419-435.
28. Vaz De Almeida, M. D., et al. (2005). "Alcohol consumption in elderly people across European countries: Results from the food in later life project." Ageing International **30**(4): 377-395.
29. Ward, L., et al. (2008). Cheers!? A project about older people and alcohol.
30. Ward, L., et al. (2011). "Alcohol use in later life - older people's perspectives." Quality in Ageing and Older Adults **12**(4): 1-14.
31. Watling, H. and K. Armstrong (2015). "Exploring the influences of country-level factors on mature-aged women's drink driving attitudes." Transportation Research Part F: Traffic Psychology and Behaviour **30**: 57-65.
32. Wight, D. (1987). Hard workers and big spenders facing the bru: Understanding men's employment and consumption in a de-industrialized scottish village, The University of Edinburgh. **PhD**.
33. Wight, D. (1993). Workers Not Wasters: Masculine respectability, consumption and employment in Central Scotland. Edinburgh, Edinburgh University Press.
34. Wilson, G. B., et al. (2013). "A qualitative study of alcohol, health and identities among UK adults in later life." PLoS ONE [Electronic Resource] **8**(8): e71792.
35. Yuan, N. P., et al. (2010). ""Alcohol is something that been with us like a common cold": Community perceptions of American Indian drinking." Substance Use and Misuse **45**(12): 1909-1929.

**TOTAL: 35**

Article linked to another study and presents no original data

1. Ward, L., et al. (2008). Cheers!? A project about older people and alcohol.

**TOTAL: 1**

Item inaccessible

1. Haarni, I. & Hautamäki, L. (2008): Ikääntyvät juomatavat. Elämänkokemus ja muuttuva suhde alkoholiin [Ageing drinking habits. Life experience and the changing relationship with alcohol]. Helsinki: Gaudeamus
2. Oinonen, S. (2008): Vanhuus, sukupuoli jasuomalainen alkoholikulttuuri. Tutkimusikäntyneiden alkoholinkäytöstä käydystä keskustelusta [Old age, gender and Finnish alcohol culture. A study of discussions about alcohol use among the elderly]. Unpublished Master's thesis in social work. Helsinki: University of Helsinki

**Reason****Items excluded on this basis**

3. Roos, F. and K. Hakola (2015). "Innanför hemmets väggar" en kvalitativ studie om bistandshandlaggares erfarenheter och uppfattningar kring äldre personer med problematiskt förhållande till alkohol. Hälsöögskolan i Jönköping.
4. Zanjani, F., et al. (2015). "Community campaign to prevent alcohol and medication interactions." The Gerontologist **55**(S2): 617.

**TOTAL: 4**

## Appendix G - Summaries of studies included within the systematic review

*Table Apx G-1 Extended descriptive summaries of studies included within the synthesis of studies reporting older adults' perspectives, with narrative summary of findings from quality appraisal.*

Article and country	Aims	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Abrahamson, 2009 (165) (a) Sweden and Finland Abrahamson et al, 2012 (166) (b), Sweden	a) To investigate how old people - who during their lives have experienced the displacement of drinking's moral border from soberness to moderate drinking - are presenting themselves, and their values, and attitudes towards alcohol b) To examine changes in women's relationship to alcohol during the 1960s	Call for participants by the Nordic Mudeuym SoRAD and the Wine and Spirits Historical Museum a) <i>n</i> = 32, Gender reported to be mostly female, age = 78-94, Drinking status = sober or moderate b) <i>n</i> = 25, Gender = 100% female, Age = 61-94 years, Drinking status = light or moderate.	Written responses to autobiographical questions, a) Qualitative thematic analysis b) Narrative construction and rhetoric motives	a) Sober repertoire (Childhood, teenage years and young adulthood; Social devotedness; sobrieties repertoire of the youth of today; experiences of alcohol problems); Moderation repertoire (Childhood and youth; Early adulthood; Adulthood and travelling; Social devotedness; The moderation repertoire of today's youth; Experiences of alcohol problems) b) Women in their 80s (Scene and co-agents; Scene and counter-agents; Choice of the protagonist; Alcohol as agency); Women in their 70s (Scene and co-agents; Scene and counter-agents; Choice of the protagonist; Alcohol as agency); Women in their 60s (Scene and co-agents; Scene and counter-agents; Choice of the protagonist; Alcohol as agency)	a) The aims were clearly detailed and consistent with the design and methods of the study. Some aspects of the design of the study lacked transparency in reporting. Limitations were not explored, nor were any biases of the research team and potential implications. No methods of triangulation were reported. A thick description of the findings was provided with reference to trends, contextual details and participant characteristics. b) Whilst some areas were reported in great detail (for example the methods of analysis), other areas lacked transparency. Details were not given for many areas of the methods of the study. No methods of triangulation were reported. No reflexive measures were described. The findings were to some extent thick in nature. Some contextual details were provided to support the points made, and trends were presented.
Aitken, 2015 (180), New Zealand	To understand the meanings of alcohol use for older people who use alcohol and to understand older people's reasons for drinking and identify the discourses they draw on to construct their alcohol use.	Recruited from the New Zealand Longitudinal Study of Ageing <i>n</i> = 18, Gender = 61% female, Age = 53-74 years, Drinking status = responsible and potentially hazardous drinkers, Participants described to have a range of chronic health conditions, all lived independently.	Semi-structured interviews, Discourse analysis	A 'social life' discourse (it's customary; social facilitation); A 'drinking to relax' discourse; The 'health issue' discourse (it's a medicine; older and wiser); A 'problem' discourse (young people and New Zealand binge drinking culture; being responsible)	Considerations for this study were to the most part detailed and justified. Reporting of the individual participant characteristics lacked detail. There was no direct reference to any efforts to triangulate or establish reliability of findings. Findings were well supported by data.

Article and country	Aims	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Billinger et al, 2012 (181), Sweden	To examine how older adults reason their relationship with alcohol and how they see the boundaries between what is acceptable and unacceptable drinking	Opportunistic and snowball sampling $n = 20$ , Gender = 55% male, Age = 61-70 years, Drinking status: not reported, Participants described to have a mixture of work statuses.	Focus groups, Hermeneutic interpretation analysis	How the participants described the role of alcohol in their childhood; How participants described their first experience with alcohol; The participants' definition of their current alcohol consumption; The boundary between acceptable and unacceptable alcohol use; Other people's means of dealing with alcohol	Reporting was generally explicit and justified, with only a few details missing surrounding the methods. The researcher does not explore the potential impact of their assumptions on reporting and does not report engaging in any method of reflexivity. Only one method of triangulation was presented. Limitations of the study design were considered. Quotes were provided, supporting a thick description of the findings, rich with contextual detail, characteristics and trends.
Bobrova et al 2010 (187), Russia	To investigate gender differences in drinking patterns and the reasons behind them among men and women in the Russian city of Novosibirsk	Convenience sample from the HAPIEE cohort $n = 44$ , Gender = 55% male, Age = 48-63 years, Drinking status = abstainers, occasional drinkers, frequent drinkers and heavy drinkers.	Semi-structured interviews, Framework approach and inductive and thematic analysis	Traditional drinking patterns; Individual drinking patterns; Perceived reasons behind the gender differences in drinking	Reporting lacked sufficient detail in many areas, such as methods of recruitment, data collection and data analysis. Findings were supported with some quotes.
Burruss et al 2014 (174), United States of America	To explore alcohol use among a subpopulation of older adults in congregate living, specifically a continuing care retirement community	Sub-sample of participants included in a daily alcohol diary study $n = 11$ , Gender = 55% female, Age = 68-90 years, Drinking status = regular drinkers, Participants all lived within a continuing care retirement community, described to have a mixture of marital status', all Caucasian.	In-depth interviews, Thematic analysis	Drinking as habit/routine; Peers as catalysts for increased consumption; Alcohol use and congregate living	Reporting of the study design and methods lacks explicit detail. Where detail was given, justifications for such details were not reported. The findings were well supported with quotes. The findings do appear to be positive in nature, however this was reasoned and discussed in reporting in the context of other studies.



Article and country	Aims	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Dare et al 2014 (182), Australia	To explore: 1) What role does alcohol play in older people's lives? 2) What factors facilitate or constrain alcohol use in different residential settings? 3) How does setting influence older people's alcohol use?	Purposive sample (target characteristics not detailed) from responses to local radio and newspaper advertisements $n = 44$ , Gender = 52% female, Age = 65-74 years, Drinking status = frequent drinkers, mostly low risk, Participants lived in either retirement villages (48%) or private residences (52%).	In-depth interviews, Thematic analysis	Research question 1) What role does alcohol play in older people's lives? (Alcohol and social engagement; Alcohol and relaxation; Alcohol, work and leisure); Research question 2) What factors facilitate or constrain alcohol use in these different settings? (Social engagement; Social norms; Self-imposed regulations; Driving); Research question 3: How does setting influence older people's alcohol use? (Convenient and regular access to social activities; Driving and setting)	Explicit detail and justification was inconsistent in the areas of methods and design. Reporting of the findings was rich, exploring how views and experiences differed in different contexts.
del Pino et al, 2013 (170), United States of America	To understand unhealthy alcohol use behaviours in socially disadvantaged, middle-aged and older Latino day labourers.	Recruited from a job centre through opportunistic and snowball sampling $n = 14$ , Gender = 100% male, Age = 50-64 years, Drinking status = occasional and frequent binge drinkers, Participants described to be day labourers from Mexico (living in the United States of America for at least 10 years) mostly living away from home, with less than high school level education, a family history of alcohol abuse and fair to poor self-rated health, reporting conditions that may be worsened by alcohol.	Semi-structured interviews, Grounded theory	Perceived consequences of unhealthy alcohol use on physical and mental health; The impact of unhealthy alcohol use on family relationships; The family as a key factor in efforts to change behaviour	Reporting of the aims and methods lacked explicit detail in places. Researcher bias was not explored, making it difficult to judge whether findings emerged from the experiences of the sample given the negative framing of alcohol use. Whilst contextual detail was given when reporting quotes from participants, no attempts were made to indicate trends for particular characteristic types. Quotes were provided, but were not always supportive of the points made.

Article and country	Aims	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Edgar et al, 2016 (171), United Kingdom	<p>To: 1. Investigate how the process of retiring and ageing shapes alcohol use and its role in the lives of retired people</p> <p>2. Explore the meaning and uses of alcohol in retirement</p> <p>3. Explore the lives of older people more broadly, including social networks, interests and family life</p> <p>4. Capture the intersections of gender, age and socio-economic status in shaping the experience of retirement and how it relates to alcohol use. This was achieved by including men and women, three specific age groups, and those from areas categorised as 'more deprived' and 'less deprived', according to the Scottish Index of Multiple Deprivation (SIMD).</p> <p>5. Consider service and policy implications flowing from an enhanced understanding of alcohol use in later years.</p>	<p>Purposive recruitment (for age range, gender and socio-economic deprivation) from general practices and community groups <math>n = 40</math>, Gender = 58% female, Age = 55-81 years, Drinking status = current or non-drinkers, participants resided in less deprived areas (48%) and more deprived areas (52%).</p>	<p>Semi-structured interviews, Thematic analysis</p>	<p>Routes into retirement; Drinking routines; "Keeping busy": work and leisure in retirement; Adapting to changing social networks; Processes offering protection: adapting drinking routines</p>	<p>Some areas of the design and methods lacked detail in reporting. This may be due to the nature of the article (a report with a specific purpose of communicating findings). Findings offered rich descriptions supported by contextual detail, presenting trends in the data.</p>

Article and country	Aims	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Gell et al, 2013 (172), United Kingdom	To explore: 1) What purpose(s) does drinking serve for older adults? 2) What kind of knowledge do older adults have of the relationship between health and alcohol consumption? 3) Why do older adults change (or maintain) their alcohol consumption over time? 4) What mechanisms lead to a change or maintenance of alcohol consumption behaviour in older adults after change in health?	Purposive (for change in alcohol intake) and snowball sampling from organisations registered on the 'Help Yourself' database $n = 19$ , Gender = 53% male, Age = 59-80 years, Drinking status = abstainers, low-level drinkers, mid-level drinkers or high-level drinkers, Participants all described as having chronic conditions, level of socio-economic deprivation varied.	Semi-structured interviews, Thematic and framework analysis	Current alcohol consumption among interview participants (Routine social drinkers; routine private drinkers; spontaneous drinkers); Changes in alcohol consumption among interview participants (patterns of consumption over time); Psychological capability (Initiation and avoidance of knowledge; types of medical knowledge); Reflective motivation (Willingness to consider medical knowledge; existing belief systems and medical knowledge; personal experiences); Automatic motivation (Habitual drinking and emotion; associative learning); Physical opportunity (Legislation; finance; physical environment); Social opportunity (Changes in social activity; drinking as a social activity; spousal influence)	In almost all areas, reporting was explicit, transparent and well-reasoned. Findings were reported in rich detail. However, quotes at times seemed to be used out of their original context to support the points made.
Haarni and Hautamaki, 2010 (173), Finland	To analyse the relationship third-age people have with alcohol: how does long life experience affect drinking habits and what are those habits actually like in the everyday life of older adults?	Opportunistic and snowball sampling through a wine website and social, addiction and elderly services $n = 31$ , Gender = 52%, Age = 60-75 years, Drinking status = current or ex consumers of alcohol, All participants lived in cities, described to have a range of marital status', work status', level of education and living situation. Most experienced fairly good health and a reasonable income.	Biographical and semi-structured interviews, Content and biographical analysis	Different kinds of drinking career (Uncontrolled heavy use, mid-range use or special event use; controlled frequent use, reactive use or occasional slips); The ideal of moderation; Ageing, generation and period of time	Most details were reported giving some transparency. Limitations were not considered. Reporting was reflexive. The quotes provided do not always fully support the findings presented (this may be due to the focus of analytical methods on content analysis).

Article and country	Aims	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Johannessen et al, 2015 (185), Norway	To investigate older peoples' experiences with and reflections on the use and misuse of alcohol and psychotropic drugs among older people	Heads of local health services recruited patients $n = 16$ , Gender = 63% female, Age = 65-92 years, Drinking status = experience with drinking but no known history of misuse, 88% participants widowed.	Narrative interviews, Phenomenological-hermeneutic analysis	To be a part of a culture in change (to use and attitudes towards use; to trivialise use and risks of use; to disclaim responsibility for use and misuse); To explain use and misuse (to be afraid; to be lonely; to be informed)	The methods of the study were mostly explicitly stated, with justification provided. The methods fitted with the research question. Some limitations of the study were presented. The researcher team do not explore their biases and assumptions and any potential impact in reporting. Multiple methods of triangulation were employed. Whilst some details of the sample were provided, these were not discussed in the context of reporting the findings and no trends were presented. The findings presented were thin in terms of descriptive detail.
Joseph, 2012 (175), Canada	To examine the alcohol-infused leisure practices of a group of older Afro-Caribbean men in Canada and the ways alcohol consumption at cricket grounds plays an integral role in the reproduction of club members' gender as well as their homeland cultures, age, class and national identities	All members of a local cricket and social club were involved $n$ : not reported due to study design, Gender = 100% male, Age = 44-74 years, Drinking status = leisurely drinkers, All participants were Caribbean-Canadians who migrated in the 1960s-1970s. Participants described to have a mixed work history/ status.	Observations and interviews, Inductive analysis	Drunkness as a mask of physical degeneration; Drunkness as temporal escape from femininity and family; Alcohol brands as class and (trans)nationality markers	Contextual detail and descriptions of recruitment, data collection and analysis were transparent. Justifications were provided for many key details of the study design. Limitations of the study design were not explored thoroughly, and few considerations were presented. The findings presented were rich in contextual detail.

Article and country	Aims	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Kim, 2009 (176), Canada	To explore the drinking behaviour of elderly Korean immigrants	Convenience sample referred by Korean senior centre workers, personal connections and snowball sampling $n = 19$ , Gender = 74% male, Age = 62-83 years, Drinking status = mostly (63%) drank more than once a week, All participants were Korean immigrants living in Canada, mostly married (72%), most reported to be catholic (58%).	Semi-structured focus groups, Thematic analysis	Reasons for drinking among men versus women; Health and alcohol; Signs of problem drinking; drinking in immigrant life; Reasons for a change in drinking behaviour; Religion	The reporting of this study was explicit in many areas and provided justification for the decisions of the design. Descriptions of the individual involvement of the researchers in the study and any reflections on personal biases and assumptions were not provided. The reporting of the findings was rich in nature and there was explicit effort made to explore trends in the data based on contextual details of the speakers.
Reczek et al, 2016 (186), United States of America	To provide insight into the processes that underlie the alcohol trajectories of mid- to later-life men's and women's heavy alcohol use identified in the quantitative results	Couples were recruited through convenience sampling $n = 88$ , Gender = 50% male, Age = 40-89 years, Drinking status = self-reported heavy alcohol users, All participants were either in a long-term marriage or had completed at least one marital transition such as remarriage.	In-depth interviews, Inductive analysis	The gendered context of (re)marriage (convergence; social control); The gendered context of divorce (divergence and stress among women; divergence, social control, and stress among men)	Details of the research design were mostly described explicitly, and some justification was provided. Details of how the sample was selected were not given and justification was not provided for its final size and composition. It was not clear whether any methods of triangulation were employed as part of the analysis. The possible implications of any biases of the research team were also not explored in reporting. Rich contextual detail was provided and trends were presented in describing the findings - therefore a thick account was reported.

Article and country	Aims	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Sharp, 2011 (177), United States of America	To understand the communication between community-based older adults and their physicians regarding their alcohol use	Convenience and snowball sampling within a retirement community $n = 11$ , Gender = 55% female, Age = 79 years (mean), Drinking status = frequent drinkers, Participants described to be mostly Caucasian (91%), at least high school level education and varied marital status (82% married, 18% widowed).	Semi-structured interviews, Interpretive phenomenological analysis	Factors that hinder alcohol conversations (lack of alcohol problems; alcohol not main focus during appointment; physician disinterest; office form dissuades conversation; past experience with alcohol); Characteristics that promote positive patient-doctor relationships (perception of adequate time; humour; knowledgeable; longevity; age of physician; physician-initiated preference)	Reporting and justification within this article were explicit for most elements of the study design and methods. Multiple measures were taken to ensure reliability and validity. Researcher biases in data collection and analysis as well as reporting were also described. It was unclear whether the sample was appropriate for the purpose of the study as most participants had not previously discussed alcohol use with their physician. Whilst contextual details were provided to describe the sample and also in reporting of the findings, contextual details were not provided to support excerpts or present trends. A thin description of the data was presented.
Stanojevic-Jerkovic et al, 2011 (188), Slovenia	To describe drinking patterns in the elderly, to identify the most common risk factors and protective factors for hazardous or harmful drinking, older people's empowerment for resisting social pressure to drink and their knowledge about low risk drinking limits	Staff working in two elderly care homes organized four focus groups with residents $n = 20$ , Gender = 65% female, Age = 63-89 years, Drinking status = current drinkers, abstainers or occasional drinkers.	Focus groups, Thematic analysis	Factors that stimulate drinking; factors hindering drinking; Factors that for some people encourage drinking, for others hinder it; Behaviour in a drinking company; Seeking for help; Familiarity with the recommendations for low-risk drinking; Further findings	The methods of this study were reported explicitly with the exception of details about sample selection. One method of triangulation was used. Researchers do not report exploring the potential implications of their own biases and assumptions. Biases in the design of the study were discussed. The findings presented were thick in nature - contextual details and characteristics were presented alongside some trends

Article and country	Aims	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Tolvanen, 1998 (189), Finland	To examine the ways in which older people in Finland talk about their use of alcohol. It also aims to shed light on the meaning of alcohol use in the context of social ageing	Random sample from participants of the European Longitudinal Study on Ageing (ELSA) <i>n</i> = 40, Gender: not reported, Age = 60-89 years, Drinking status: not reported.	Structured interviews, Discourse and conversation analysis	Alcohol use as discussed by older people (no; no longer; yes when; yes but no, no but yes); Who is the 'one' who drinks? (I drink – or do I?; We do and I do – couples and others; others in a gendered world)	This study gives little explicit detail or justification for many areas of the design and execution of this study. This deficiency in reporting may be due to the age of the paper. Whilst the suitability of the type of data for qualitative analysis was questionable, some justification was presented in reporting. No methods of triangulation were stated. A rich description of the findings was given and contextual trends were presented.
Tolvanen and Jylha, 2005 (183), Finland	To explore how alcohol use was constructed in life story interviews with people aged 90 or over	Relevant material from 254 life story interviews from the Vitality 90+ project <i>n</i> = 181, Gender = 66% female, Age = 90+ years, Drinking status = abstainers and current drinkers, Most participants were described to live independently.	Semi-structured/life story interviews, Discourse analysis	I and others: the use of alcohol as a moral issue; Men's and women's drinking; Alcohol as a man's destiny and a threat to the happiness of homes; Alcohol use as part of social interaction; Alcohol use as a health issue	Explicit detail and justification was provided for some areas (aims and methods of analysis) more than others (for example recruitment, data collection and participant characteristics). Whilst the stance of the researchers was initially stated in reporting, the potential effects of any biases and assumptions upon the findings presented were not discussed. Limitations of the study design were not explored. Whilst some trends were presented in reporting based on participant characteristics, reporting of other contextual information was limited making it difficult to gauge the generalisability of the findings.

Article and country	Aims	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Vaz De Almeida et al, 2005, (184), Europe (Denmark, Germany, Italy, Poland, Portugal, Spain, Sweden and the United Kingdom)	To explore social and cultural aspects of alcohol consumption in a sample of older people living in their own homes, in eight different European countries	Relevant material within interviews for the European 'Food in Later Life' study n=644, Gender = 50% female, Age = 65-74 years, Drinking status = non-dependent. Participants lived in their own homes.	Semi-structured interviews, Grounded theory	Alcohol consumption narratives of older people (Reasons for not drinking alcohol; Alcohol consumption as an aid to health); Gender differences in the narratives (Similarities between genders; Most marked differences); Specific cultural differences between the eight countries	The aims and methods were generally reported in detail. Whilst reflections were provided within the discussion, these were with reference to the study design rather than the influence of the research team upon results. No methods of triangulation were described. The reported methods of analysis appeared incompatible with the data collected. Quotes were inconsistently provided to support some of the points made, and those presented lacked depth. Trends were presented within the findings, however the overarching themes were descriptive in nature and structured around these trends.



Article and country	Aims	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Ward et al, 2011 (178), England	To generate a wider evidence base by exploring the circumstances in which older people drink, the meaning that drinking alcohol has for them and its impact, acknowledging that this can be a pleasurable and positive experience, as well as something that can have adverse health, financial, personal and interpersonal impacts	Convenience sampling through response to flyer distribution through the steering group's network, sheltered housing, day centres, community projects, residents' newsletters and the Age Concern database $n = 21$ , Gender: not reported, Age = mid 50s to late 80s (years), Drinking status = regular drinkers who may or may not have a problem with their level of alcohol consumption, Participants reported to have varied living situations and varied marital status, were mostly Caucasian and all heterosexual.	Semi-structured interviews and focus groups, Thematic analysis	Drinking practices and styles (Social-regular; Social-occasional; Heavy lone drinking; Heavy drinking in a drinking network); What affects drinking styles (Social relationships; Loss, change and adaptation; cost and availability; health, wellbeing and growing older; responsibility, control and independence); Seeking help	Elements of the design and analysis were not described explicitly or justified. Limitations and biases in the study were also insufficiently explored in reporting. The data presented was rich in contextual detail, and some trends were presented based on participant characteristics.
Watling and Armstrong, 2015 (179), Australia and Sweden	To identify attitudes that might influence drink driving tendency among this group of women and further show how these attitudes vary across countries	Convenience and snowball sampling $n = 30$ , Gender = 100% female, Age = 52 years (mean), Drinking status = low-risk or risky drinkers, Participants were either Australian (50%) or Swedish (50%) with varied marital status.	Semi-structured interviews, Thematic analysis	Findings were not organised under theme headings	Most details of the design and methods were reported explicitly. Multiple methods of triangulation were reported, and member checking was employed which represents a particular strength. Whilst limitations with the study design were discussed, possible implications of the biases and assumption of the researcher upon the findings were not explored in reporting. Additionally, whilst quotes were provided to support the points made, the provision of contextual data was inconsistent. The reporting of the findings therefore was not rich in nature.

Article and country	Aims	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Wilson et al, 2013 (169) (a), Haighton et al, 2016 (168) (b), Haighton et al, 2018 (167) (c), United Kingdom	a) To elucidate the views of older individuals aged over 50 years about alcohol consumption, health and well-being, to inform future targeted prevention in this group b) To gain an in-depth understanding of experiences of, and attitudes towards, support for alcohol related health issues in people aged 50 and over c) Explored concurrent alcohol and medication use, as well as the use of alcohol for medicinal purposes, in a sample of individuals in mid to later life	Purposive (for gender, age and self-reported drinking) and snowball sampling through Age UK and alcohol services $n = 51$ , Gender = 65% female, Age = 51-95, Drinking status = abstainers, occasional drinkers, moderate drinkers, heavy drinkers, recovering dependent drinkers and dependent drinkers.	In-depth interviews and semi-structured focus groups, Grounded theory and discursive analysis	a) Alcohol identities (individual interviews; focus groups); Health and changing drinking behaviour (individual interviews; focus groups); gendered patterns of drinking b) Drinking in mid to later life; Deciding to change; Experiences of primary care; Experience of detoxification and rehabilitation; Experience of counselling and therapy c) Drinking and using medication regardless of consequences; Health professionals being unaware of alcohol use; Reducing or stopping alcohol consumption because of medication; using alcohol to self-medicate; Differences related to gender and age	a) For the most part, reporting was explicitly detailed and justified. The design of the study and analysis were clearly described. Multiple methods of triangulation were employed. Personal biases and reflexivity were not explored in reporting. Limitations to the study design were discussed. Quotes were provided at every opportunity with rich contextual detail. Trends were presented based on the characteristics of the participants. The findings were therefore thick in nature. b) Explicit detail was provided for most of the study methods and design, although most decisions and details were not reasoned in reporting. The reporting of analysis provided a thick description grounded in contextual detail, describing trends where possible. Reflexivity was not discussed. c) Many details were reported explicitly but justification was not provided in reporting. Some areas such as reflexivity lacked any description in reporting. The data itself was presented with a thick description, with contextual details supplied to help the reader understand the grounding of the findings.

Table Apx G-2 Extended descriptive summaries of studies included within the synthesis of studies reporting care providers' perspectives, with narrative summary of findings from quality appraisal.

Study and country	Aims	Level of alcohol use discussed	Age group discussed	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Andersson & Bommelin, 2013 (203), Sweden	To examine domiciliary care managers' understanding of older people's hazardous use of alcohol, in the context of aid assessment	Hazardous use of alcohol, alcohol abuse and alcohol dependence	65 years+	Elderly care managers strategically selected from four different Swedish municipalities, n = 5, occupation = domiciliary care managers, years in practice, age, gender and ethnicity not reported	Semi-structured interviews, analytical systematic text condensation	Perilous use or misuse; Neglected social needs; Assistance based on the elders' own request or initiative	Details surrounding study aims, data collection and analysis are generally presented explicitly with justification provided. Biases and limitations within the study design and as researchers are presented. However, the sample size is smaller than in other included studies. This is explained, but is not discussed with reference to data saturation or sufficiency. Two authors worked collaboratively to collect and analyse the data, however no other methods of triangulation are reported. The authors are reflexive within reporting. In presenting the findings, a small number of quotes are provided to support some of the points made. The findings themselves were on the most part descriptive in nature and reflect the topic guide, although some deeper analysis is provided through relation to relevant theoretical frameworks. No trends are presented and few details are given surrounding the context of this study or the participants. Therefore the description provided is thin in nature.
Andersson & Johansson, 2013 (201), Sweden	To describe how municipal elderly care providers perceive, manage and treat older people with alcohol use and abuse	Alcohol use and abuse	65 years+	Elderly residential and domiciliary care providers contacted through centre managers for domiciliary care services in Southern Sweden, n = 6, occupation = elderly residential care providers (n = 3) and domiciliary care providers (n = 3), years in practice, age, gender and ethnicity not reported	Semi-structured interviews, thematic analysis	Alcohol policy; An individual's own choice; Medicine and alcohol; The staff's view of the importance of alcohol to the elderly; The care recipients' background; Relatives and over reporting; The future	Described methods appeared to be consistent with the aims of the study. However, some details of the methods for the study were lacking. The reported sample size also seemed to be lower than comparable studies. No methods of triangulation or reflexivity were reported, and whilst biases of the research team were consequently unexplored, biases in the study design were discussed. The method of data analysis was not presented in enough detail to give transparency to the process. This was a particular flaw considering findings from pre-existing literature appeared to have contributed towards presented themes. It is consequently unclear to what extent the study findings were grounded within participants' experiences. Quotes were provided to support the findings presented and reporting of the findings was rich with deep contextual detail.

Study and country	Aims	Level of alcohol use discussed	Age group discussed	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Broyles et al, 2012 (199), United States of America	To identify the potential barriers and facilitators associated with nurse-delivered alcohol screening, brief intervention and referral to treatment for hospitalised patients	Unhealthy alcohol use, from risky drinking to alcohol use disorders	65 years+	Nurses recruited through email and information sessions held on the units, <i>n</i> = 33, occupation = medical-surgical nurses, years in practice not reported, age = 18-70 years (mostly <50 years), gender = 97% female, ethnicity = 83% white	Semi-structured focus groups, constant comparison	Anticipated barriers (nurses' lack of alcohol-related knowledge and skills; limited interdisciplinary collaboration and communication around alcohol-related care; inadequate alcohol assessment protocols and poor integration with the electronic medical record (EMR); concerns about negative patient reaction and limited patient motivation to address alcohol use; questionable compatibility of alcohol screening, BI and RT with the acute care paradigm and nursing role; logistical issues (e.g. lack of time/privacy)); Suggested facilitators (improved provider knowledge, skills, communication, and collaboration; expanded processes of care and nursing roles; enhanced EMR features)	The reporting of the design and methods for this study is extensive in most areas, with justification provided for many of the decisions made. The authors were transparent about their assumptions and limitations of the study, however researcher biases are not discussed. Multiple methods of triangulation are reported. Both positive and negative findings are presented. Whilst some details of participant characteristics are presented and some trends are reported, additional detail of the individual participants and context would have provided greater insight.

Study and country	Aims	Level of alcohol use discussed	Age group discussed	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Claiborne et al, 2010 (193), United States of America	To identify the primary care practice patterns relevant to patients' alcohol problems, and the barriers and incentives for use of particular Veteran's acute care guidelines for screening and referral for evaluation and treatment of these problems	Any level of alcohol use	Veterans, 90% of which were over the age of 50 years (mean = 68 years)	Primary care team members selected from six primary care clinics, <i>n</i> = 31, occupation = medical physicians/ medical nurse practitioners ( <i>n</i> = 9), registered nurses or nurse practitioners ( <i>n</i> = 11), behavioural health providers ( <i>n</i> = 8), administrative support staff ( <i>n</i> = 3), mean years in practice = 12 (range 1-36 years), age, gender and ethnicity not reported	Structured one-to-one interviews, constant comparison	AUDIT-C screening process; Identifying alcohol problems; Referral for further evaluation and treatment; Follow-up with patients; Perception of behavioural health provider	The aims, design and methods of the study are generally described in detail. Some details of these areas are not reported. Whilst the authors explore biases in the study design, the biases of the research team are not considered and there is no mention of any method of reflexivity. Further, no methods of triangulation are reported. Whilst some contextual detail is supplied, very few quotes (one) are provided to support the presented themes and the findings are quantified in places. The findings presented were consequently thin in nature.

Study and country	Aims	Level of alcohol use discussed	Age group discussed	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Darwish & Fyrpihl, 2015 (195), Sweden	To investigate how care workers for the elderly handle and interpret alcohol problems in elderly people. Examines how care workers define an alcohol problem, the ethical dilemmas in caring for elderly people with drinking problems, and strategies, conditions and policies that cater for the need for support for elderly people with alcohol problems	Alcohol abuse	Elderly (specific age range not stated)	Care workers contacted in settings where there is a problem with alcohol abuse among service users, snowball sampling to seek further participants, <i>n</i> = 9, occupation = care manager ( <i>n</i> = 3), nurse ( <i>n</i> = 1), auxiliary nurse ( <i>n</i> = 4), years in practice, age, gender and ethnicity not reported	Semi-structured interviews (and one ad-hoc triad), thematic analysis	The interpretation of an alcohol problem; The ethical dilemma; Flaws within the field; Strategies and policies	Most elements of the study design and methods were reported explicitly, with justification provided. However, the justification provided for the sample size is inadequate given it is smaller than that of other included studies employing similar methods of analysis. One method of triangulation is reported. Biases within the study design are reported, but biases with regards to the researchers are not explored. Quotes are provided, but not always intuitively supportive of the points made. Findings generally appear to be grounded in the views of participants, however some seem to be imposed by the theoretical framework with little support provided from the perspective of the participants. The authors' value judgements are also presented within the findings. Due to the lack of description surrounding the sample and limited trends presented, the findings presented are not especially thick in detail.

Study and country	Aims	Level of alcohol use discussed	Age group discussed	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Gunnarsson, 2010 (197), Sweden	To conduct an exploratory study of the perspectives of home help workers working with the elderly with substance abuse problems	Alcohol abuse	Elderly (refers to 65 years+)	Recruitment not described in reporting, <i>n</i> = 11, occupation = home help staff (4 nurses/nursing assistants specialising in substance abuse or mental health, 3 nurses or nursing assistants specialising in elderly care, 1 head of elderly care service, 2 aid workers working with older homeless people, 1 elderly care worker), years in practice, age, gender and ethnicity not reported	One-to-one interviews, thematic analysis	Assessment of needs and substance abuse (Elderly care versus treatment for substance abuse; Who are the users/clients?; About the assessment of needs [the customer's choice; relatives]; cooperation); The domiciliary carer's every day (Building a relationship – continuity; Competence – education; The question of alcohol [To purchase, or not purchase alcohol; Strategies of rationing; Age taking its toll; Different care recipients]; We fend for ourselves – cooperation)	Reporting of the methods for this study were predominantly clear. Details of recruitment and analysis lacked transparency. The methods described do however appear to be compatible with the stated aims. No methods of reflexivity or triangulation were reported. Details of ethical considerations or approval are also lacking. Biases in the study design or the stance of the research team are not explored. However, quotes are provided to support the findings presented, and rich contextual detail is given.
Gunnarsson & Karlsson, 2013 (196), Sweden	To explore domiciliary care assistants' perceptions of drinking in later life (not explicitly reported)	Not reported	65 years+	Domiciliary care staff recruited from units in different areas, <i>n</i> = 34, occupation = domiciliary care manager ( <i>n</i> = 18), domiciliary care nurses and auxiliary nurses ( <i>n</i> = 15), nursing assistant ( <i>n</i> = 1), years in practice not reported, age = 20-60 years, gender = 82%	Focus groups and one interview, thematic analysis	The care takers' opinion of the work with elderly and alcohol problems: How the care takers act (the task as a care planner (assessor); who calls the alarm; reasonable standard of living and purchasing alcohol; self-determination as a challenge); Care planners' view of elderly and alcohol (women have a reason for their consumption, men consume anyway; having, or lacking resources; to hide, be ashamed or	Reporting of the aims and methods for this study lacked explicit detail and justification in places. However, the method of analysis is presented transparently. No methods of triangulation or reflexivity were reported and the limitations of the study design were not discussed. However, the findings were presented in rich contextual detail with quotes provided in support.

Study and country	Aims	Level of alcohol use discussed	Age group discussed	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
				female, ethnicity not reported		admitting to their addiction; knocked out in the older days; cultural background – “that depends”; the gradual bodily breakdown and consequent social isolation). The care staffs’ talking about their work with the elderly with alcohol problems (not a pretty picture; the amount of garbage indicates misuse; older people’s problematic drinking as a specific type of work burden; who is responsible?)	
Herring & Thom, a) 1997 (191); b) 1998 (192) United Kingdom (England)	a) To explore policy and practice regarding the purchase of alcohol for older clients of domiciliary carers in three local authorities in the Greater London area b) To assess the current and potential role of domiciliary carers in the identification and response to problems associated with alcohol use and misuse in older people	a) not reported b) alcohol use and misuse	Older adults (age range not stated)	Findings drawn from a larger study of domiciliary carers working in three local authorities in London, n = not reported, occupation = domiciliary carers and their managers, years in practice, age, gender and ethnicity not reported	Semi-structured interviews (with domiciliary care managers), focus groups (with domiciliary carers), and written responses to postal questionnaire s (domiciliary carers), a) qualitative analysis b) grounded theory approach	a) Netherfield; Longbourn; Pemberley b) Alcohol policy; Domiciliary carers’ perceptions of alcohol misuse; Domiciliary carers’ ideas about why older people may misuse alcohol (loss; loneliness; depression); Spotting alcohol misuse: what do domiciliary carers think are the signs? (the physical effects of drinking; self-neglect; behaviour; evidence of drinking); Response to alcohol misuse; ‘Like a daughter’; The relationship between domiciliary carers and their clients	a) There is little detail provided in the reporting of the methods of this study. From the little detail given, however, the methods do appear to be consistent with the research question. Little detail is provided on the sample (however further detail may be provided in an associated study which was inaccessible), making it difficult to gauge the generalisability of the findings. Some contextual details are presented in reporting trends in the findings. b) The aims of the study are clear and some elements of the methodology were described. However, the methodological process was not made transparent by reporting and many details are missing. No methods of triangulation were reported and methods of reflexivity were not discussed. Biases of the research team and the study design were not presented or discussed in the context of possible implications for the findings presented. Quotes were provided to support the themes. However, whilst some contextual details were supplied, these were not provided in the context of presenting the findings and no trends were presented in the analysis.



Study and country	Aims	Level of alcohol use discussed	Age group discussed	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Johannessen et al, 2015 (205), Norway	To investigate health personnel's perceptions and experiences of alcohol and psychotropic drug use among older people (65 years and above) and to what extent this is an issue when services are planned for and implemented	Use and misuse of alcohol	65 years+	Participants were selected purposively to form a heterogeneous group from a pool of individuals identified by leads of 14 municipalities in southern Norway, <i>n</i> = 16, occupation = district nurse ( <i>n</i> = 13), occupational therapist ( <i>n</i> = 2), physiotherapist ( <i>n</i> = 1), years in practice = 1-34, age = 34-62 years, gender = 75% female, ethnicity not reported	Semi-structured interviews, qualitative content analysis	State of practice (legitimacy and attention to substance use and misuse; competence and knowledge in practice); A desire to improve services (improving collaboration; changing routines)	Most elements of the methods of this study are reported clearly, with justification provided in places. Weaknesses of this study include the fact that only one method of triangulation was used and that researchers did not reflect on their own biases in reporting. Biases and limitations of the study were discussed. Some contextual details and characteristics were supplied, but these are not presented alongside reporting of the findings. Few quotes provided to support the authors' narrative.
Johannessen et al, 2015 (206), Norway	To investigate general practitioners' experiences and reflections on use and misuse of alcohol and psychotropic drugs among older people, and to what extent this is an issue for treatment	Use and misuse of alcohol	65 years+	Recruited the first 11 general practitioners responding to the study having been contacted by the head of one of eight municipalities in southern or western Norway, <i>n</i> = 11, occupation = general practitioner, years in practice = 0-35, age = 29-65 years (mean = 48 years), gender	One-to-one interviews, phenomenological-hermeneutical method	The GP's opinion of older people's alcohol and psychotropic use (older people's situation; older people's alcohol use; older people's psychotropic drug use); The GP's practice (Assessment of alcohol use; prescription of psychotropic drugs)	The reporting of the methods of this study was generally transparent, with justification often provided. Multiple methods of triangulation were applied. The researchers did not reflect upon their biases and assumptions and there was no mention of any reflexive methods. Some details of the characteristics and setting were provided, however these were not presented in the context of the findings and no trends were indicated. Few quotes were provided to support the author's narrative.

Study and country	Aims	Level of alcohol use discussed	Age group discussed	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
				and ethnicity not reported			
Millard & McAuley, 2008 (202), United Kingdom (Scotland)	To explore: 1) how clients' alcohol problems were identified 2) was it the domiciliary care providers' work role to raise a possible alcohol problem with a client 3) whether domiciliary care providers had sought help for a client with alcohol problems, and if there were any barriers 4) were there any gaps in services for older people with alcohol problems, and if so, how might they be filled?	Not reported	65 years+	Recruited from a local social work department, <i>n</i> = 90, occupation = domiciliary care staff and domiciliary care managers, years of practice, age, gender and ethnicity not reported	Focus groups, method of analysis not reported	None – overview: Trusting relationship between domiciliary care workers and clients; domiciliary care workers' perceptions regarding the clients' alcohol consumption; barriers to involvement in day care or residential settings secondary to the clients' alcohol usage; the impact of Scottish culture	The aims of the study were clear. No elements of the methodology for the study were adequately described and very few elements were given any mention. No methods of triangulation or reflexivity are supplied and biases are not explored in either the research design or the research teams' own personal biases. Very few details of the setting or sample were provided and no trends were presented, very few quotes were provided to support the findings presented and the findings were not presented in depth. Consequently, the description provided was very thin in nature.

Study and country	Aims	Level of alcohol use discussed	Age group discussed	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Serbic & Sundbring, 2015 (198), Sweden	To investigate how residents' alcohol consumption is treated and handled by nursing staff	Alcohol use	Not reported (refers to age 60 years+ and age 65 years+)	Participants recruited by heads of units in Jonkoping County, n = 6, occupation = trained nurse working in elderly care (n = 5), elderly care worker (n = 1), years of practice, age, gender and ethnicity not reported, gender = 100% female	Semi-structured interviews, thematic analysis	A picture of consumption; Self-determination and quality of life; Cumbersome situations; Different experiences	The aims of the study were clearly stated and the methods described were compatible. Justification for the sample size and composition was not discussed in reporting. Whilst the authors explored their assumptions and theoretical background, reflexive considerations were not reported. No methods of triangulation were reported. Biases in the study design were explored. Quotes were provided to support presented findings, and contextual detail was provided to give background and present trends.
Severin & Keller, 2016 (204), Sweden	To explore the domiciliary care staffs' experiences of working with older patients who have alcohol problems	Problematic alcohol use	65 years+	Potential participants were contacted within two units through the head of the unit and through presentations and invitation letters from the research team, n = 6, occupation = domiciliary care nursing assistants, years of practice = 2-26, age = 32-46 years, gender = 100% female, ethnicity not reported	Semi-structured interviews, inductive thematic analysis	Self-determination as an obstacle – dilemmas at work (to meet their needs; Purchasing and control of alcohol; medicine and alcohol); Adaptation and flexibility as a means of management strategy; Support that is lacking in the work – support in the current situation (Time for reflection; increased knowledge within the field)	The aims and methods were reported transparently but lacked explicit detail or justification in places. However, no methods of triangulation or reflexivity were reported. The research team did explore their own biases and biases in the design of the study during reporting. Whilst quotes were provided, these were not always fully supportive of the points made. However, contextual detail is provided to give a thick description findings.

Study and country	Aims	Level of alcohol use discussed	Age group discussed	Sample description and recruitment	Data collection methods and analysis	Author-identified themes	Summary of quality appraisal
Shaw & Palattiyil, 2008 (200), United Kingdom (Scotland)	To explore social work practitioners' awareness of alcohol misuse in older people, and their attitudes towards the current support services.	Alcohol misuse	65 years+	Participants were recruited from the Older People's Team, <i>n</i> = 18, occupation = social work practitioners, mean years of practice = 5 (within the Older People's Team), age = 31-54 years, gender = 78% female, ethnicity not reported	Semi-structured interviews, thematic analysis	Extent of the problem; Difficulties identifying the problem; Reasons for alcohol problems among older people; Unmet need among older people with alcohol problems; More effective service provision	Whilst the aims of the study were clear, reporting of the design and methods of the study lacked transparency. Details presented suggested study aims and methods were compatible. Biases of the research team and the design of the study were not explored in reporting. No methods of triangulation were presented, and there was no mention of any methods of reflexivity reported. The quotes provided supported presented findings. Some contextual detail and participant information was provided, however this was not presented in the context of presenting the findings and no trends are identified in reporting. The description offered therefore seems to be thin in nature.

## Appendix H - Evidence of NHS Ethical Approval



**Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval**

01 November 2016

Miss Bethany K Bareham  
PhD researcher  
Newcastle University Institute for Health and Society  
Institute of Health and Society / Newcastle University Institute for Ageing  
Biomedical Research Building (Second floor)  
Campus for Ageing and Vitality  
NE4 5PL

Dear Miss Bareham

<b>Study title:</b>	<b>Exploring older adults' and health and social care workers' perceptions of the positive and negative consequences for alcohol consumption in old age</b>
<b>REC reference:</b>	<b>16/EM/0435</b>
<b>Protocol number:</b>	<b>BH153679</b>
<b>IRAS project ID:</b>	<b>209426</b>

Thank you for your letter of 31/10/2016 responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Assistant Teagan Allen, [NRESCcommittee.EastMidlands-Nottingham1@nhs.net](mailto:NRESCcommittee.EastMidlands-Nottingham1@nhs.net)

Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

#### **Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

#### **Conditions of the favourable opinion**

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).*

*Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, [www.hra.nhs.uk](http://www.hra.nhs.uk) or at <http://www.rdforum.nhs.uk>.*

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of management permissions from host organisations.*

#### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net). The expectation is that all clinical trials will

be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

#### Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" above).

#### Approved documents

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Copies of advertisement materials for research participants [65+ flyer]	1	22 September 2016
Covering letter on headed paper [Cover letter]	1	22 September 2016
Covering letter on headed paper [Cover letter]	1.1	31 October 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance letter]	1	22 September 2016
GP/consultant information sheets or letters [65+ GP letter]	1	22 September 2016
Interview schedules or topic guides for participants [65+ interview topic guide]	1	22 September 2016
Interview schedules or topic guides for participants [65+ focus group topic guide]	1	22 September 2016
Interview schedules or topic guides for participants [HS+C worker interview topic guide]	1	22 September 2016
Interview schedules or topic guides for participants [HS+C worker focus group topic guide]	1	22 September 2016
IRAS Application Form [IRAS_Form_30092016]		30 September 2016
Letter from funder [Funding letter]	1	22 September 2016
Letter from sponsor [Sponsorship letter]	1	22 September 2016
Letters of invitation to participant [65+ group member information invitation letter]	1	22 September 2016
Letters of invitation to participant [65+ patient information invitation letter]	1	22 September 2016
Letters of invitation to participant [65+ snowball information invitation letter]	1	22 September 2016
Letters of invitation to participant [65+ flyer response information invitation letter]	1	22 September 2016
Letters of invitation to participant [HS+C worker information invitation letter]	1	22 September 2016
Other [65+ expression of interest]	1	22 September 2016
Other [65+ potential participant characteristics]	1	22 September 2016
Other [Interviewer screening form]	1	22 September 2016
Other [65+ data collection sheet]	1	22 September 2016

Other [65+ timeline]	1	22 September 2016
Other [65+ debrief]	1	22 September 2016
Other [HS+C worker data collection sheet]	1	22 September 2016
Other [65+ AUDIT post-screening debrief]	1	17 October 2016
Participant consent form [HS+C worker interview consent form]	1	22 September 2016
Participant consent form [HS+C worker focus group consent form]	1	22 September 2016
Participant consent form [65+ focus group consent form]	1.1	31 October 2016
Participant consent form [65+ interview consent form]	1.1	31 October 2016
Participant information sheet (PIS) [HS+C worker interview information sheet]	1	22 September 2016
Participant information sheet (PIS) [HS+C worker focus group information sheet]	1	22 September 2016
Participant information sheet (PIS) [65+ interview information sheet]	1.1	17 October 2016
Participant information sheet (PIS) [65+ focus group information sheet]	1.1	17 October 2016
Research protocol or project proposal [Protocol]	1	22 September 2016
Summary CV for Chief Investigator (CI) [BB CV]	1	22 September 2016
Summary CV for student [BB CV]	1	22 September 2016
Summary CV for supervisor (student research) [BH CV]	1	22 September 2016
Summary CV for supervisor (student research) [EK CV]	1	22 September 2016
Summary, synopsis or diagram (flowchart) of protocol in non-technical language [Design diagram]	1	22 September 2016
Validated questionnaire [AUDIT]	1	22 September 2016

#### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

#### **After ethical review**

##### Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

##### Feedback




You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:  
<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance>

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

<b>16/EM/0435</b>	<b>Please quote this number on all correspondence</b>
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With the Committee's best wishes for the success of this project.

Yours sincerely



**Dr Carl Edwards**  
**Chair**

Email: [NRESCommittee.EastMidlands-Nottingham1@nhs.net](mailto:NRESCommittee.EastMidlands-Nottingham1@nhs.net)

Enclosures: *"After ethical review – guidance for researchers"*

Copy to: *Ms Lois Neal*

*Ms Sally Dunn, NECS Research & Development*

# Appendix I - Evidence of Newcastle University Ethical Approval

Ethics Form Completed for Project: Exploring perceptio... - Beth Bareham (PGR)

Page 1 of 1

Ethics Form Completed for Project: Exploring perceptions for the consequences of alcohol use in later life

Policy & Information Team, Newcastle University <noreply@limeservice.com>

Tue 01/11/2016 14:50

To: Beth Bareham (PGR) <b.k.bareham@newcastle.ac.uk>;

Ref: 9525/2016

Thank you for submitting the ethical approval form for the project 'Exploring perceptions for the consequences of alcohol use in later life' (Lead Investigator: Bethany Bareham). Expected to run from 01/11/2016 to 30/09/2018.

Your project already has ethical approval in place and your faculty representative has agreed to accept this approval in lieu of a new application. Based on this the University is satisfied that your project has met its ethical expectations and that no further review is required before you begin your research. Please be aware that if you make any significant changes to your project then you should complete this form again as further review may be required. If you have any queries please contact [res.policy@ncl.ac.uk](mailto:res.policy@ncl.ac.uk)

Best wishes

Policy & Information Team, Newcastle University Research Office

[res.policy@ncl.ac.uk](mailto:res.policy@ncl.ac.uk)

<https://outlook.office.com/owa/?viewmodel=ReadMessageItem&ItemID=AAMkADg...> 01/11/2016

## Appendix J - Evidence of Health Research Authority Approval

RE: IRAS 209426. Exploring perceptions for the consequences of alcohol use in later life. Outcome of Application for HRA Approval

**From:** APPROVAL, hra (HEALTH RESEARCH AUTHORITY) <[hra.approval@nhs.net](mailto:hra.approval@nhs.net)>  
**Sent:** 21 December 2016 10:49  
**To:** Beth Bareham (PGR); Lois Neal  
**Cc:** Eileen Kaner; Barbara Hanratty; DUNN, Sally (THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST)  
**Subject:** IRAS 209426. Exploring perceptions for the consequence of alcohol use in later life. Outcome of Application for HRA Approval

Dear Miss Bareham,

**RE: IRAS 209426. Exploring perceptions for the consequence of alcohol use in later life.  
Outcome of Application for HRA Approval**

Please find attached a letter informing you of the outcome of your application for HRA Approval.

Please read all attached documents with care.

You may now commence your study at those participating NHS organisations in England that have confirmed their capacity and capability to undertake their role in your study (where applicable). Detail on what form this confirmation should take, including when it may be assumed, is given in Appendix B of the HRA Approval letter.

If you have any queries please do not hesitate to contact me.

Kind regards

**Gemma Oakes**

**Assessor**

cid:image0

**Health Research Authority**

D18F4B.4<sup>01</sup>.jpg@01\_2

HRA, Ground Floor, Skipton House, 80 London Road, London, SE1

6LH C37540

E: [hra.approval@nhs.net](mailto:hra.approval@nhs.net) [www.hra.nhs.uk](http://www.hra.nhs.uk)

The HRA is keen to know your views on the service you received – our short feedback form is available [here](#)

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# Thinking about Drinking

## 65+ interview information sheet

I am inviting you to take part in a research study. This work forms part of my PhD at Newcastle University, funded by the National Institute for Health Research School for Primary Care Research.

My aim is to understand **how people aged 65+ weigh up the positive and negative effects of drinking alcohol, and how this influences their behaviours.**

Before you decide whether to take part in this study, it is important for you to understand why the research is being done and what your participation in the study will involve. Please take time to read the following information carefully:

### **What is the project about?**

There is a lot of evidence to suggest that drinking alcohol can be both a good and a bad thing for people to do. The evidence for effects on health is especially relevant to people aged over 65, but they may also benefit most from the social side of drinking. In this study, I want to learn more about what people aged over 65 think are the pros and cons of their drinking, and what is important to them, when they make decisions about their drinking?

I would like to speak to anybody aged over 65 who consumes alcohol (or who has consumed alcohol in the past). This study does not focus on people with severe problems linked to drinking alcohol. Unfortunately, this means that I will not be able to include anybody who has sought help for alcohol problems in the past.

### **What am I being asked to do?**

You have expressed that you would like to take part in an interview about how you think about drinking. This will be conducted by the lead researcher, Bethany Bareham. Bethany has arranged a time and place to meet with you and conduct this interview. The interview should last approximately an hour and a half.

Before you take part in the interview, I will ask you to complete a screening questionnaire. This will ask you some questions about how you drink. The information you give will give us some background to consider when we analyse your data from the interview. It will also help me make sure that you are not a dependent drinker. Dependent drinkers think about alcohol differently to others, so unfortunately I will not be able to include dependent drinkers in this study.

During the interview, I will ask you questions about your views of the effects of alcohol. I will ask you how you consider these effects and which you choose to prioritise in your drinking. I will also ask you about times in your life where your alcohol consumption may have changed. I will additionally ask you whether you have ever been asked to talk about your drinking before.

You will receive a £10 Love2shop voucher to say thank you for participating in this study. Please be assured that your participation is entirely voluntary. You can choose to end your participation at any point, even during your interview. Information we have already collected with your consent will be retained and used in the study. Normal care as a patient will not be affected by withdrawal from this study.

### **What happens to the data?**

The discussion will be recorded so that I have an accurate account of your views. The recording will then be put into writing by a member of the study team. The interview will then be analysed alongside other data and focus groups to identify themes that relate to how people over the age of 65 consider and prioritise the positive and negative effects of drinking alcohol. These findings will be written up to contribute to a thesis to be submitted for my PhD. The findings will also be reported for submission to a scientific journal, which may be read by other researchers, health and social care workers and policy makers. Quotes from interviews and focus groups will be used in reporting to support the findings presented. Participant names will be changed so that readers cannot identify the individuals contributing the quotes.

### **Will I be identified?**

No other individuals will have access to the recording of this interview. As soon as the recording has been put into writing by a member of the study team, we will change your name so that you cannot be identified. The recording will then be destroyed. Anything you say will be kept confidential, unless it suggests that someone is at risk of harm.

### **What are the possible disadvantages of taking part in this study?**

I acknowledge that participants will be contributing a period of their time to take part in this research study, and this may be a disadvantage. Additionally, I understand that alcohol can be a sensitive topic for discussion. I have spoken with individuals over the age of 65 in designing this project to ensure that the questions asked within this interview are acceptable and do not cause discomfort.

### **What are the possible benefits of taking part in this research?**

Taking part in this research will offer participants a chance to share their views on this important subject and know that their views are valued.

### **Questions**

If you have any further questions about this project, please speak to the lead researcher, Bethany Barham. Contact details, should you require them, are at the end of this document.

### **Ethics**

This project has received ethical approval from the East Midlands – Nottingham 1 Research Ethics Committee and from Newcastle University.

### **What if there is a problem?**

If you have a concern about any aspect of the study, you should contact the lead researcher, Bethany Bareham, who will do her best to answer your questions. Contact details are provided at the end of this information sheet. If you remain unhappy, please get in touch with either of the project supervisors, Barbara Hanratty or Eileen Kaner. Details of how to contact the project supervisors are supplied at the end of this document. If you were recruited as a patient through your general practice (GP), any complaints about the conduct of this project may also be directed to your local Patient and Liaison Service. The contact details for your local service can be identified by calling 0800 032 0202 or through the following website:

[http://www.nhs.uk/service-search/Patient-advice-and-liaison-services-\(PALS\)/Location/363](http://www.nhs.uk/service-search/Patient-advice-and-liaison-services-(PALS)/Location/363)

Thank you for considering participating in my project



Bethany Bareham

PhD researcher at Newcastle University



E: [b.k.bareham@ncl.ac.uk](mailto:b.k.bareham@ncl.ac.uk)

T: 0191 20 82056

*This research project is supervised by Professor Barbara Hanratty and Professor Eileen Kaner.*

*Professor Barbara Hanratty can be contacted as follows:*

*T: 0191 208 1121     E: [barbara.hanratty@ncl.ac.uk](mailto:barbara.hanratty@ncl.ac.uk)*

*Professor Eileen Kaner can be contacted as follows:*

*T: 0191 208 7884     E: [eileen.kaner@ncl.ac.uk](mailto:eileen.kaner@ncl.ac.uk)*

# Thinking about Drinking

## 65+ focus group information sheet

I am inviting you to take part in a research study. This work forms part of my PhD at Newcastle University, funded by the National Institute for Health Research School for Primary Care Research.

My aim is to understand **how people aged 65+ weigh up the positive and negative effects of drinking alcohol, and how this influences their behaviours.**

Before you decide whether to take part in this study, it is important for you to understand why the research is being done and what your participation in the study will involve. Please take time to read the following information carefully:

### **What is the project about?**

There is a lot of evidence to suggest that drinking alcohol can be both a good and a bad thing for people to do. The evidence for effects on health is especially relevant to people aged over 65, but they may also benefit most from the social side of drinking. In this study, I want to learn more about what people aged over 65 think are the pros and cons of their drinking, and what is important to them, when they make decisions about their drinking?

I would like to speak to anybody aged over 65 who consumes alcohol (or who has consumed alcohol in the past). This study does not focus on people with severe problems linked to drinking alcohol. Unfortunately, this means that I will not be able to include anybody who has sought help for alcohol problems in the past.

### **What am I being asked to do?**

You have expressed that you would like to take part in a focus group about how you think about drinking. This will be conducted by the lead researcher, Bethany Bareham. Bethany has arranged a time and place to meet as a group and conduct this focus group. The focus group should last approximately an hour and a half.

Before you take part in the focus group, I will ask you to complete a screening questionnaire. This will ask you some questions about how you drink. The information you give will give me some background to consider when I analyse your data from the interview. It will also help me make sure that you are not a dependent drinker. Dependent drinkers think about alcohol differently to others, so unfortunately I will not be able to include dependent drinkers in this study.

During the focus group, I will ask you questions about your views of the effects of alcohol. I will ask you how people over the age of 65 consider these effects and which they might choose to prioritise in their drinking. I will also ask you about times in a persons' life where alcohol consumption may change. I will additionally ask you where people over the age of 65 may be asked to talk about your drinking.

You do not have to give responses from your own personal experience. You may choose to draw from the experiences of other people you know who are over the age of 65.

You will receive a £10 Love2shop voucher to say thank you for participating in this study. Please be assured that your participation is entirely voluntary. You can choose to end your participation at any point, even during the focus group. Information I have already collected with your consent will be retained and

used in the study. Normal care as a patient will not be affected by withdrawal from this study.

### **What happens to the data?**

The discussion will be recorded so that I have an accurate account of your views. The recording will then be put into writing by a member of the study team. The focus group will then be analysed alongside data from other focus groups and interviews to identify themes. These findings will be written up to contribute to a thesis to be submitted for my PhD. The findings will also be reported for submission to a scientific journal, which may be read by other researchers, health and social care workers and policy makers. Quotes from interviews and focus groups will be used in reporting to support the findings. Participant names will be changed so that readers cannot identify the individuals contributing the quotes.

### **Will I be identified?**

No other individuals will have access to the recording of this focus group. As soon as the recording has been put into writing by a member of the study team, we will change your name so that you cannot be identified. The recording will then be destroyed. Anything you say will be kept confidential, unless it suggests that someone is at risk of harm.

### **What are the possible disadvantages of taking part in this study?**

I acknowledge that participants will be contributing a period of their time to take part in this research study, and this may present as a disadvantage. Additionally, I understand that alcohol can be a sensitive topic for discussion. I have spoken with individuals over the age of 65 in designing this project to

ensure that the questions asked within this interview are acceptable and do not cause discomfort.

### **What are the possible benefits of taking part in this research?**

Taking part in this research will offer participants a chance to share their views on this important subject and know that their views are valued.

### **Questions**

If you have any further questions about this project, please speak to the lead researcher, Bethany Barham. Contact details, should you require them, are at the end of this document.

### **Ethics**

This project has received ethical approval from the East Midlands – Nottingham 1 Research Ethics Committee and from Newcastle University.

### **What if there is a problem?**

If you have a concern about any aspect of the study, you should contact the lead researcher, Bethany Barham, who will do her best to answer your questions. Contact details are provided at the end of this information sheet. If you remain unhappy, please get in touch with either of the project supervisors, Barbara Hanratty or Eileen Kaner. Details of how to contact the project supervisors are supplied at the end of this document. If you were recruited as a patient through your general practice (GP), any complaints about the conduct of this project may also be directed to your local Patient and Liaison Service. The contact details for your local service can be identified by calling 0800 032 0202 or through the following website:

[http://www.nhs.uk/service-search/Patient-advice-and-liaison-services-\(PALS\)/Location/363](http://www.nhs.uk/service-search/Patient-advice-and-liaison-services-(PALS)/Location/363)

Thank you for considering participating in my project

Bethany Bareham

PhD researcher at Newcastle University



E: [b.k.bareham@ncl.ac.uk](mailto:b.k.bareham@ncl.ac.uk)

T: 0191 20 82056

*This research project is supervised by Professor Barbara Hanratty and Professor Eileen Kaner.*

*Professor Barbara Hanratty can be contacted as follows:*

*T: 0191 208 1121      E: [barbara.hanratty@ncl.ac.uk](mailto:barbara.hanratty@ncl.ac.uk)*

*Professor Eileen Kaner can be contacted as follows:*

*T: 0191 208 7884      E: [eileen.kaner@ncl.ac.uk](mailto:eileen.kaner@ncl.ac.uk)*

# Thinking about Drinking for people in later life: Health and social care worker interview information sheet

I am inviting you to participate in a research study. The study is being undertaken as part of a PhD project by the Institute of Health and Society and is sponsored by the School for Primary Care Research, funded by the National Health Service (NHS).

My research study aims to explore **how people working in health and social care with older adults consider the positive and negative consequences associated with drinking in later life.**

Before you decide whether to take part in this study, it is important for you to understand why the research is being done and what your participation in the study will involve. Please take time to read the following information carefully:

## **What is the project about?**

I recognise that there a lot of evidence to suggest both positive and negative consequences of drinking to peoples' health. Much of this evidence is especially relevant to people aged over 65 because this group are more susceptible to many of the diseases effected by drinking alcohol. I also recognise that drinking can play many roles in people's lives, especially after the age of 65. Many of these, such as drinking to socialise, can be considered to be positive to people's wellbeing. I aim to explore how people working in health and social care with older adults consider the positive and negative consequences associated with drinking in later life. I want to know how people working in health and social care prioritise these considerations to form their opinions and recommendations for older people. I also want to find out if health and social care workers have different opinions to their older clients, and how this can effect discussion with them about their drinking.

Please note that this study focuses on non-dependent older drinkers. The people we wish to talk about may have any relationship with alcohol. They may be light, moderate or heavy drinkers.

### **What am I being asked to do?**

You have expressed that you would like to take part in an interview about how health and social care workers consider and prioritise the positive and negative effects of drinking in later life. This will be conducted by the lead researcher, Bethany Bareham. Bethany has arranged a time and place to meet with you and conduct this interview. The interview should last approximately an hour and a half.

During the interview, I will ask you questions about your views of the effects of alcohol. I will ask you how people working in health and social care consider these effects and which they may choose to prioritise in making recommendations to older people about their drinking. I will additionally ask you if there are any times you can think of where older clients have different opinions to their health and social care workers about their own drinking, and how this may affect discussion in practice.

Please be assured that your participation is entirely voluntary. You can choose to end your participation at any point, even during the interview. Information we have already collected with your consent will be retained and used in the study. Withdrawal from the study will not affect your legal rights.

### **What happens to the data?**

The discussion will be recorded so that we have an accurate account of your views. The recording will then be put into writing by a member of the study team. The interview will then be analysed alongside data from other focus groups and interviews to identify themes that relate to how health and social care workers consider and prioritise the positive and negative effects of drinking alcohol in making recommendations to their older clients. These findings will be written up to contribute to a thesis to be submitted for the lead researcher's PhD qualification. The findings will also be reported for submission to a relevant peer reviewed scientific journal, which may be read by other researchers, health and social care workers and policy makers. Quotes from interviews and focus groups will be used in reporting to support the findings presented. Participant names will be changed so that readers cannot identify the individuals contributing the quotes.



### **Will I be identified?**

No other individuals will have access to the recording of this interview. As soon as the recording has been put into writing by a member of the study team, we will change your name so that you cannot be identified. The recording will then be destroyed. Anything you say will be kept confidential, unless it suggests a safeguarding or legal issue.

### **What are the possible disadvantages of taking part in this study?**

No risks are envisaged for you as a result of taking part in this study. The only possible disadvantage is that you will be giving up some of your time to take part in the research.

### **What are the possible benefits of taking part in this research?**

Taking part in this research will offer participants a chance to share their views on this important subject and know that their views are valued.

### **Questions**

If you have any further questions about this project, please speak to the lead researcher, Bethany Barham. Contact details, should you require them, are at the end of this document.

### **Ethics**

This project has received ethical approval from the East Midlands – Nottingham 1 Research Ethics Committee and from Newcastle University.

### **What if there is a problem?**

If you have a concern about any aspect of the study, you should contact the lead researcher, Bethany Bareham, who will do her best to answer your questions. Contact details are provided at the end of this information sheet. If you remain unhappy, please get in touch with either of the project supervisors, Barbara Hanratty or Eileen Kaner. Details of how to contact the project supervisors are supplied at the end of this document.

Thank you for considering participating in my project

Bethany Bareham

PhD researcher at Newcastle University



E: [b.k.bareham@ncl.ac.uk](mailto:b.k.bareham@ncl.ac.uk)

T: 0191 20 82056

*This research project is supervised by Professor Barbara Hanratty and Professor Eileen Kaner.*

*Professor Barbara can be contacted as follows:*

*T: 0191 208 1121    E: [barbara.hanratty@ncl.ac.uk](mailto:barbara.hanratty@ncl.ac.uk)*

*Professor Eileen Kaner can be contacted as follows:*

*T: 0191 208 7884    E: [eileen.kaner@ncl.ac.uk](mailto:eileen.kaner@ncl.ac.uk)*

# Thinking about Drinking for people in later life: Health and social care worker focus group information sheet

I am inviting you to participate in a research study. The study is being undertaken as part of a PhD project by the Institute of Health and Society and is sponsored by the School for Primary Care Research.

My research study aims to explore **how people working in health and social care with older adults consider the positive and negative consequences associated with drinking in later life.**

Before you decide whether to take part in this study, it is important for you to understand why the research is being done and what your participation in the study will involve. Please take time to read the following information carefully:

## **What is the project about?**

I recognise that there is a lot of evidence to suggest both positive and negative consequences of drinking to peoples' health. Much of this evidence is especially relevant to people aged over 65 because this group are more susceptible to many of the diseases effected by drinking alcohol. I also recognise that drinking can play many roles in people's lives, especially after the age of 65. Many of these, such as drinking to socialise, can be considered to be positive to people's wellbeing. I aim to explore how people working in health and social care with older adults consider the positive and negative consequences associated with drinking in later life. I want to know how people working in health and social care prioritise these considerations to form their opinions and recommendations for older people. I also want to find out if health and social care workers have different opinions to their older clients, and how this can effect discussion with them about their drinking.

Please note that this study focuses on non-dependent older drinkers. The people we wish to talk about may have any relationship with alcohol. They may be light, moderate or heavy drinkers.

### **What am I being asked to do?**

You have expressed that you would like to take part in a focus group about how you consider and prioritise the positive and negative effects of drinking. This will be conducted by the lead researcher, Bethany Bareham. Bethany has arranged a time and place to meet as a group and conduct this focus group. The focus group should last approximately an hour and a half.

During the focus group, I will ask you questions about your views of the effects of alcohol. I will ask you how people working in health and social care consider these effects and which they may choose to prioritise in making recommendations to older people about their drinking. I will additionally ask you if there are any times you can think of where older clients have different opinions to their health and social care workers about their own drinking, and how this may affect discussion in practice.

You do not have to give responses from your own personal experience. You may choose to draw from the experiences of other people you know or have worked with.

Please be assured that your participation is entirely voluntary. You can choose to end your participation at any point, even during the focus group. Information I have already collected with your consent will be retained and used in the study. Withdrawal from the study will not affect your legal rights.

### **What happens to the data?**

The discussion will be recorded so that I have an accurate account of your views. The recording will then be put into writing by a member of the study team. The focus group will then be analysed alongside data from other focus groups and interviews to identify themes that relate to how health and social care workers consider and prioritise the positive and negative effects of drinking alcohol in making recommendations to their older clients. These findings will be written up to contribute to a thesis to be submitted for my PhD. The findings will also be reported for submission to a relevant peer reviewed scientific journal, which may be read by other researchers, health and social care workers and policy makers. Quotes from interviews and focus groups will be used in reporting to support the findings presented. Participant names will be changed so that readers cannot identify the individuals contributing the quotes.

### **Will I be identified?**

No other individuals will have access to the recording of this focus group. As soon as the recording has been put into writing by a member of the study team, we will change your name so that you cannot be identified. The recording will then be destroyed. Anything you say will be kept confidential, unless it suggests a threat to others.

### **What are the possible disadvantages of taking part in this study?**

No risks are envisaged for you as a result of taking part in this study. The only possible disadvantage is that you and other staff will be giving up some of your time to take part in the research.

### **What are the possible benefits of taking part in this research?**

Taking part in this research will offer participants a chance to share their views on this important subject and know that their views are valued.

### **Questions**

If you have any further questions about this project, please speak to the lead researcher, Bethany Barham. Contact details, should you require them, are at the end of this document.

### **Ethics**

This project has received ethical approval from the East Midlands – Nottingham 1 Research Ethics Committee and from Newcastle University.

### **What if there is a problem?**

If you have a concern about any aspect of the study, you should contact the lead researcher, Bethany Bareham, who will do her best to answer your questions. Contact details are provided at the end of this information sheet. If you remain unhappy, please get in touch with either of the project supervisors, Barbara Hanratty or Eileen Kaner. Details of how to contact the project supervisors are supplied at the end of this document.

Thank you for considering participating in my project

Bethany Bareham

PhD researcher at Newcastle University



E: [b.k.bareham@ncl.ac.uk](mailto:b.k.bareham@ncl.ac.uk)

T: 0191 20 82056

*This research project is supervised by Professor Barbara Hanratty and Professor Eileen Kaner.*

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## Appendix L - Advertisements produced for dissemination in materials accessed by older adults, including elders' council and rotary club newsletters

Figure Apx L-1 Advert in elders' council newsletter, produced by the local group



### Thinking about drinking



If you have any experience of drinking alcohol and are over 65, a researcher at Newcastle University would like you to get in touch to take part in her investigation of what older people think about drinking.

If you are interested in finding out more, please ring Bethany Bareham on 0191 208 2056 or email her at [b.k.bareham@newcastle.ac.uk](mailto:b.k.bareham@newcastle.ac.uk).



If you agree to take part, you get a £10 Love2shop voucher as a thank-you.

Figure Apx L-2 Advert in rotary club newsletter, produced by the local group:

## *Twenty Minutes of Whining.*

A talk by Bethany Bareham post graduate PhD student at Newcastle University.

In order to capture our interest the title of her talk *Twenty minutes of whining* had us all wondering as to which direction we were heading. Then suddenly when the word *Win* was mentioned followed by other similar words such as beer and spirits and alcohol it was noticeable that people's minds had started to focus, but still not certain as to the final direction. Next our attention was drawn to an age group which for the most of the Rotarians present was an age gone by, the age group 65+.



Ah, now we are getting there, Alcohol and Older people, what Beth then proceeded to do was to put the letter H into *Winning* to give us the word in her title *Whining*. I would like to think that the letter H stood for Health as Beth suggested we should all have a greater awareness of the health risk of increased alcohol consumption.

The guidelines keep changing and now men and women's recommended levels of alcohol consumption is 14 units per week spread over at least three or four days. What is your approach to alcohol, do you drink more or less than the recommended level, and do you consume more than the recommended 14 units all at once or spread over a few days?

Are you a generous pourer?

Beth's research programme is over three years and as she said during that time she will be reading a lot, talking a lot, and listening a lot, and in order to listen she has to hear, and that is where you could help.

Beth would like to meet and speak with a group of five or six members of the club and hear their thoughts about drinking alcohol. Would you be interested? The meeting would take place locally and would be conducted by Beth herself. There is only one stipulation the people taking part must not be known to Beth socially.

Would you like to help, I am sure you would, names to me [Anonymised] please, and we will arrange the detail.

[Anonymised]



Figure Apx L-3 Advertisement for general distribution

Exploring perceptions for the consequences of  
alcohol use in later life IRAS ID: 209426  
Version 1 22.09.16



# Thinking about Drinking! Participants Required

- Are you aged 65 or over?
- Do you have any experience of drinking alcohol?



If you answered **yes** to these questions, we would like to speak to you about our research project

## We really need your help!

Our project aims to study **how people aged 65 and over think about drinking alcohol**. We would like to speak with people individually or in small groups. All conversations will be confidential and no names will appear in our reports.



If you would like to find out more about this project or are interested in taking part, please get in touch by calling Bethany Bareham at Newcastle University on **0191 20 82056** or emailing **b.k.bareham@ncl.ac.uk**

Participants will receive a **£10 Love2shop voucher** as a thank you for taking part.

*Love2shop vouchers can be spent in many high street and online stores, supermarkets, and a variety of leisure facilities (restaurants and spas)*

School for Primary Care Research

The National Institute for Health Research School for Primary Care Research (NIHR SPCR) is a partnership between the Universities of Bristol, Cambridge, Keele, Manchester, Newcastle, Nottingham, Oxford, Southampton and University College London.

This poster summarises independent research funded by the National Institute for Health Research School for Primary Care Research. The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health. Grant No.

**NIHR** at 10

Funded by  
**NHS**  
National Institute for  
Health Research

## Appendix M - Advert For Care Providers

Figure Apx M-1 Example of advert for care providers disseminated via my personal Twitter and Facebook accounts.

# Home Care Workers wanted for study

## £20 shopping voucher for less than an hour of your time



**We really need your help!**

Our project aims to study **what home care workers** (based in the North East or North Cumbria) **think about older people's drinking**. We would like to speak with you for between half an hour to an hour (either over the phone or in person in a location of your choice). All conversations will be entirely confidential and no names will appear in our reports.

If you might be interested in taking part or would like to find out more, please get in touch by:  
Messaging <https://www.facebook.com/bethany.bareham>  
Calling Bethany Bareham at Newcastle University on 0191 20 82056  
Emailing [b.k.bareham@ncl.ac.uk](mailto:b.k.bareham@ncl.ac.uk)



**School for Primary Care Research**

The National Institute for Health Research School for Primary Care Research (NIHR SPCR) is a partnership between the Universities of Bristol, Cambridge, Keele, Manchester, Newcastle, Nottingham, Oxford, Southampton and University College London.



# 65+ interview topic guide

- Tell about self
  - Ask about them
  - Any time-constraints?
  - Consent
  - Focus for this interview on what and how you think about drinking. Opportunity to talk about anything else at the end. Will come back to some areas – part of the interview process. Ask that you focus predominantly on your thoughts since 50/65.
  - Checking battery/recording tape
- 
1. How would you describe your drinking?
    - a. How would you usually drink? Can you tell me about the last time you drank alcohol?
    - b. Are there any other occasions when you'd usually drink?
    - c. Is alcohol important in your life?
  2. How do you gauge what type of drinker you are? How do you know?
    - a. With comparison to others?
    - b. Are you aware of any guidelines about drinking? What do you think of these?
      - i. What do you think of suggesting a set amount of units?
  3. Is there anything you might consider before you drink? (i.e. driving, looking after family, health?)
  4. Timeline exercise – could you draw out on this timeline times in your lifetime so far where you might have changed the way you drink? (starting example could be the first time they had a drink) **Give full instructions**
  5. What are the upsides to drinking? **IN LATER LIFE PARTICULARLY**
    - a. What do you enjoy about drinking?
    - b. What types of situations are made better when drinking?
    - c. How do you think drinking might benefit your health? ST/LT
    - d. How do you think drinking might benefit your wellbeing? ST/LT
  6. What are the downsides to drinking? **IN LATER LIFE PARTICULARLY**
-

- a. What do you not enjoy about drinking?
  - b. What types of situations do you think are made worse by drinking?
  - c. How do you think drinking might be unhealthy?
  - d. How do you think drinking might be bad for your wellbeing?
7. Do you consider any of these upsides or downsides in planning how much you drink?
- a. On a day-to-day basis?
  - b. In determining the amount that you generally choose to drink?
  - c. Which effects do you think are more important?
  - d. Is health key consideration? Is something else more important?
    - i. **Is health generally important to you?** (particularly at this stage in life?)  
Do you generally follow recommendations for a healthy lifestyle?  
Why?
  - e. Do/have you ever consciously considered how you drink?
    - i. In the moment?
    - ii. With a longer-term perspective?
  - f. Is there anything that you think is particularly important to think about surrounding drinking when you get older?
  - g. How has your attitude towards drinking alcohol changed over the years?
  - h. Do you think that people really have control over their drinking? *Why is this?*
    - i. What occasions might it be difficult to control your drinking?
    - ii. Do you do anything to limit your drinking?
    - iii. Do people generally consciously consider their drinking?
    - iv. **If you were to be honest, and not afraid of judgement:** Are there any occasions where you might try to hide how much you've been drinking?
8. Do you think the benefits of drinking outweigh the risks in later life? Or vice-versa?
- a. Is there anything you can think of that has particularly effected your view on drinking?
9. How do you know how drinking can affect you?
- a. Does experience play a role?
  - b. Is experience important? Are older people more experienced? Are older people more knowledgeable?

- c. Where do you hear about how drinking can affect people? (in the media?)  
How often do you come across this information?
  - d. Do you ever come across any reminders about how much you should be drinking? Where?
  - e. What do you think of government restrictions on people's drinking? Are you aware of any restrictions that already exist? How do you think these effect *older* people's drinking?
10. Who would you say is responsible for shaping how much you drink?
- a. Is anyone else important in shaping your drinking?
11. Have you ever talked about/*been asked about* your drinking with/*by* a health worker, such as a doctor or a nurse, or somebody who provides any other kind of care?
- a. Who was this with? Have there been any other occasions?
    - i. Can you tell me about any time when you might have discussed this at your GP surgery?
    - ii. Can you tell me about any time when you might have talked about drinking when you were in hospital?
    - iii. Can you tell me about any time when you might have talked about drinking at any type of walk in centre?
  - b. Can you tell me what you talked about?
  - c. Would you say you both thought the same thing about drinking?
  - d. Did they give you any advice about your drinking? What did you think about this? Do you follow this advice? (Why?)
  - e. Do you think that these sorts of people should ask about your drinking? Is that their place?
    - i. Do you think that these sorts of people have the right priorities in mind? Can you explain?
    - ii. Do you think health and social care workers care about how much you drink? Why? Should they?
    - iii. Do you think that people generally respond honestly when questioned about their drinking? Why might a person respond honestly? Why might they respond dishonestly?
  - f. Have you ever known a person working in health or social care recommend drinking? *Can you tell me about this?*

- g. Are you aware of the health checks by general practices for people over the age of fifty? (well man/well woman checks – stop at a certain age)
  - i. At these health checks, GPs ask about the patients' drinking. What do you think about this?
  - h. Is alcohol important to consider in terms of health?
- 12. Can you tell me about when you might talk about drinking with anyone else?
  - a. Who has talked to you about drinking? (yours or theirs)
  - b. Did this encourage you to change or reconsider your drinking?
- 13. Are there any reasons that you could give for why you drink the way that you choose to?
  - a. Have you ever consciously considered this?
  - b. How might an older persons' drinking differ to a younger persons'?
    - i. Why do you think older people might drink differently to younger people?
- 14. Is there anything else you'd like to say about drinking at this stage in life?
- 15. Present ideas? Dichotomy of problematic drinking - could your drinking be seen as problematic on any other level?

- Thank you
- Advise of materials for help and support if needed
- Welcome to pass on details of the study to anyone you think might be interested
- Ask for **pseudonym**

# 65+ focus group topic guide

## *Housekeeping:*

- Important to be respectful of each other
- Don't talk over each other
- Confidentiality is guaranteed from me but cannot guarantee that people in this room won't repeat what was said. Be mindful of this in what you share.
- Tell about self – name, age, previous profession
- Introductions – each person in the room
- Consent

## *Topics for discussion:*

1. How do older people drink? Is alcohol important to older people's lives?
2. How do older people gauge/know what type of drinker they are? (comparison to others/guidelines)
3. Are there any particular issues you think people at your stage in life might consider before they drink? (i.e. driving, looking after family, health)
4. How do people change their drinking patterns as they get older?
5. What are the upsides to drinking? (enjoyment, ST/LT health/wellbeing)
6. What are the downsides to drinking? (enjoyment, ST/LT health/wellbeing)
7. Is health a key consideration or is something else more important?
  - Is health especially important in later life? Do older people generally follow recommendations for a healthy lifestyle?
8. Do you think the benefits of drinking outweigh any risks in later life? Or vice-versa?
  - Is there anything that might particularly affect an older person's view on drinking?
9. Who would you say is involved in shaping how much a person drinks? (Them? Partner? Family? Medical professionals?)
10. Does anybody has any experience of health or social care workers asking about people's drinking? Who might ask? (GP, hospital, dentist, well man/woman checks)
11. Should health or social care workers be giving advice about older people's drinking?
12. Do older people talk to anybody else about their drinking?
13. Is there anything else you'd like to say about drinking at this stage in life?

*Housekeeping:*

- Thank you
- Advise of materials for help and support if needed
- Welcome to pass on details of the study to anyone you think might be interested
- Ask for **pseudonym**



# Health and Social Care worker interview topic guide

- Tell about self
  - Ask about them
  - Consent
  - State the **level of consumption** that I am referring to/**age range**
1. What are your views about alcohol? (guidelines?)
    - a. Without your health/social worker hat on/do you mind me asking about your own relationship with alcohol?
    - b. What is your view on health-promoting behaviour generally? Is this important to you/in your work?
  2. What do you think about older people drinking alcohol?
    - a. How should considerations surrounding alcohol be different for older people? (particular risks (medications/conditions)? Role in social life?)
    - b. What benefits do you think older people get from drinking?
    - c. What problems do you think older people might face through their drinking?
    - d. How might alcohol be particularly important in older people's lives? (Social)
    - e. How do older people's considerations about their drinking differ from younger age groups? Why?
      - i. [vignette exercise]
  3. What happens when you give advice to people about their drinking? (how often? When? How introduced?)
    - a. How would this differ if the patients were older? (Acceptable? Honest? Followed?)
    - b. Who else do you think older people rely on to reflect on their drinking habits? Whose thoughts do they value most (family/H+SC)?
    - c. What prevents you giving advice about drinking to your patients/clients – particularly the older ones?
    - d. How important is talking about an older patient/client's drinking, compared to other health/social care issues they may have?

- i. Is this part of your role? Is this an *important* part of your role?
  - ii. Who do you think *should* be responsible for an older person's drinking?
    - 1. In terms of community health/social care team?
  - e. Are health considerations or social considerations more important to prioritise in considering older peoples' drinking?
  - f. Currently, people over the age of 50 are invited to have a health check at their general practice. This includes an assessment of their drinking. What do you think about this?
4. Is there anything else you'd like to mention about drinking in older age?
- Thank you

# Health and social care workers focus group

This focus group is about your perceptions and experiences of older people's drinking. I have defined older age as 65+, as this is the age range that many studies and communications refer to when describing the health consequences of older people's drinking. I am looking at non-dependent drinking in older adults, as dependent drinkers would have a different relationship with alcohol and are at risk of different health consequences, and require different considerations in practice. Can I therefore ask that we focus on older adults' non-dependent drinking in discussion today.

During the focus group, I will ask you questions about your views of the effects of alcohol. I will ask you how people working in health and social care consider these effects and which they may choose to prioritise in making recommendations to older people about their drinking. I will additionally ask you if there are any times you can think of where older clients have different opinions to their health and social care workers about their own drinking, and how this may affect discussion in practice.

Whilst I can guarantee full confidentiality from myself, I cannot guarantee that others in this room will not repeat what has been discussed today. It's important to be mindful of this in what you contribute to discussion. You don't have to give responses from your personal experience – you might choose to draw from the experiences of other people you know or work with instead.

- Tell about self
- Ask about them
- Consent
- State the level of consumption that I am referring to.

1. What are your views about alcohol? (guidelines?)
  - a. What are your views on health-promoting behaviour generally? Is this important to you/in your work?
2. What do you think about older people drinking alcohol?

- a. How should considerations surrounding alcohol be different for older people? (particular risks (medications/conditions)? Role in social life?)
  - b. What benefits do you think older people get from drinking?
  - c. What problems do you think older people might face through their drinking?
  - d. How might alcohol be particularly important in older people's lives? (Social)
  - e. How do older people's considerations about their drinking differ from younger age groups? Why?
    - i. [vignette exercise]
3. What happens when you give advice to people about their drinking? (how often? When? How introduced?)
- a. How would this differ if the patients were older? (Acceptable? Honest? Followed?)
  - b. Who else do you think older people rely on to reflect on their drinking habits? Whose thoughts do they value most (family/H+SC)?
  - c. What prevents you giving advice about drinking to your patients/clients – particularly the older ones?
  - d. How important is talking about an older patient/client's drinking, compared to other health/social care issues they may have?
    - i. Is this part of your role? Is this an *important* part of your role?
    - ii. Who do you think *should* be responsible for an older person's drinking?
      - 1. In terms of community health/social care team?
  - e. Are health considerations or social considerations more important to prioritise in considering older people's drinking?
  - f. Currently, people over the age of 50 are invited to have a health check at their general practice. This includes an assessment of their drinking. What do you think about this?
4. Is there anything else you'd like to mention about drinking in older age?

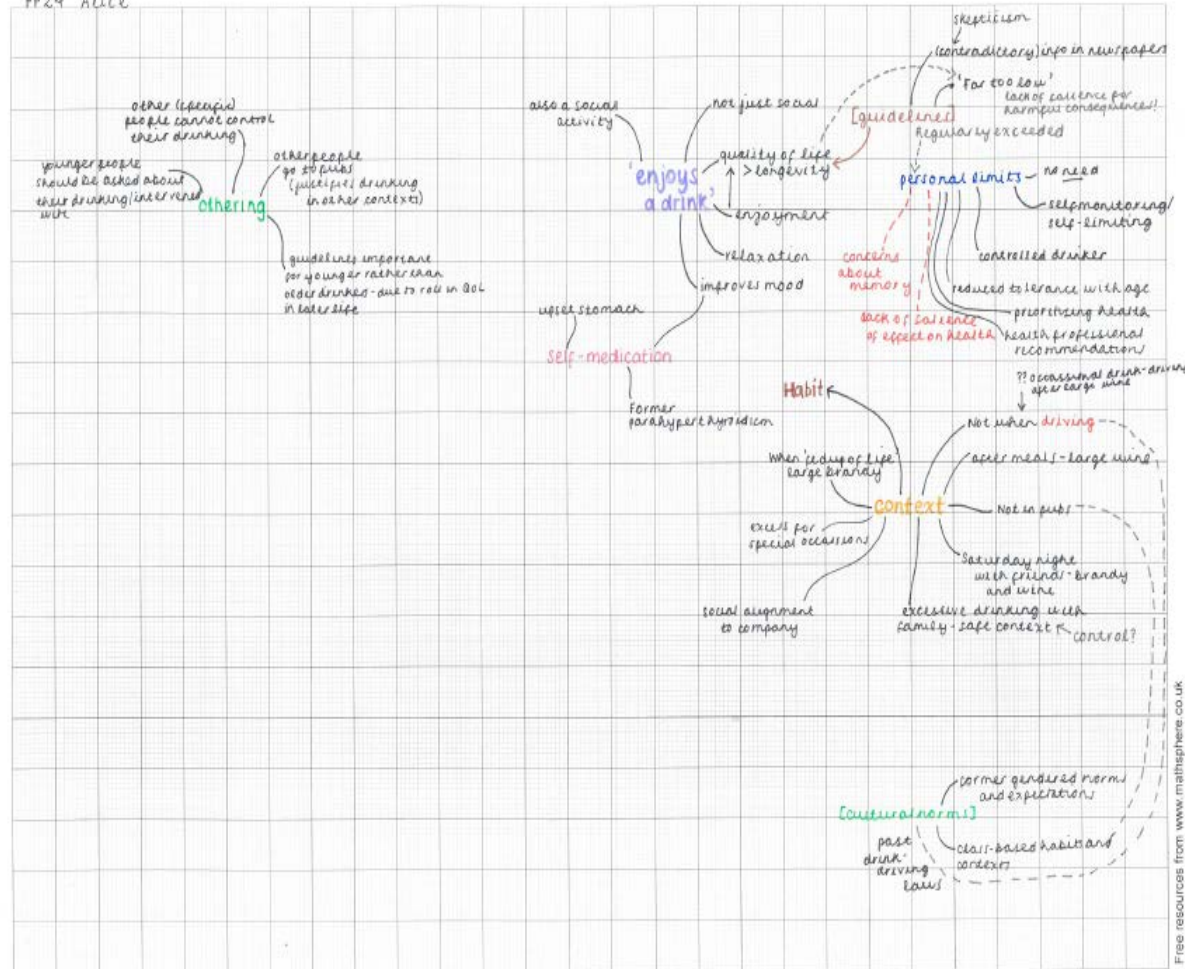
## Appendix O - Vignette Exercise

I am going to present a few scenarios to you. Please can you imagine that you have come across this individual in your work? Can you tell me what you think about their level of drinking? How much do you think they should be drinking? Why is this important? How might this affect them?

1. Ginny is 65 and took early retirement from her job in her 50s, and lives with her husband. She takes statins to reduce her level of cholesterol, and beta blockers to control her blood pressure. Ginny meets up with her girlfriends once a week to drink gin and tonic and eat cake. She likes to enjoy a few drinks on special occasions with their friends. When she hasn't been drinking socially, Ginny usually shares a bottle of wine with her husband on an evening.
2. David is 78, and spends much of his time caring for his wife, Aida, who is currently receiving "end of life care" for a cancer that has affected her for 5 years. David takes Ibuprofen most days to help a pain in his shoulder. He enjoys a glass of red wine with his evening meal at weekends, but avoids drinking more as he feels this would affect his caring abilities.
3. Flora is 85 and has lived alone in her home since her husband died. She has Type II Diabetes, and takes Metformin to treat this. She also takes statins to reduce her likelihood of a heart attack or stroke. She is visited once a day by home help staff to help her keep her house and ensure she is fed. She has poor mobility, and doesn't often leave the house. She usually has a drink with her lunch, and enjoys sherry on an evening, as this helps her to relax and helps her get to sleep.

# Appendix P - Example case map

PP24 Alice



## Appendix Q - Development of Candidate Themes and Sub-themes

Figure Apx Q-1 Sorting process of collated codes, leading to the development of candidate themes and sub-themes



Figure Apx Q-2 Themes and sub-themes developed as a result of the sorting process, applied systematically to data in NVivo:

### Theme 1 *Socially defined and positioned practices*

*Drawing on wider justification for intake, may explain why practices aren't particularly negotiable. Theory of practice particularly applicable to this theme. Biographical disruption/flow can explain identity component. Interesting how 'choices' correspond to identity yet are socially defined.*

- Culturally determined practices: cultural norms (local, gendered, generational, religious), normalised behaviour
  - Justifies drinking outside of their own choice. Links also to availability/accessibility.
- Acceptable/appropriate drinking: contexts, intake, type, reasons (medicinal, food, social etc)
  - Moralises (?) practices
- Drinking identities: non-drinker identity, geographical identity, gendered identity, retaining identity, late-life identity (also health-related identity?). Taste/preferences, tolerance, values, class/capital Self-determination, stereotypes also links here.
  - Drinking identities based around wider, socially-defined identity (continuity of which is important in later life). Identity changes across the biography but has ultimate bounds. Late-life identities often justified as 'non-drinker' etc – this is usually relative to former practices. Manifestation into practice often determined by class (creates stereotypes amongst care providers). Justifications often related to identities rather than guidelines.
- Social positioning: social comparison, considerate and responsible use, socially determined rules (contexts, driving, responsibilities), social alignment, moralistic distancing, othering.
  - Responsibilities decline in later life. Structures intake as opposed to guidelines. Moral loading of justifications make this a sensitive area.
- Moderation as unproblematic: moderate as unproblematic (dichotomised – what it isn't, not what it is, and often not guidelines), problematic as dispositional (not always), 'safe' limits

### Theme 3 *Symbolic meaning of drinking in older people's lives*

- Symbolic meaning for quality of life: wellbeing as QoL, deservedness of QoL in retirement, increased weight of social and leisure for QoL in later life (+stereotyping), continuity as QoL, encompassing health and function in QoL
  - Benefits of drinking served to justify practices. As roles depleted in later life, social and leisure lives were more important to their identities and wellbeing
- Alcohol as pleasure: pleasure of intoxication, accessible pleasure, drinking as pleasure, coping with disruptions.
  - Across the life course alcohol has been associated with pleasurable contexts, giving it symbolic meaning as a pleasurable activity. This quality can mean alcohol plays a role as a form of escape from late-life stressors and disruptions.
- Social importance: depleting social network, incidental to social activity (theme 1?), drinking companions (and role in relationships), social enabler, social dependence
  - Depleting networks may be difficult to negotiate in later life, and some may have little experience of building relations, making the social enablement of alcohol more important.
  - The social opportunities attached to drinking may cause social dependence as an alternative to loneliness.
- Leisure activity: reduced opportunity, late life leisure diversions
  - Alcohol is incidental to leisure in later life. Can represent an opportunity to 'get out'. Which represents diversion (alcohol or other opportunities) is debatable.
  - Related to above, the role of alcohol is equated to that of tea in their social and leisure lives – highlighting symbolic meaning.

### Theme 2 *Routinised drinking in later life*

*Examines late-life and life-long practices. Explains why excesses may not be disclosed or recognised. Routines must be acknowledged when addressing misuse in practice.*

- Continuing developed practices (without consideration)
- Cued by context
- Defining routines/structure by marking social and leisure space
- Engrained behaviour
- Impact of transitions on routines (network, social and leisure opportunities)
- Excesses/risks in drinking routines (underestimated intake)
- Exploring routines
  - Structured/systematic approach to addressing in practice
- Self-regulating routine practices
- Negotiating change around habits and routines

### Theme 4 *Tangibility of drinking practices as a relevant risk*

*Knowledge hierarchy reflects tangibility – exposures, tailored health messages, public health messages, might incompatibility of alcohol with disease be understood through field?*

- Recognisable signs as indicative of misuse: screenings as reassurance, attributing symptoms to ageing, reversible versus irreversible damage
- Relevance of alcohol to health: Linking behaviour with consequence, health priorities (including weight management), conflicting health priorities, promoting health retirement
- Susceptibility to alcohol-related harm: disease status, tolerance of alcohol, decreasing physical resilience with age, incompatibility of alcohol with disease, acknowledgement of risks for self-referral, associated risk factors, Perceived prevalence of excess in older population
- Tangibility of death and disease in later life
  - Linking to temporal order in public health approach?
- Exposures and availability bias: positive exposures, negative exposures
- Optimistic bias
- Aged scepticism (of guidelines)
  - Through living through many manifestations of public health messages, older adults are more sceptical of public health messages as they're deemed to be fickle and unfixed
- Survival as indicative of harmless intake
- Cues to addressing drinking practices (incentives, pop-ups, QoF, signs)
- Paternalistic expectations versus mutualistic care: personalised discussion, supporting informed choice, 'protectionism', prescriptive discussion, generational respect for doctors, second-line assurance of safe practice (including social network), health agency/locus of control, health literacy, public awareness of 'safe' practices
- Capacity for care provision: care provider's perceived role in health promotion, focus of legitimised care (professional lenses-teeth, disease, wellbeing), resources to facilitate role in prevention, value of prevention, accruing contact time with older person (and capitalising on continuity), negotiating responsibility, uniform health messages



# Appendix R - Sample Characteristics

Table Apx R-1 Older adult sample characteristics

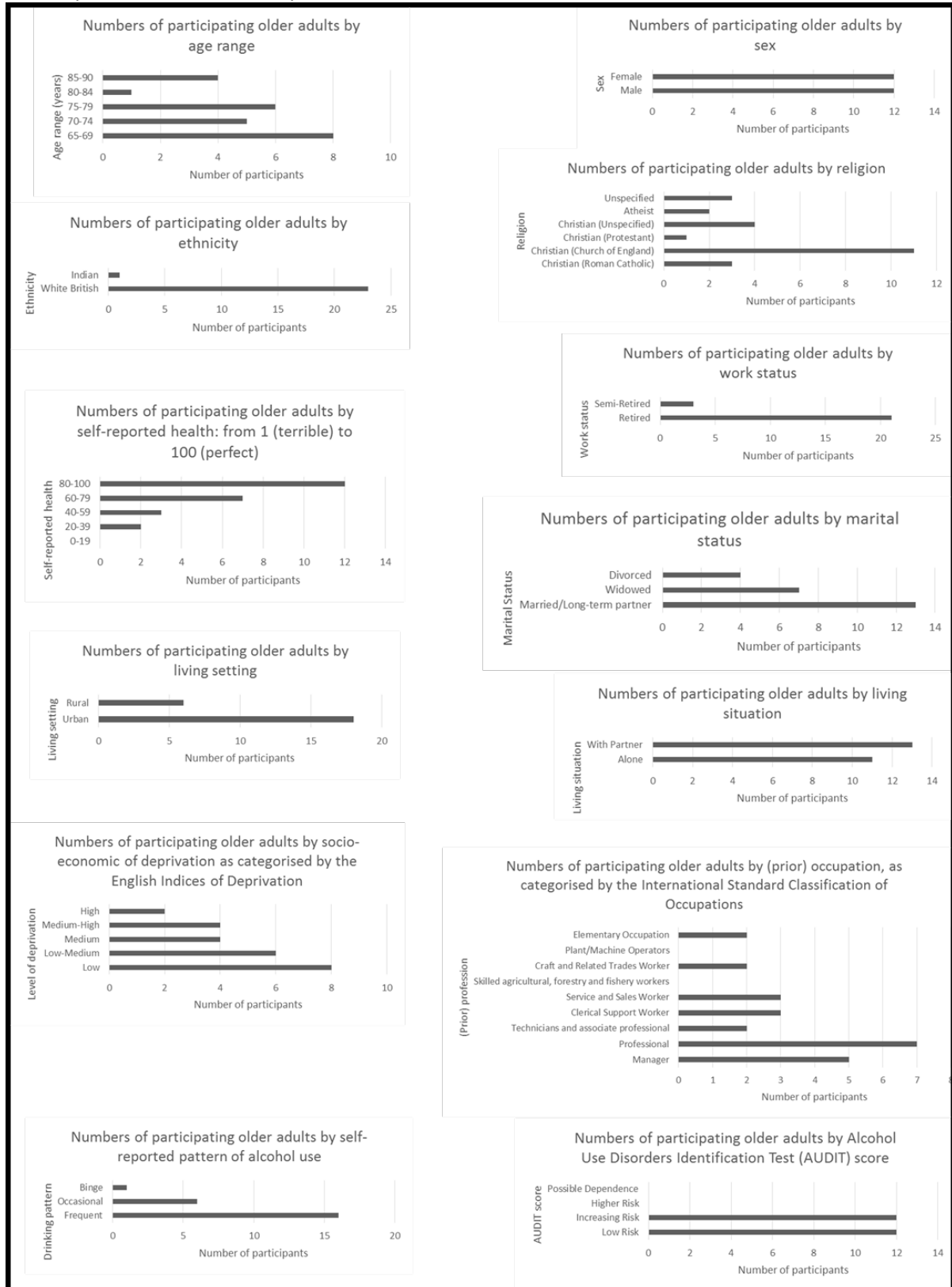
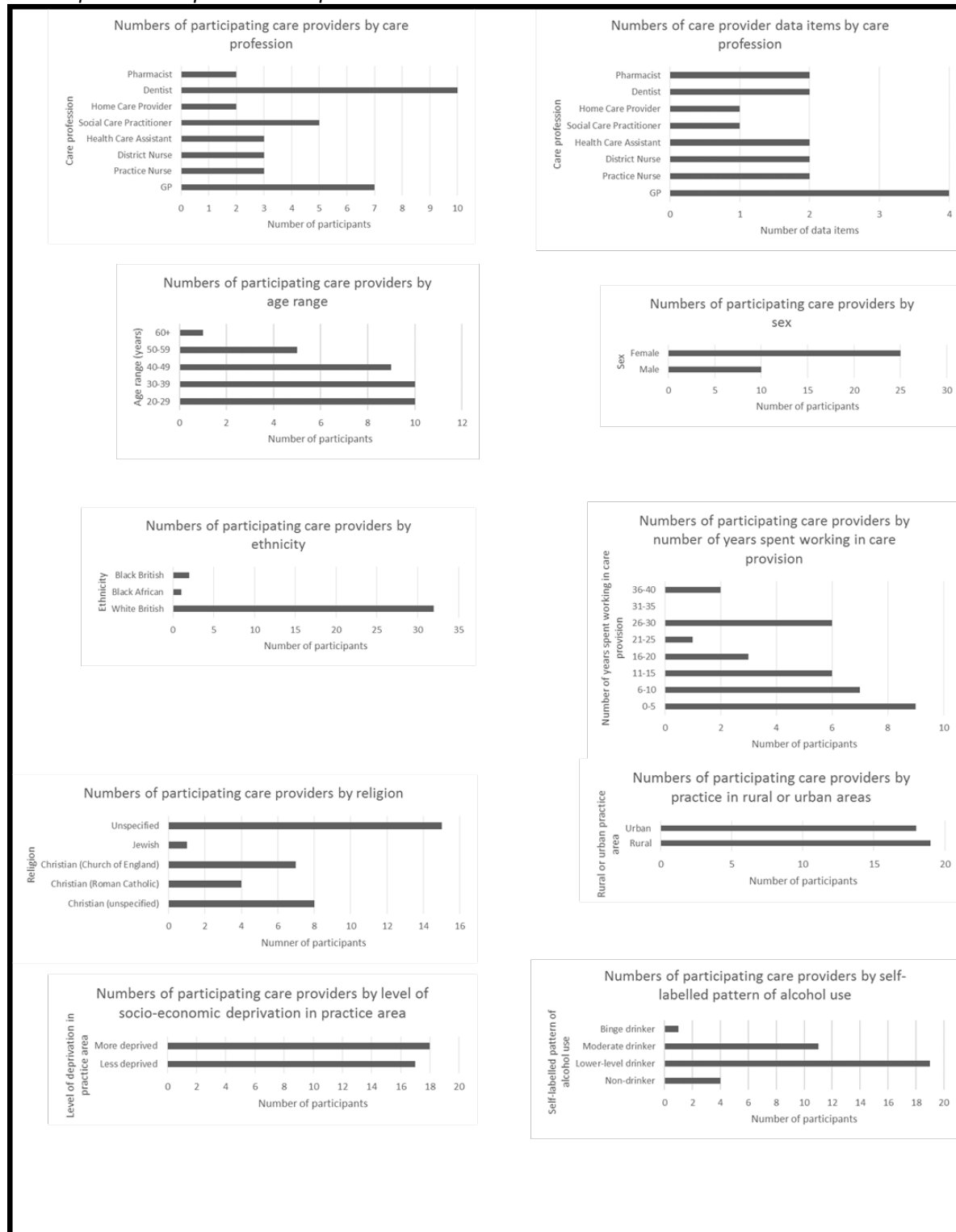


Table Apx R-2 Care provider sample characteristics



## Appendix S - Individual Participant Characteristics

*Table Apx S-1 Demographic, alcohol use, recruitment and participation details of participating older adults*

Participant	Age (years)	Sex	Ethnic group	Religion	Living situation (with partner or alone)	Marital status	Living setting (urban or rural)	Self-reported health status: 1 (terrible) to 100 (perfect)	Employment status	Level of deprivation*	(Prior) profession**	Self-reported pattern of alcohol use	Alcohol Use Disorders Identification Test (AUDIT) score***	Details from older adults' narratives that may be suggestive of risks associated with their alcohol use	Recruitment pathway	Context of participation
Serena (pp01)	78	Female	White British	Christian (Roman Catholic)	Alone	Widowed	Urban	70	Retired	Low deprivation	Former clerical support worker	Frequent	(Missing data)	Reported being unable to stop drinking once started; conveyed discomfort with recent alcohol use Occasional binges (had consumed a full bottle of wine the night before the interview); memory issues; history of heavy alcohol use; use in conjunction with medications that may be negatively affected by drinking (statins, blood pressure medication); high blood pressure; occasionally driving following intake I felt would have taken her beyond lawful limits; social disinhibition through alcohol use causing issues in developing relationships with acquaintances	Pathway 1: Response to advertisement	One-to-one interview
Julia (pp03)	66	Female	White British	Christian (Church of England)	With partner	Married	Urban	100	Retired/volunteer	Low-medium deprivation	Former clerical support worker	Occasional	1 (lower risk)	Use of blood pressure medication	Pathway 1: Response to advertisement	One-to-one interview
Janice (pp07)	71	Female	White British	Atheist	Alone	Divorced	Urban	80 (had a cold)	Retired	Low-medium deprivation	Former professional	Binge	5 (lower risk)	N/A	Pathway 1: Response to advertisement	One-to-one interview
Jenni (pp08)	79	Female	White British	Christian (Church of England)	With partner	Married	Urban	95	Retired/volunteer	Medium deprivation	Former clerical support worker	Frequent	5 (lower risk)	Use of prednisone, Ventolin, antibiotics; diabetes and a number of other medical conditions; history of depression	Pathway 1: Response to advertisement	One-to-one interview
Maya (pp11)	67	Female	Indian	Christian (Church of England)	With partner	Married	Urban	50	Retired/volunteer	Low deprivation	Former associate professional (health)	Occasional	(Missing data)	Daily alcohol use well in excess of weekly guidelines for lower-risk drinking (>40 units/week); history of cardiac arrest; use of atenolol and statins (swallowed with alcohol); participant's wife had expressed concerns about his alcohol intake; history of injury from alcohol use earlier in life	Pathway 1: Response to advertisement	One-to-one interview
Malcolm (pp12)	67	Male	White British	Christian (Unspecified)	With partner	Married	Rural	75	Retired	Medium-high deprivation	Former craft and related trades worker	Frequent	9 (increasing risk)	Intake in excess of guidelines; intake prior to driving that I felt would take him beyond lawful limits (2.5-4pts); infrequent binge	Pathway 4: Snowball recruitment	One-to-one interview
Charlie (pp15)	76	Male	White British	Christian (Unspecified)	With partner	Married	Urban	90	Retired/volunteer	Low-medium deprivation	Former professional	Frequent	8 (increasing risk)		Pathway 1: Response to advertisement	One-to-one interview

Participant ID	Age	Sex	Ethnicity	Religion	Living Situation	Marital Status	Residence Type	Disability	Employment Status	Deprivation Level	Occupation	Alcohol Consumption	Risk Score	Key Health Issues	Recruitment Pathway	Interview Type
Oscar (pp17)	89	Male	White British	Atheist	Alone	Widowed	Urban	80	Retired/volunteer	Low deprivation	Former professional	Frequent	4 (lower risk)	drinking; history of unexplained heart palpitations; history of depression Driving following half a bottle of wine; use concurrent with multiple medications; ongoing experience of memory issues and falls	Pathway 1: Response to advertisement	One-to-one interview
Alice (pp24)	70	Female	White British	Religion unspecified	Alone	Divorced	Rural	80	Retired	Low-medium	Former service and sales worker	Frequent	9 (increasing risk)	Weekly binge drinking; weekly intake above lower-risk guidelines; problems sleeping; alcohol use to cope with mental illness; recent use concurrent with tramadol (lost consciousness); use in conjunction with antidepressants; expressed concerns about effects of alcohol for memory; high blood pressure; intake prior to driving that I felt would exceed lawful limits	Pathway 2: Recruited as member of social group	One-to-one interview
Stanley (pp26)	69	Male	White British	Christian (Protestant)	With partner	Married	Urban	20 (paraplegic)	Semi-retired	Low deprivation	Professional	Frequent	6 (lower risk)	Participant's wife has expressed concerns regarding his alcohol use; paraplegic and associated risks to remaining physical ability	Pathway 2: Recruited as member of social group	One-to-one interview
Nancy (pp27)	66	Female	White British	Religion unspecified	With partner	Long-term partner	Urban	90	Retired	Low deprivation	Former professional	Frequent	8 (increasing risk)	Occasional binge drinking; history of heavy alcohol use; history of risk taking when intoxicated; high blood pressure; obesity	Pathway 3: Response to invitation from GP	One-to-one interview
John (pp32)	66	Male	White British	Christian (Roman Catholic)	Alone (sheltered accommodation)	Divorced	Rural	30	Retired	High deprivation	Former service and sales worker	Frequent	9 (increasing risk)	Twice-weekly binges; consistent use in excess of weekly guidance for lower-risk drinking; use in conjunction with conditions that may be negatively affected by alcohol (type II diabetes, osteoarthritis, high blood pressure); use in conjunction with multiple medications; frequent hospitalisations through acute ill health (at least annually)	Pathway 3: Response to invitation from GP	One-to-one interview
Helen (pp33)	77	Female	White British	Christian (Church of England)	Alone	Widowed	Urban	90	Retired	Medium-high deprivation	Former elementary occupation	Frequent	9 (increasing risk)	Twice-weekly binge drinking; use of steroids for polymyalgia and proton pump inhibitors to prevent stomach irritation	Pathway 3: Response to invitation from GP	One-to-one interview
William (pp37)	80	Male	White British	Christian (Church of England)	Alone	Widowed	Urban	50	Retired	Medium-high deprivation	Former service and sales worker	Frequent	12 (increasing risk)	Weekly binge drinking; frailty; history of reactive use (period of heavy drinking following wife's death); limited mobility; use of painkillers known to be	Pathway 3: Response to invitation from GP	One-to-one interview

															negatively affected by alcohol; use of statins and blood pressure medications		
Denise (pp39)	77	Female	White British	Christian (Church of England)	Alone (sheltered accommodation)	Divorced	Urban	60	Retired	High deprivation	Former elementary occupation	Occasional	6 (lower risk)	Use of medicines that interact with alcohol including gabapentin; multiple chronic conditions (osteoarthritis, asthma, high blood pressure); history of blackouts through use of alcohol in conjunction with medication	Pathway 3: Response to invitation from GP	One-to-one interview	
Valerie (pp14)	88	Female	White British	Christian (Church of England)	Alone	Widowed	Urban	50	Retired	Low deprivation	Former associate professional (health)	Frequent	8 (increasing risk)	History of cardiac arrest; arranges her day to account for decreased motivation following alcohol use after lunch; consumption in excess of lower-risk guidelines	Pathway 1: Response to advertisement	Focus group 1****	
Sheila (pp09)	86	Female	White British	Religion unspecified	Alone	Widowed	Urban	100	Retired/volunteer	Medium-high deprivation	Former professional	Frequent	7 (lower risk)	History of reactive drinking (bottle of wine per night following loss of husband)	Pathway 1: Response to advertisement	Focus group 1****	
Jill (pp13)	87	Female	White British	Christian (Church of England)	With partner	Married	Urban	80	Retired	Low-medium deprivation	Former manager/associate professional	Frequent	6 (lower risk)	Binge drinking in certain contexts; experienced consequences of excess (dizziness, sluggishness, headaches, upset stomach, impaired memory; variable health; memory issues)	Pathway 1: Response to advertisement	Focus group 1****	
Billy (pp20)	77	Male	White British	Christian (Unspecified)	With partner	Married	Rural	90	Retired	Medium deprivation	Former manager	Frequent	8 (increasing risk)	(difficult to discern in focus group setting)	Pathway 2: Recruited as member of social group	Focus group 2*****	
Paul (pp22)	67	Male	White British	Christian (Church of England)	With partner	Married	Urban	75	Retired	Low deprivation	Manager	Occasional	4 (lower risk)	(difficult to discern in focus group setting)	Pathway 2: Recruited as member of social group	Focus group 2*****	
Thomas (pp21)	76	Male	White British	Christian (Church of England)	With partner	Married	Rural	75	Semi-retired	Medium deprivation	Manager	Frequent	9 (increasing risk)	(difficult to discern in focus group setting)	Pathway 2: Recruited as member of social group	Focus group 2*****	
Fred (pp23)	75	Male	White British	Christian (Church of England)	With partner	Married	Urban	70	Semi-retired	Low deprivation	Manager	(Not reported)	13 (increasing risk)	(difficult to discern in focus group setting)	Pathway 2: Recruited as member of social group	Focus group 2*****	
Alan (pp19)	77	Male	White British	Christian (Unspecified)	With partner	Married	Urban	80	Retired	Low-medium deprivation	Former service and sales worker	Occasional	3 (lower risk)	(difficult to discern in focus group setting)	Pathway 2: Recruited as member of social group	Focus group 2*****	
Jack (pp25)	73	Male	White British	Christian (Roman Catholic)	Alone	Widowed	Rural	70	Retired	Medium deprivation	Former professional	Occasional	4 (lower risk)	(difficult to discern in focus group setting)	Pathway 2: Recruited as member of social group	Focus group 2*****	

Table Apx S-2 Demographic, alcohol use, recruitment and participation details of participating care providers

Participant	Profession	Practice area (urban or rural)	Years spent working in care provision	Gender	Age	Ethnicity/ religion	Religion	Self-reported pattern of alcohol use	Context of participation
GP1	GP trainee/ academic GP	Rural	13	Female	39	White British	Religion unspecified	Light	One-to-one interview
GP2	GP	Urban	10	Female	39	White British	Christian (unspecified)	Moderate	One-to-one interview
Ph1	Pharmacist	Urban?	3	Female	26	White British	Religion unspecified	Light	One-to-one interview
Ph2	Pharmacist	Rural?	28	Male	51	White British	Christian (Roman Catholic)	Occasional	One-to-one interview
GP7	GP	Rural	40	Male	64	White British	Religion unspecified	Moderate	One-to-one interview
N3	Nurse	Rural	16	Female	38	White British	Christian (unspecified)	Light	One-to-one interview
DN3	District and practice nurse	Rural	30	Female	48	White British	Religion unspecified	Moderate	One-to-one interview
HCA3	Health care assistant	Rural	15	Female	49	White British	Christian (Roman Catholic)	Light	One-to-one interview
HCA1	Healthcare Assistant	Rural	(not recorded)	Female	57	White British	Christian (unspecified)	Moderate	Focus group 3: General practice team
N1	Nurse	Rural	27	Female	46	White British	Christian (Church of England)	12 units/week	Focus group 3: General practice team
DN1	District Nurse	Rural	17	Female	41	White British	Religion unspecified	Moderate	Focus group 3: General practice team
GP3	GP	Rural	13	Male	37	White British	Jewish	Drinker	Focus group 3: General practice team
GP4	GP	Rural	15	Female	37	White British	Religion unspecified	Moderate	Focus group 3: General practice team
HCA2	Health care assistant	Rural	16	Female	36	White British	Religion unspecified	Very light	Focus group 3: General practice team
DN2	Nurse	Rural	26	Female	46	White British	Christian (Church of England)	Sporadic	Focus group 3: General practice team
GP5	GP	Rural	10	Male	34	White British	Christian (Church of England)	Light	Focus group 3: General practice team
GP6	GP	Rural	13	Female	36	White British	Christian (Church of England)	Occasional	Focus group 3: General practice team

Participant	Profession	Practice area (urban or rural)	Years spent working in care provision	Gender	Age	Ethnicity/ religion	Religion	Self-reported pattern of alcohol use	Context of participation
N2	Nurse	Rural	39	Female	57	White British	Christian (Church of England)	Light	Focus group 3: General practice team
SW1	Social worker (older adult team)	Urban	6	Male	44	Black African	Christian (unspecified)	Very light	Focus group 4: Social worker team
SW2	Social worker (older adult team)	Urban	5	Male	29	White British	Religion unspecified	Moderate	Focus group 4: Social worker team
SW3	Social work team manager (older adult team)	Urban	20	Female	49	White British	Christian (Roman Catholic)	Weekend binge	Focus group 4: Social worker team
SW4	Social worker (older adult team)	Urban	8	Female	35	White British	Religion unspecified	Light	Focus group 4: Social worker team
SW5	Social worker (older adult team)	Urban	5	Male	44	White British	Religion unspecified	Infrequent	Focus group 4: Social worker team
Den1	Dentist	Rural	27	Male	50	White British	Religion unspecified	Social	Focus group 5: Dentist team A
Den2	Dentist	Rural	15	Male	39	White British	Christian (unspecified)	Social	Focus group 5: Dentist team A
Den3	Dentist	Rural	27	Female	51	White British	Religion unspecified	Light	Focus group 5: Dentist team A
Den4	Dentist	Urban	3	Male	25	White British	Religion unspecified	non-drinker	Focus group 6: Dentist team B
Den5	Dentist	Urban	4	Female	24	Black British	Christian (Roman Catholic)	light/social	Focus group 6: Dentist team B
Den6	Dentist	Urban	5	Female	26	White British	Christian (Church of England)	non-drinker	Focus group 6: Dentist team B
Den7	Dentist	Urban	4	Female	25	White British	Christian (unspecified)	non-drinker	Focus group 6: Dentist team B
Den8	Dentist	Urban	4	Female	24	White British; N/A	Religion unspecified	non-drinker	Focus group 6: Dentist team B
Den9	Dentist	Urban	4	Female	24	Black British	Christian (unspecified)	Frequent	Focus group 6: Dentist team B
Den10	Dentist	Urban	6	Female	27	White British; Christian	Christian (unspecified)	Occasional	Focus group 6: Dentist team B

Participant	Profession	Practice area (urban or rural)	Years spent working in care provision	Gender	Age	Ethnicity/ religion	Religion	Self-reported pattern of alcohol use	Context of participation
Car1	Home Care Coordinator	Urban	6	Female	41	White British	Christian (Church of England)	Occasional binge	Focus group 7: Home care team
Car2	Home Carer	Urban	6	Female	27	White British	Religion unspecified	Moderate	Focus group 7: Home care team



## Appendix T - Details of Practice Relevant to Care Providers' Work With Older Care Recipients

Table Apx T- 1 Details of practice relevant to care providers' work with older care recipients, as identified within participating care providers' narratives

Care provider:	How alcohol related discussion is systematised and incorporated within care practice	Level of training regarding alcohol-related health risk and intervention (relative to others in sample)	Notes on professional accountability and perceptions of their role in the care system for addressing non-dependent drinking	Available supportive materials for alcohol-related health risk screening and discussion	Signs indicative of alcohol misuse available to the provider through their practice	Frequency of interactions with individual care recipients	Working exclusively/ predominantly with older adults?
General Practitioners	Not systematised within consultations. Non-dependent alcohol use did border on some issues discussed in consultations, such as managing mental health and bereavement.	High	Practice lists associated with accountability for individual patients; but acknowledge that much intervention is conducted by Allied Health Professionals (practice nurses and health care assistants); with the exception of GP7, who conveyed a sense of individual accountability for his patients.	Varied between providers. GP7 utilised SystemOne screenings, which provided a visual indicator of risks associated with patients' reported alcohol intake, as a tangible indicator of risk from drinking.	Variable. Many available indicators i.e. blood screening results or patient presentation would only indicate very excessive use or alcohol dependence. Access to Alcohol Use Disorders Identification Test (AUDIT) results, but unlikely to evaluate these in consultations. Symptoms discussed in practice that may be caused by alcohol use may not be attributed to alcohol by GPs.	Can be frequent (several times a year) with older patients; but variable.	No
Practice Nurses	Alcohol-related discussion involved in chronic condition reviews/follow up of Alcohol Use Disorders Identification Test (AUDIT) results*.	High	Practice lists associated with accountability for individual patients; recognised role in providing feedback for risky alcohol use.	Alcohol Use Disorders Identification Test (AUDIT) results (generic, not visual)	Alcohol Use Disorders Identification Test (AUDIT) results; other indicators signalling heavy use such as blood screening results and patient presentation.	Can be frequent (several times a year) with older patients; but variable.	No
District Nurses	Not systematised within interactions with patients. But considered in managing falls risk*.	High	Practice lists associated with accountability for individual patients; recognised role in supporting older people to live safely in their home environment, to which feedback about alcohol use was relevant.	N/A	Consultations within patients' home environment – indicators of misuse e.g. bottles available.	Can be frequent (several times a year) with older patients unable to attend practice; but variable.	Yes

Health Care Assistants	Involved in screening for risky alcohol use, but not intervention*.	Low; but developed skills for alcohol-related discussion through systematised screening within their work	Practice lists associated with accountability for individual patients; not accountable for intervention*	Alcohol Use Disorders Identification Test (AUDIT) results (generic, not visual)	Alcohol Use Disorders Identification Test (AUDIT) results; other indicators signalling heavy use such as patient presentation (but not involved in intervention*).	Infrequent – involved in health checks; frequency of which varies between patient (annually if living with a chronic health condition such as diabetes or hypertension).	Yes
Pharmacists	Alcohol represented one of four health-related behaviours discussed in medicine use reviews with patients using high risk medicines, or >4 medicines in combination.	Very high	No patient lists, but both interviewed felt accountable for addressing alcohol use of those visiting the pharmacy regularly or for medicine use reviews.	N/A	Intake discussed, list of medicines, conditions and symptoms that may be effected by alcohol available through consultation.	Annual medicine use reviews with patients using high risk medicines or >4 medicines in combination; plus interactions when dispensing medicines.	Yes
Dentists	Screening for risky drinking using Alcohol Use Disorders Identification Test-C (AUDIT-C) results and very brief advice in assessments; also Denplan Previser Patient Assessment (DEPPA) and very brief advice in private practice.	Low for older practitioners, higher for trainee dentists	Low sense of professional accountability; acknowledged that their alcohol-related discussion was part of a broader system of care providers contributing to assess and address care recipients' alcohol use.	Denplan Previser Patient Assessment (DEPPA) – an oral health risk screening tool that included an assessment of alcohol-related risk to oral health, giving a coloured grading of patients' personal risks of specific diseases given their current behaviour	Care recipient presentation, any signs of alcohol-related disease from oral health exam, Alcohol Use Disorders Identification Test-C (AUDIT-C) results, DEPPA score.	Once or twice a year.	No

Social Care Providers	Screening and discussion involved in mental health assessments (including alcohol use); exploring and addressing care recipients' and their informal care givers' alcohol use when supporting them with mental health and coping.	High	High sense of professional accountability; concerned with their care recipients' (and recipients' informal care givers') overall wellbeing, which alcohol was recognised to affect in both positive and negative ways.	N/A	Care recipients' presentation in home environment; signs available in home environment; mental health assessment (including alcohol use).	Variable – often concentrated periods.	Yes
Domiciliary Care Providers	Not systematised. Involvement in care recipients' alcohol purchase and drinking practices through role in supporting their daily living.	None	Low sense of professional accountability. Flagged concerns for care recipients when alcohol use was perceived to have become problematic; but little scope for any level of intervention beyond suggesting reduced intake. Fundamental role in supporting the older person in continuity of their lifestyle and related choices (which could involve supporting purchase and consumption of alcohol). Through relationship with care recipient, felt a high level of individual responsibility for promoting and monitoring their wellbeing, including how it might be effected by alcohol.	N/A	Care recipients' presentation in home environment; signs available in home environment; involvement in alcohol purchase and drinking practices through role in supporting care recipient's lifestyle.	Weekly or more.	Yes

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*\*Likely varies between practices; recorded as reported by providers participating in this study.*

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