Older Drinkers: Alcohol consumption, drinking context and "successful ageing"

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Introduction

Research on alcohol consumption among older age groups has largely approached the topic from a public health perspective, adopting a biomedical model of ageing which emphasises avoidance, or minimisation, of a range of risk factors, including alcohol consumption, or at least consumption above 'recommended levels'. Psychosocial models, which emphasise social engagement and satisfaction, and lay models, based on older people's own views of successful ageing (Bowling and Dieppe, 2005), are rarely used as conceptual frameworks for examining the role of alcohol use in older age. Equally few studies consider the wider cultural and situational contexts that influence individual drinking patterns and behaviours or examine the perceived benefits of alcohol consumption as well as the risks. This chapter draws on insights from the "successful ageing" literature to consider alcohol consumption in older age and the importance of considering the context of drinking when providing guidance to older people. As discussed below, the concept of "successful ageing" lacks clarity; it is a multi-dimensional concept that generally includes aspects of physical, mental and social functioning which indicate better quality of life in older age (Urtamo *et al*. 2019)

The term "baby boomers" is used to describe individuals born between 1946-1964 and it was estimated that, for this cohort, problems from substance misuse (including drug use) requiring treatment were likely to treble in the US and double in Europe between 2000 and 2020 (Rao and Roche, 2017). This framed drinking in older populations in terms of risks which were consistent with general population trends. In the UK in 2017, men and women 45+ were the highest age band for those drinking five days or more in a typical week (National Statistics, 2018). One suggestion to explain this finding was that heavier drinking patterns in older people have become more entrenched compared to previous generations (Holley-Moore and Beach, 2016), possibly due to greater availability of alcohol and lower cost (Pullianen and Voltonen, 2017). The price of alcohol in the UK has decreased in recent years and by 2019 it was 74% more affordable than in 1987 (NHS Digital, 2019). These trends drew attention to alcohol consumption among older people and led to increasing concern regarding alcohol-related harm in this population group (Royal College of Psychiatrists, 2018). One of the issues debated was the relevance of existing low-risk guidelines on alcohol consumption to older age groups. Most research that considers the impact of alcohol consumption does so in the context of the increased risk of contracting different diseases or adverse consequences. Rehm (2011) states that alcohol is an underlying cause in more than 30 diseases and contributes to many more. The most common conditions where the risks are heightened by increased alcohol consumption are infectious diseases, cancers, neuropsychiatric diseases, cardiovascular disease, liver and pancreas disease and unintentional and intentional injury. Risk ratios associated with these conditions have been used internationally to inform low-risk drinking guidelines, mostly

targeted at adults age 18-65 and not at older drinkers. As we will discuss later, there has been considerable debate regarding the need for guidelines specific to older people.

As we mentioned above, research on older people has tended to look at risks and has paid less attention to lay perceptions of risk and benefits from alcohol consumption. One exception is the English Longitudinal Study of Ageing (ELSA), a cohort study of individuals aged 50 and over, which examines a number of health-related variables including alcohol consumption. A 10-year follow-up study that has used ELSA data (2002-2011) (Holdsworth *et al*., 2016) found that alcohol consumption in older people could be a proxy for a better quality of life and increased social integration. In this study daily consumption fell from (n=4741) in 2002 21.9% of the participants and in 2011 the equvalent figure was 15.6%. Key variables which explained a positive perception of general health over this period were affluence, higher education levels and frequency of drinking rather than a reduction in drinking. Another paper using ELSA data concluded that alcohol consumption, affluence and social class may be associated with "successful ageing" (Iparraguire, 2015). The discussion of successful ageing in this paper was based upon the definition set out by Rowe and Kahn (1987) and this will be discussed in greater depth later in the chapter. A systematic review of qualitative research (Bareham *et al*., 2020) found that many older people saw themselves as controlled and responsible drinkers and that alcohol was integral to their social and leisure activities. Thus, consideration of alcohol consumption in later life needs to take account of other factors such as context and "occasion" in assessing the balance between risk and benefit.

The debate between the balance of risk and benefits conferred by alcohol consumption has tended to ignore the context in which the drinking takes place. Zinberg (1986) in his seminal work concerning the controlled substance use (in his case heroin) postulates that there are three interacting factors that explain controlled substance use. Firstly, the pharmacological makeup of the drug, e.g. whether a sedative or a stimulant; secondly the mindset of the substance user (the set); and finally social/environmental context (the setting). In this chapter we will use findings from one study to illustrate the value of looking at the context of alcohol consumption in older people. In the UK, drinking at home has become more important over recent decades. In 2017 the amount of alcohol sold "on-trade" (in pubs bars and restaurants) was 31%. This was in comparison to 47% in 2000 (British Beer and Pub Association, 2018). Similar trends have been reported in Australia (Callinan *et al*., 2016). Studies conducted by Foster *et al.* (2010) and Foster and Canfield (2017) found that the motivations for drinking at home revolved around cost, convenience and relaxation. Ally *et al*. (2016) suggest there are eight typologies of drinking in the UK, six of these include drinking at home: mixed location heavy drinking, heavy drinking at home with a partner, getting together at someone's house, drinking at home alone, light drinking at home with the family and light drinking at home with a partner. Currently, however, there has been very little research that has considered the context of drinking (in particular drinking at home) in older people.

In this chapter we will present data from an EU funded survey that considered the context of drinking in older people and how it was linked to at-risk drinking. We also tested gender differences by developing models of drinking for men and women using Principal Components Analyses. The study produced some evidence for successful ageing in the the

context of home drinking in family situations. The sections below provide an overview of the international guidelines for low-risk drinking with special reference to those relating to older people, followed by a discussion on the "successful ageing' concept and the case study illustrating the importance of drinking context. Finally, we draw some conclusions pertinent to policy and practice.

Low-Risk Drinking Guidelines

One of the ways in which policy makers attempt to manage alcohol-related risk at a population level is by designing low-risk drinking guidelines specific to their country. These usually relate to a daily or weekly recommendation for what constitutes low-risk drinking levels. Paula *et al*. (2020) have recently reviewed low-risk drinking guidelines across the world, and point out there are a number of difficulties with making international comparisons. The authors examined web-based alcohol policies in 194 countries and found that 58 (29.8%) had low-risk drinking guidelines which were designed around the concept of a standard drink or unit of alcohol and derived from the number of grams of alcohol in a given drink. The majority were in the range of 10-12 grams but there was a wide range, the lowest was 8 grams of alcohol (Republic of Korea, United Kingdom, Bulgaria, Guyana and Mauritius) and the highest was 20 grams of alcohol (Austria). A standard drink in the US is 14 grams of alcohol, and Canada 13.54 grams, others that are 13 grams or above are Serbia (13) and Macedonia (14.2). There are no countries between Macedonia and Austria, and Austria stands as an outlier.

Guidelines are largely aimed at adults 18-65 but there is also guidance aimed at "older adults" or the "elderly" and these will be touched upon shortly. Most of the guidelines (84.5%) make a distinction between genders, with the guidance for men suggesting higher levels of consumption for men than for women. The countries that make no distinction between genders are Albania, Chile, France, Grenada, Guiana, Kazakhstan, the Netherlands, Japan and the United Kingdom. The lack of distinction is justified by UK policy makers on the grounds that although women have long term health risks (in particular breast cancer) men are more likely to face risks from accidents and injuries (Department of Health, 2015). The recommendations are based on different time frames as follows: firstly per day, 86.2% of the countries provided daily recommendations and these ranged from less than 8 grams – Bulgaria and Mauritius – to 60 grams per day (Vietnam). Secondly per week, 46.5% produced weekly recommendations, ranging from 15 grams (China) to 280 grams (Spain, Portugal) of alcohol per week. Finally, "per occasion", ranging from 30 grams (Slovenia, Malta) to 70 grams (United States).

It is recognised that drinking above the low-risk guidelines in those over 65 often declines "naturally", in part because of an increased likelihood of ill health (NHS Digital, 2017) and because of use of prescription drugs (Foster and Patel, 2019). However, there has been considerable pressure to provide guidelines for low-risk drinking specific to older people. In 2011, the Royal College of Psychiatrists (Royal College of Psychiatrists 2011) recommended that the daily low-risk recommended units for individuals in the UK for both men and women over 65 should be 1.5 units per day with two days alcohol free, a recommendation which was repeated in a second report in 2018 (Royal College of Psychiatrists, 2018). This

equates to 7 units per week. The suggestion has not been adopted in the UK as yet. There are ten (19%) countries that have produced guidelines for older people (defined as above 60 or 65). These are Australia, Canada, Croatia, United States, Slovenia, France, Italy, Japan, New Zealand and Romania. Three countries, Canada, United States and New Zealand have different recommendations for men and women, the other seven are identical. Most provide recommendations for a week's drinking and there is a large range from 70-204 grams per week; the US also provides guidance for "an occasion", 28 grams for women and 42 grams for men. Australia, Germany, Denmark, Estonia, Finland and Mauritius do not have guidelines for older people but recommend individuals 65 plus should be cautious about their alcohol consumption or drink less than their recommended adult low-risk levels. Paraguay recommends complete abstinence for men and women who are aged 65 or more.

The concept of providing guidelines for low-risk drinking is a predominantly Western European, American, Canadian, Asian and Australasian one. The only countries that provide guidelines in the African sub-continent are South Africa and Namibia. Mexico and Uruguay are the only countries in Latin America. Where they do exist, there is a great deal of variation, and international comparisons are difficult to make. In the UK there is evidence that there is a lack of understanding of the concept of a unit and that individuals judge risk according their own experience; this was termed "lay-epidemiology (Lovatt *et al*., 2015). Foster and Heyman (2013) examined drinking at home and found that participants have their own perception of risk and developed a number of protective rituals to control their drinking, such as not drinking before a fixed time. However, the tendency was to consider short-term risks, usually relating to intoxication, such as falling over or being sick. In contrast long-term health risks tended to be disregarded. When examining drinking in older people the importance of understanding this as part of their identity and an indication that they are socially active/integrated has to be considered when assessing risk. There has been very little research to date that has looked at the context of drinking when balancing risk and benefits in older people.

Successful ageing

Emerging in the late 1980s (Rowe and Kahn, 1987), the term 'successful ageing' has been defined in various ways and has generated considerable debate regarding what is meant by 'successful ageing' and how it should be measured. To varying degrees, definitions have emphasised biomedical, psychosocial and lay understandings of ageing (Bowling and Dieppe, 2005, Urtamo *et al* 2019) and there has been a spate of related terms such as 'active ageing', 'positive ageing', 'healthy ageing' and 'optimal ageing' (Bülow and Söderqvist, 2014). But, as Wahl *et al.* (2016: p1) argue, "cultural differences in successful ageing dynamics continue to surface, and there is still no robust and culturally invariant measure of successful ageing". A key aspect of the successful ageing debate is the consideration of how to separate definition and measurement of disease from understanding of the ageing process. Doyle *et al.* (2010) suggest that there are two central definitions of successful ageing; the first has a focus on avoidance of disease and associated risk factors, maintenance of high functioning and social engagement; the second definition describes a process of selection, optimization and compensation as people adapt to old age.

These elements of the ageing process are not mutually exclusive and incorporate both subjective and objective understandings of the ageing process (Doyle *et al.,* 2010).

The question of how one achieves successful ageing has sparked examination of a range of risk and protective factors associated with optimal physical, mental and social functioning as individuals grow older. Numerous publications examine different factors, often looking for predictors of successful ageing in the lifestyles of middle-aged people (e.g. dietary patterns, examined by Milte and McNaughton, 2016) or consideration of how older people can preserve successful functioning for longer (e.g. through physical activity, Menai *et al.,* 2017; Kelly *et al.*, 2016). Healthy lifestyles are rarely clearly defined, but generally the indicators used are physical exercise, diet, smoking (with 'yes' being a risk factor) and alcohol consumption (again, often viewed as a risk factor). The results of such studies tend to generate very similar conclusions. One review of primary studies found consistent evidence of beneficial associations between mid-life physical activity, healthy ageing and disease outcomes. The same review reported consistent evidence that mid-life smoking has a detrimental effect on health, mixed evidence regarding alcohol consumption, limited (but supportive) evidence relating to mid-life diet, leisure and social activities or health inequalities (Lafortune *et al.,* 2016).

Given the lack of clear evidence regarding the role of alcohol consumption in the lifestyles of older people, and whether this may or may not be linked with successful ageing, the wider debate and critiques of the concept become particularly relevant. It has been argued that the emergence of the concept reflected political concerns about the burdens posed by an ageing population and shifted the emphasis from social responsibility to individual responsibility for maintaining optimum functioning into old age (Bulow and Soderqvist 2014). The parallel shift from treatment to prevention expanded the role of medicine and medical scrutiny over everyday life, and along with this trend, knowledge about predictive factors and risk provided tools for individuals to self-monitor health behaviour as well as tools for health practitioners working with older people (arguments summarised in Bülow and Söderqvist, 2014). As Bülow and Söderqvist (2014: p142) noted, ".. conceptual frameworks like 'active ageing' and new formulations of 'productive ageing' were becoming increasingly popular, emphasising activity and productivity as a norm that the elder populace should strive to attain". Thus, the new conceptualisations, while offering the possibility of modifiable lifestyles to enhance longer term functionality in old age, also risked placing responsibility for its achievement – and blame for failure - on the individual and ignoring the extrinsic factors that impact on individual choices and behaviours.

As stated above, research on alcohol consumption among older people has largely approached the topic from a public health lens. It tends to adopt a biomedical model of ageing, focussing on avoidance, or minimisation, of a variety of risk factors, including drinking alcohol above 'recommended levels'. Psychosocial models, which focus on social engagement and satisfaction, and lay models, premised on older people's own views of successful ageing, are rarely used as conceptual frameworks for investigating the role of alcohol use in older age (see Bowling and Dieppe 2005, for further discussion of these models). Moreover, the wider cultural and situational contexts that influence individual drinking patterns and behaviours are rarely explored. One exception is a study by Feng *et al.* (2015). They looked at the prevalence and correlates of successful ageing in a comparative

study of community dwelling older people in China (n=15,191, 47% female) and South Korea (n=4,155, 58% female). Alcohol consumption was one of the variables considered. The authors found that, in both countries, alcohol consumption promoted successful ageing, a result they described as "not surprising" because alcohol consumption is, " .. a sociocultural ritual, whereby social connections or the so-called *Guanxi* are built, maintained, and strengthened. Therefore, alcohol-drinking behaviour of an elder is possibly an indication of maintenance of social network, which is highly associated with a better health of late life" (Feng *et al.,* 2015: p92). The case study below provides an illustration of the links between alcohol consumption, context of drinking and lifestyle from the perspective of a sample of older people in the United Kingdom.

A case study – Alcohol and Successful Ageing.

As part of a larger EU funded study (Moskalewicz *et al*. 2016), individuals aged 50-80+, resident in the UK, were surveyed to collect information on alcohol consumption, perceptions of related harms and lifestyle issues. The survey was conducted between February and May 2015. A 'dialer system', using landline telephone numbers and a call algorithm to ensure that phone numbers were selected randomly, was used to generate a sample of 1,087 participants (Note 1 – details of samplng). Data collected included demographic details, alcohol consumption and perceptions of alcohol-related harm, perceived health status, and information about personal relationships and drinking contexts (see Note 2 below). The data analysis is presented in Note 3.

The survey sample represents a cross section of older adults living in the community, who, according to their responses, might be considered as individuals who have aged successfully, the majority of whom were consuming alcohol as part of their lifestyle. This was sample that felt their physical health was good or very good relationships with others and very few alcohol-related problems. Descriptive data is initially presented and then the relationships between age, gender, social class, perceived physical health, alcohol related context relationships and alcohol consumption were tested. Thereafter in order to investigate the relationships between gender and drinking relationships and drinking context variables were investigated by Principal Components analyses.

Table 1 provides details of the survey respondents. The sample included 513 males and 573 females between the age of 50 and 80+. This was a sample that felt their physical health was good; they reported good or very good relationships with others and very few alcohol-related problems. The main strength of this sampling technique is that it was a random sample of individuals aged 50 or more and weights were applied to provide a reflection of the age and gender distribution of the UK population. To our knowledge this is the first attempt to investigate domestic drinking in this age group. Individuals were selected using landlines and up to seven attempts were made to contact them at different times of the day. Whilst the majority of households still have a landline, an increasing number use a mobile phones. The use of landlines rather than mobile phones may also have meant that individuals who were working could be under-represented in this sample.

Table 1. Sociodemographic characteristics of the sample (n=1,087).

Variable	Number	%
Gender (Weighted) (n=1086)		
Male	513	47.2
Female	573	52.7
Age (n=1085)		
50-55	209	19.3
56-59	181	16.7
60-64	162	14.9
65-69	166	15.3
70-74	125	11.5
75-79	99	9.2
80 or more	143	13.2
Living Status (n=1081)		
Married/Living Together	602	55.4
Married but Living Apart	14	1.3
Widowed	191	17.6
Divorced	139	12.8
Never Married/Partnerships	135	12.4
Living Alone: (n=374)	374	100
Social Class (n= 650)		
Unskilled Manual Worker	93	11.4
Skilled Manual Worker	153	18.9
Manager/Supervisor/Other White Collar	111	13.7
Professional- eg lawyer	223	27.6
Business Person/Proprietor	70	8.6
Physical Health (**n=1083**)		
Very Good	292	27.0
Good	435	40.1
Fair	253	23.3
Bad	85	7.9
Very Bad	17	1.6
Relationship with Others (n= 1007)		
Very Good/Good	1,006	92.6
Fair	59	5.4
Very Bad/Bad	12	1.2
RAPS		
Feeling Guilty (n=837)	61	7.2
Blackouts (n=836)	54	6.4
Failing to do what was normally expected (n=835)	21	2.5
Taking a drink in the morning (n=832)	15	< 1

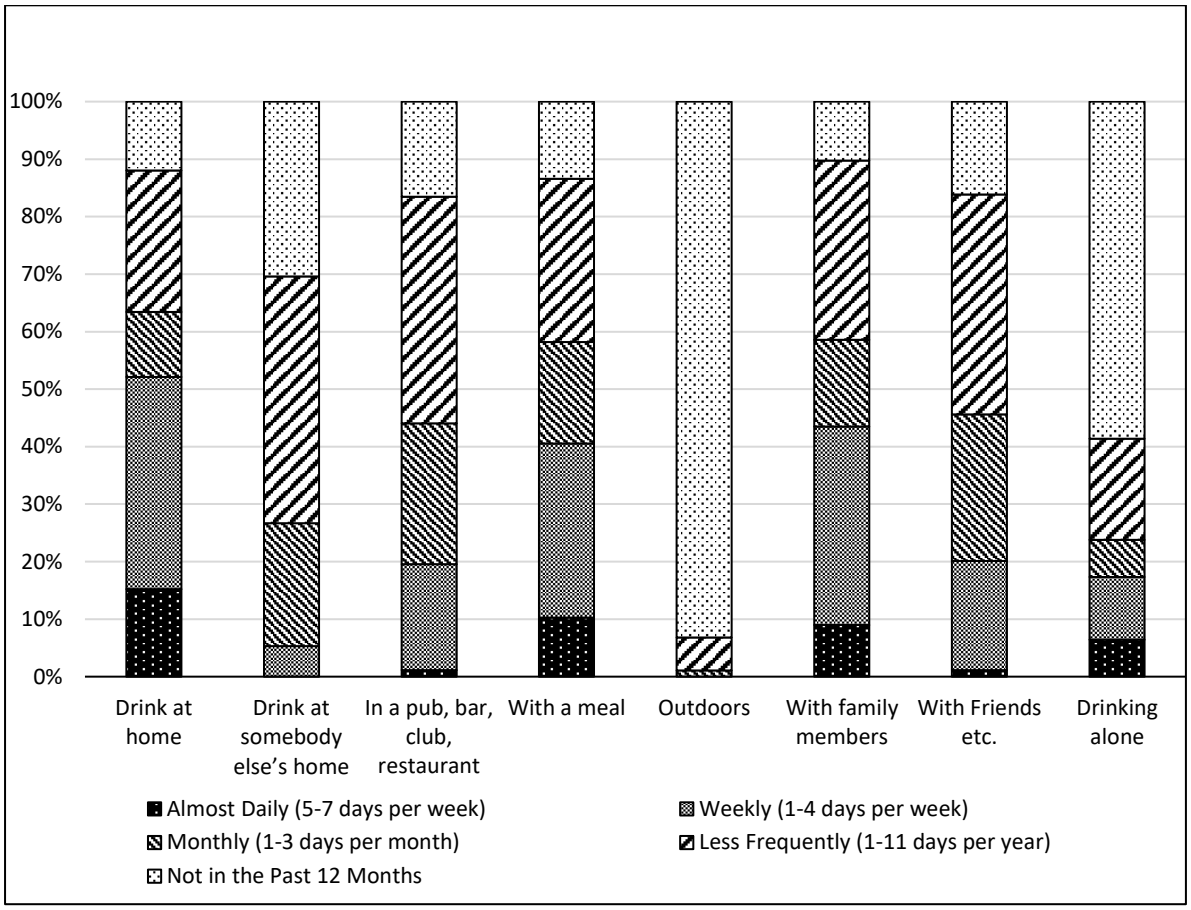
Alcohol consumption was grouped into four categories on the basis of units of alcohol consumed per week. Non-drinkers (n=198, 18.6%) were excluded from analysis. There were 282 (26.6%) drinking within the weekly recommended allowance; 408 (38.4%) were hazardous drinkers (at- risk) and 173 (16.3%) harmful drinkers (high-risk). Hazardous and harmful drinkers[1] were grouped together to form an "at-risk" drinkers'

[1] A hazardous drinker is one who reports a pattern of weekly drinking that increases the risk of physical or mental health (>15 - <34 units for females and >22 units- 49 units for males). A harmful drinkers reports a pattern of weekly drinking that is already causing mental or physical damage. (≥ 35 units for females), > 50 units for males). The survey was conducted prior to the changes to the guidelines in 2016

category, equating to 54.7% of the total sample. Males were more likely to be at-risk drinkers (Chi-Square = 32.69, df=2, $p < 0.001$) and unskilled workers were less likely to be at-risk drinkers than firstly, managers/supervisors/other white collar workers, secondly, Professionals and thirdly Business Persons/Proprietors (Chi-Square = 29.71, df=10, $p = 0.001$). Differences between age bands and at-risk drinking were not significant (Two-tailed Chi-Square Test) (Chi Square = 8.68, df=12, $p=0.729$). Based on the Rapid Alcohol Problems Screen (RAPS) measure (Cherpital, 2000), very few people reported experiencing alcohol-related harm. The variables included in the RAPS are shown in Table 1.

Drinking Contexts and Relationships were divided into "context" and "relationships" (see Note 2). Non-drinkers and those who answered "does not apply" (n=83, 8.8%) to the context and relationship questions were removed from the analysis. The data includes 863 participants (81.3% of the total) and the results are shown in Figure 1. Drinking at home (daily or weekly) was the most frequent response. This was followed by drinking with a meal. The third most frequent context was drinking in a pub or bar, club or restaurant. Drinking in someone else's home and drinking outdoors were both infrequent. The most frequent "relationship" category of drinking with was family members (including partner). The next most common mode of relationship was with friends, colleagues and acquaintances. Finally, the least common was drinking alone (Figure 1), and over half of the sample had not drank alone in the past 12 months. The findings are consistent with Ally *et al*. (2016) who found that drinking alone at home was generally associated with low-risk drinking; it was linked to having an opportunity to wind down, time alone on a quiet night in or to end an evening.

Figure 1. Frequency of drinking contexts and relationships (n=863)



Relationship between drinking context/ relationships and gender, age, perceived physical health and social class.

The association between drinking contexts and relationship with other people was not investigated as over 90% of the respondents described these as very good. Telephone interviews have been shown to be an effective way of collecting data but research has that compared to face to face interviews revealed that there is a predisposition towards social desirability response bias (Holbrook *et al* 2003), that is, the tendency to underreport unfavourable issues and present yourself in a positive manner (Latkin et al 2017).

Differences in the context and relationship data for males and females and occupational class were tested. Males were more likely to drink at home ($p=0.003$) and in a pub, bar and restaurant (≤ 0.001) on a daily or weekly basis. There was no gender difference in the likelihood of drinking alcohol with meals ($p=0.143$). Unskilled and skilled manual workers were less likely to drink in all three drinking contexts (daily or weekly) than white collar workers, professionals, managers/supervisors and businesspersons ($p \leq 0.003$). Greater frequency of drinking daily or weekly at home, in a pub, bar or restaurant or with a meal were all positively associated with (perceived) physical health status ($p \leq 0.001$).

Males were more likely to drink with family members (p=0.011), friends and acquaintances (≤ 0.001) and alone (p=0.005) on a daily or weekly basis. White collar workers, professionals, managers/supervisors and businesspeople of both genders were more likely to drink daily or weekly with family members and friends, colleagues and acquaintances than skilled or unskilled manual workers ($p < 0.001$). There was not a significant association between social class and living alone (p=0.647), meaning that living alone or social class were not related to frequency of drinking.

Daily or weekly drinking with family members, and with friends and acquaintances was positively related to perceived good physical health ($p \leq 0.001$). Drinking alone was not related to self-reported health status (p=0.059).

A drinking context hierarchy emerged with respect to greater frequency of alcohol consumption (in descending order): a) at home, b) with meals and c) at pubs, bars and restaurants. There was also a drinking relationships hierarchy. Drinking was more frequent with family members, and then friends. Most of the sample had not drank alone in the past year.

Factors influencing drinking behaviour: Gender Differences

To explore further the factors driving drinking behaviours, a Principal Components Analysis was conducted on the context and relationship variables (Table 2). Context variables centre on drinking at home, someone else's home, in a pub bar or restaurants, with a meal or drinking outside. Relationship variables concern drinking with family members, friends or alone. The analysis showed a strong overlap between the context and relationship variables, making it difficult to disentangle specific effects, such as whether gender, social class or health status are driving what are largely positive outcomes. In what follows we examine whether there are gender differences in the context in which drinking takes place that may provide further opportunities for social integration and more positive outcomes in older drinkers. This is tested by the construction of a Principal Components Analyses which will separate the opportunities for drinking into sub-categories know as factors. In what follows the term variance is used. This is best considered as the extent to which the individual and combined factors explain the concept being examined, in this case drinking contexts and relationships in older people.

For both genders drinking in social situations was a driver of consumption but there were differences for men and women. Men were more likely to be at-risk drinkers and the context variables suggest their drinking contexts are more varied than women. Table 2 shows the results for both genders: males (n=366, 43.4%), females (n=477, 56.6%). Three components emerged for males. Component one was "drinking in all social contexts and relationships" which explained 43.2% of the variance. Component two was "drinking at home alone" (22.6% of the variance). Component three was "drinking alone and with others in social contexts" (explained 17.2% of the variance).[2] In total, these three components

[2] ~~The relevant statistics for the three components are: Males: Component 1: (χ^2 = 242.11, p ≤ 0.001) (OR= 0.0223, 95% CI 0.0092- 0.0537). Component 2: (χ^2 = 8.44, p = 0.004) (OR=~~

explained 83.0% of the variance which is best understood as explaining 83% drinking contexts and relationships in men 50+ in this sample. These findings indicate that men over 50 drink in social and domestic contexts both in groups and alone.

The model for females suggested two components. Component one was "drinking in all social contexts and relationships" (53.2% of the variance). Component two provided a contrast between drinking alone and drinking in social spaces. We have called this "drinking alone at home" (17.2% of the variance). The two components for women explained 70.4% of the total variance which is best recognised as explaining 70.4% drinking contexts and relationships in women 50+ in this sample. From these findings we can conclude that similarly to men, women drink in social and domestic settings but are unlikely to drink alone in social settings. Briefly, what conclusions can we draw about older women's drinking from these results?

The variances for both genders are good, as several factors underpinning drinking contexts and relationships are explained by the variables used in this study. However,the above analyses of variances indicate that when considering the context of drinking, further explanations for factors influencing drinking in women aged 50 or more need to be investigated.

Table 2: Principal Components Analysis of Context and Relationship Variables.

	Men (n=366)			Women (n=477)	
	Factor 1	Factor 2	Factor 3	Factor 1	Factor 2
How often do you drink with family members?	0.729	(-) 0.087	(-) 0.535	0.792	(-) 0.084
How often do you drink with a meal?	0.742	0.226	(-) 0.256	0.833	0.050
How often do you drink at home?	0.707	0.576	(-) 0.111	0.853	0.338
How often do you drink with friends etc?	0.697	(-) 0.500	0.331	0.716	(-) 0.353
How often do you drink in a pub, bar or restaurant?	0.674	(-) 0.512	0.379	0.664	(-) 0.500
How often do you drink alone?	0.268	0.676	0.643	0.437	0.733

As we modeled for males and females separately, the weightings to compensate for the gender sampling disparity were removed.

Successful ageing among survey respondents

This case study suggests that alcohol plays a key role for many people in the 50-80+ age groups. Despite over half of the sample reporting drinking at a level where they may be compromising their physical or mental health, responses suggested that the majority were "ageing successfully". Few reported alcohol-related harms, most were very happy with their relationships and drank in contexts where others were present. The case study is limited in that it may be biased towards a healthier group of people, missing those who were experiencing more severe alcohol-related harms. Nevertheless, the results are consistent with the ELSA study that examined the concept of "successful ageing" in the context of alcohol consumption in older people. That study also found that 'risk' drinking

~~0.5399, 95% CI 0.3469- 0.8404). Component 3 (Chi-Square = χ^2, p = 0.004) OR= 0.5162, 95% CI 0.3220-(0.8273). Females: Component 1: (χ^2 = 454.92, p $\leq$ 0.001) (OR=0.0093, 95% CI 0.0038- 0.0229). Component 2: (χ^2= 28.85, p $\leq$ 0.001) (OR= 0.3228, 95% CI 0.2010-0.5183).~~

was associated with greater affluence and that alcohol consumption is linked to social interaction (Iparraguire, 2015; Holdsworth *et al*., 2016). Similarly, research by Feng *et al.* (2015), looking at totally different cultural contexts, indicated that alcohol consumption was a part of greater social interaction in older age and linked to good health. Thus, the case study findings provide some support for an association between alcohol consumption, greater social interaction, and the successful ageing hypotheses, although it would be necessary to track health status over time to confirm longer term effects, especially among those drinking at higher levels. It is also noteworthy that there were significant gender differences in the drinking contexts and relationship variables. Men had more drinking contexts than women, domestic contexts seem to play a greater role for women.

Embedding successful ageing into alcohol policy and practice

The first *Our invisible addicts* report (Royal College of Psychiatrists, 2011) focused largely on the risks presented by alcohol for older people, the second edition acknowledged the role alcohol played in encouraging social cohesion in older people (Royal College of Psychiatrists, 2018) – indicating a possible shift towards a more nuanced understanding of alcohol consumption in older age. The recommendation to adopt low-risk guidelines for older people, suggested in the 2011 report, was repeated in 2018, but with the added acknowledgement that there needs to be some recognition of the balance between risk and benefit and the role that alcohol plays in "encouraging social cohesion" in older people (Royal College of Psychiatrists, 2018, p9). Whilst the Royal College of Psychiatrists recommendations have not been adopted in the UK, in Canada and elsewhere (see above, "low risk drinking guidelines") there are separate suggested limits for older adults.

It is worth considering some of the reasons for this decision in Canada (Here to Help, 2012). Although there is some acknowledgement of the benefits provided by alcohol in terms of socializing, relaxing and celebrating, the main emphasis is upon risk and on the greater health impact of alcohol as a result of the ageing process which means the body struggles to break down alcohol. A number of conditions and consequences are then outlined where this is particularly relevant; these include high blood pressure, memory loss, mood disorders, diabetes, digestive problems, loss of appetite, osteoporosis, stroke and an increased likelihood of falling. The interaction with prescription and over the counter drugs is also discussed in terms of increasing the sedative effects of alcohol resulting in drowsiness and reduced motor-coordination. This document concludes with the possibility that drinking patterns can change as a result of life events associated with the ageing process such as bereavement and loss of structure following retirement; situations of 'loss' which may be filled through increased drinking.

On the other hand, there are drinking contexts which, research suggests, provide benefits for older people; one of these is the pub. A recent report from Loughborough University and Campaign for Real Ale (CAMRA) (Thurnell-Read 2021) has considered the role the pub plays in combatting loneliness and providing different opportunities for social interaction. Older people interviewed for the study stated that, for them, the pub was not about consuming alcohol and often it was an opportunity to have teas and coffees and a meal out which may or may not be accompanied by alcohol. Similar conclusions regarding the importance of pubs and churches for successful ageing were drawn in a study of Spanish

older people which found that these contexts were important for maintaining peripheral relations outside the family, with pub attendance being the most important variable for maintenance of social support of peripheral network members (Buz *et al*., 2014). As our case study showed, drinking in home contexts with significant others may be an important aspect of successful ageing at least for some older people. Maintenance of social interaction in different contexts has been emphasized in the literature on successful ageing, and alcohol consumption is frequently a part of social occasions, possibly, as one study from the USA suggests, providing older adults with a sense of continuity from before retirement and preserving their sense of identity and autonomy (Burruss *et al*., 2014). This may be especially valuable for people in sheltered, care or congregate living contexts – as was the case in the USA study.

However, in contexts where older people live in residential care arrangements, the balance between risks and benefits is more likely to come under the scrutiny of individuals and authorities. These will have an impact upon the older people themselves and their family or close others. Care homes, for example, are a context in which alcohol may – or may not - be consumed and where the rules may differ from one place to another. In such settings there are issues of power and control; older residents may not be in an autonomous position to make decisions about their alcohol use as this may be dependent upon the policies of the care home or residential facility. Ibrahim and Davis (2013) talk about the "dignity of risk" which means that residents should be able to make their own choices even though this could result in possible negative health outcomes. What is essentially an ethical debate has long roots in the literature around risk assessment and older people. According to Norman (1980, cited in Herring and Thom, 1997) stereotypes of the frail, vulnerable elderly have been used to infantilize and patronize older people and to prevent them from making choices about their lives. Labelling vulnerable people as "at risk" is a rationale which allows others to exercise control. There is a sparse research base in this area but ironically older studies (Chein, *et al*., 1973, Mishara, *et al*., 1975) saw alcohol having a positive effect on the residents' health, functioning and socialization. Whereas some more recent studies tend to emphasis the negative effects of alcohol and conceptualise consumption in terms of risk. (e.g White, *et al*., 2015). There has been some recent work in care homes (wet care homes) where the residents are people who have identified alcohol problems and are able to drink safely in this setting. These focus upon the balance between autonomy and risk. McCann *et al*. (2017), in a study of older people in a "wet care home", found that residents valued being able to drink but there were also concerns with how this could be managed on the part of the care home staff so that less harmful drinking was encouraged especially for residents who were on medication. More generally, staff working with older people in both residential facilities and in care services in the community (Herring and Thom, 1997) and acute hospital services (Maclean, *et al*., 2020) do face dilemmas regarding how to apply rules of the residential facility or care service provider. Where these exist, the concerns are how to individualise their approach to alcohol consumption in a way that respects older adult rights but tries to minimise harm, and how to approach discussions on drinking with older people.

Thus, when considering *alcohol* consumption in older groups, policy makers need to have a greater understanding of the context in which drinking takes place and to acknowledge the balance between the positive benefits provided by alcohol consumption and the health

risks. Respect for individual rights and the dignity of older adults, including those in care or in residential facilities, should be at the forefront of policy and practice concerned with successful ageing and embedded in national and local policies, in service development and delivery procedures. At the same time, the possible dilemmas faced by staff working with older people need to be addressed and appropriate forms of support put in place to ensure that 'good practice' does not result in a rigid 'one size fits all' approach. While accepting that for some older people in some circumstances it may be right to refuse or control alcohol consumption, successful ageing, throughout the later years of a person's life requires flexibility to take account of the individual's own views, personal circumstances and the drinking context.

NOTES

1. Sampling:
   A survey RARHA-SEAS was conducted as part of the study 'Reducing Alcohol Related Harm' (RARHA) that considered alcohol consumption, physical health, personal relationships, the context of drinking (e.g. at home or pub/restaurant) and who people are drinking with. The UK arm of this study oversampled individuals who were aged 50-80+. A random sampling method was employed which utilised a telephone call alogorithm using landline telephone numbers. The random sampling means that claims can be made for representativeness. Further details of the sampling can be found in the RARHA report. (Moskalewicz., Room R and Thom B. 2016). Ethical approval for the study was given by the Middlesex University Health and Education Ethics Sub-committee.

2. Measures:
   Socio Demographic Measures: Gender and age (both weighted), and social class were collected.
   Social Class was computed by comparing the variables relating to current or previous type of employment, and occupational status of individuals who were not working. Non-replies or "does not apply" responses were excluded for both variables.
   Alcohol Consumption: Participants were asked how often they drank beers, wines, spirits and "other drinks" over the last 12 months. This was then converted into a figure of units/grams of alcohol consumed over the past year. If an individual had not drunk in the past 12-months they were deemed to be a non-drinker and excluded from the analysis. The other three categories were: Not 'at risk', as they corresponded to the UK weekly recommended limits then in operation – those drinking within weekly recommended allowance at the time the survey was conducted ($\leq$ 14 units for females, $\leq$ 21 units for males). Two categories of "At – risk" drinkers were a) hazardous drinkers, reporting a pattern of drinking that increases the risk of physical or mental harm ($\geq$ 15 - $\leq$ 34 units for females) ($\geq$ 22 - $\leq$ 49 units for males) and b) harmful drinkers, individuals who are drinking at a level already causing mental and/ or physical damage ($\geq$35 units for females) ($\geq$ 50 units for males) [2]. Hazardous and harmful drinkers were combined to form an "at-risk" drinking category.
   Perceived Health Status**:** This was assessed by asking participants to rate their health in general as Very Good to Very Bad on a scale of 1 to 5 (lower scores indicated better health status).
   Alcohol-Related Harm**:** This was assessed by the Rapid Alcohol Screen (RAPS) (Cherpital 2000) measure. The individual was asked to reflect on their drinking over the past 12 months and answer yes or no as to whether any of the following had happened: a) felt guilt or remorse due to your drinking, b) had a blackout as a result of your drinking, c) been unable to do what was normally expected of you because of your drinking and d) taking a drink in the morning. The range of scores is 0-4. An individual was regarded as RAPS positive if s/he replied positively to one item.
   Personal Relationships: Participants were asked to rate their relationships with family, friends and other colleagues using the same principles outlined for assessing perceived health status.

Drinking Contexts and Relationships: These were both assessed on the following frequency categories within the past year: a) (almost daily): 5-7 days a week; b) (weekly): 1-4 days per week; c) (monthly): 1-3 days per month; d) (less frequently): 1-11 days per year, and e) not in the past 12 months. The context questions were drinking with meals, and where you drank (e.g. in a home or a pub/restaurant). Drinking relationships asked with whom an individual drank with, such as family members, friends, or if they drank alone. For both the context and drinking relationships questions an individual could reply to multiple categories

3. *Data Analysis*

Initially descriptive data were presented, thereafter the relationships between age, gender, social class and perceived physical health, alcohol-related context/relationships and alcohol consumption were tested using χ^2 tests or where appropriate Fishers's exact test. Acceptable probability was at the $p \leq 0.05$ level. In order to provide a between-gender stable model a series of principal component analyses were computed to investigate the relationship between the drinking relationships and drinking context variables, χ^2 statistics, p values and ORs for ordinal predictors (treated as numeric within the models) were presented to show the stability of the emerging factors.

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