

Managing older people's perceptions of alcohol-related risk:

a qualitative exploration in Northern English primary care

Abstract

Background

Risk of harm from drinking increases with age as alcohol affects health conditions and medications that are common in later life. Different types of information and experiences affect older people's perceptions of alcohol's effects, which must be navigated when supporting healthier decisions on alcohol consumption.

Aim

To explore how older people understand the effects of alcohol on their health; and how these perspectives are navigated in supportive discussions in primary care to promote healthier alcohol use.

Design and setting

A qualitative study consisting of semi-structured interviews and focus groups with older, non-dependent drinkers and primary care practitioners in Northern England.

Method

A total of 24 older adults aged ≥ 65 years and 35 primary care practitioners participated in interviews and focus groups. Data were analysed thematically, applying principles of constant comparison.

Results

Older adults were motivated to make changes to their alcohol use when they experienced symptoms, and if they felt that limiting consumption would enable them to maintain their quality of life. The results of alcohol-related screening were useful in providing insights into potential effects for individuals. Primary care practitioners motivated older people to make healthier decisions by highlighting individual risks of drinking, and potential gains of limiting intake.

Conclusion

Later life is a time when older people may be open to making changes to their alcohol use, particularly when suggested by practitioners. Older people can struggle to recognise potential risks or perceive little gain in acting on perceived risks. Such perceptions may be challenging to navigate in supportive discussions.

Keywords

ageing; alcohol consumption; harm reduction; patient perspective; primary health care.

INTRODUCTION

Alcohol use is a leading modifiable risk factor for illness and premature death.¹ Older adults are at increased risk of harm from drinking at levels that may have been inconsequential earlier in life. Physiological tolerance of alcohol decreases with age,^{2,3} and older people are more likely to have medical conditions or take medications that are adversely affected by alcohol.⁴ Older people in the UK experience more harm resulting from alcohol use than any other age group.^{5,6} Increasing numbers of older people drink alcohol at hazardous levels, where use could lead to physiological, psychological, or social harm.^{7,8}

Primary care practitioners' advice is important to inform older people's decisions about drinking, raising awareness of potential effects on health.⁹⁻¹⁴ Promoting healthier lifestyles and preventing disease are key activities in primary care.¹⁵ Screening and brief intervention to address hazardous alcohol use are integrated within primary care services,^{14,16} using specific screening tools to identify risks associated with patients' drinking.¹⁷ Alcohol-related discussion is involved in managing chronic health conditions within primary care. This work is important in the care of older patients where health status and medicine use determine hazardous levels of intake, and personalised assessment of health risks is crucial.¹⁸ Age-specific screening tools, such as the Alcohol-Related Problems Survey and the Comorbidity Alcohol Risk

Evaluation Tool, have been developed for use in primary care to inform tailored advice and are sensitive to individual risks associated with drinking that are common among older people.^{19,20}

Efforts to address hazardous drinking focus on highlighting associated health risks, and providing guidance for low-risk use.²¹ Older people's perspectives of the effects of alcohol on their health are complex, encompassing lay perceptions of protective effects of alcohol, in addition to messages conveyed by practitioners and the media regarding health risks.^{22,23} Experiences of health consequences from alcohol use influence older people's decisions to reduce intake.^{22,24} Contributions to wider wellbeing through roles in socialising, relaxing, and coping with stressors also influence their decisions for drinking.²²

Older people have maintained levels of hazardous drinking in recent years, while the rest of the population have reduced their intake. This suggests public health campaigns and efforts in clinical practice to promote healthier alcohol use have been ineffective in older age groups.²⁵⁻²⁸ To ensure future practice is responsive to the realities of older people's decisions about drinking, a good understanding is required of their perceptions of alcohol's effects on their health, and how these perspectives influence alcohol use. This study focused on understanding perspectives of older drinkers without alcohol dependence. The majority of people who experience harm

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How this fits in

Different types of information and experiences affect older people's perceptions of alcohol's effects and their decisions for alcohol use. This study suggests that older people may struggle to recognise risks associated with drinking, unless ill health or screening results indicate that they may be experiencing alcohol-related harm. Older people's perceptions that their drinking is 'sensible', or where their health has become difficult for them to manage, are challenges to be navigated in supporting healthier decisions. Primary care practitioners can help older people to recognise individual risks and the potential benefits of making healthier drinking decisions to maintain their quality of life.

from alcohol use are non-dependent drinkers,²⁹ and their decisions are not dominated by physical dependence on alcohol.³⁰ Older adults' views on how alcohol affects their health can be understood through qualitative research. Primary care practitioners can provide insights into how these perspectives affect older people's responses to alcohol-related discussions on risk management and behaviour change. This qualitative study drew on both older people's and primary care practitioners' perspectives to examine the following questions:

- How do older people understand the effects of alcohol for their health?
- How does their understanding contribute to decisions for alcohol use? and
- How are older people's perspectives of alcohol's effects on their health navigated in primary care discussions to promote healthier use?

METHOD

Sampling and recruitment

A total of 24 older adults aged ≥ 65 years, who currently, or had previously, used alcohol, and 35 primary care practitioners were recruited from Northern England.

Older adults with possible or historical alcohol dependence, where they indicated a history of treatment for alcohol use, or scored >20 when screened using the Alcohol Use Disorder Identification Test (AUDIT,³¹ used in primary care to flag possible dependence) were excluded.

Older adults were recruited via advertisements in newsletters, recruitment presentations at social groups, and invitations disseminated via general practices. Those interested in participating were asked to provide the following data known to influence alcohol use¹⁶ for maximum-variation sampling:

- age;
- sex;
- self-reported pattern of alcohol use;
- socioeconomic status (Index of Multiple Deprivation,³² and last occupation);
- self-rated health;
- living circumstances (alone/with others; rural/urban);
- ethnicity;
- religion; and
- work status.

Practitioners were recruited through invitations circulated via the North East and North Cumbria Clinical Research Network, and flyers distributed on social media. Practitioners were sampled purposively to consult individuals from a range of professions working to address older adults' alcohol use, including GPs, district and practice nurses, healthcare assistants, pharmacists, dentists, social care practitioners, and domiciliary carers.

Older members of the public were involved in developing an acceptable and effective recruitment strategy and study materials.

Box 1. Overview of questions used in discussion with older adults and primary care providers

Older adults

- How would you describe your drinking? (Participants typically began by providing a label for how they used alcohol, for example, 'moderate'. They were then probed in response to gain details of what was consumed, amounts consumed, frequency, and contexts in which consumed.)
- 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 affect 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?

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 affects whether you give advice to your older patients about their drinking?

Table 1. Characteristics of primary care practitioners, N = 35

Characteristic	n
Occupation	
GP	7
Practice nurse	3
District nurse	3
Healthcare assistant	3
Social care practitioner	5
Domiciliary care provider	2
Dentist	10
Pharmacist	2
Sex	
Female	25
Male	10
Age, years	
20–29	10
30–39	10
40–49	9
50–59	5
≥60	1
Ethnicity	
White British	32
Black African	1
Black British	2
Religion	
Christian (unspecified)	8
Christian (Roman Catholic)	4
Christian (Church of England)	7
Jewish	1
Unspecified	15
Self-reported drinking status	
Non-drinker	4
Lower-level drinker	19
Moderate drinker	11
Binge drinker	1
Time working in care provision, years (where reported)	
0–5	9
6–10	7
11–15	6
16–20	3
21–25	1
26–30	6
31–35	0
36–40	2
Practice location	
Rural	17
Urban	18
Practice area deprivation (IMD)^a	
Less deprived	17
More deprived	18

^a 1–5 = less deprived; 6–10 = more deprived. IMD = Indices of Multiple Deprivation³²

Data collection

Qualitative data were collected using in-depth, semi-structured interviews and focus groups from March to December 2017. Interviews were face-to-face, or by telephone if preferred, and audio-recorded and transcribed verbatim. Topic

guides shaped discussion (see overview in Box 1), and were designed alongside older members of the public to address gaps in the existing qualitative literature regarding late-life alcohol use.^{16,22} Guides were amended across data collection to examine emerging issues. Older adults completed a timeline of how their drinking had changed since birth, discussing reasons behind changes. Data collection ceased at the point of theoretical sufficiency,³³ where new data added little insight to arising issues.

Characteristics of practitioners were recorded, capturing factors that influence views regarding alcohol (Table 1).

Data analysis

Qualitative analysis was guided by Braun and Clarke's thematic analysis,³⁴ involving familiarisation and immersion through data collection, processing, and repeated reading; coding ideas and patterns in data; grouping codes into explanatory themes; systematic application of themes to data (using NVivo version 11 for data management); and refining and defining themes. Constant comparisons and negative case analysis deepened understanding.³⁵ Memos were collated for each theme during focused coding, and organised into a consistent narrative with supporting quotes. An inductive approach was taken. To aid interpretation, emerging ideas were discussed with other researchers and older members of the public advising the study, and relevant theoretical literature was explored.

Theoretical position

This research was conducted from a critical realist orientation: assuming a real world exists independently of perceptions, but understanding of this world is constructed from individual perspectives. Leventhal's common-sense model of self-regulation³⁶ and Crawford's writing on 'othering'³⁷ informed data interpretation.

RESULTS

The 24 older adults participated in 15 interviews and two focus groups; and the 35 practitioners participated in eight interviews and five focus groups. The composition of focus groups is presented in Box 2. Interviews lasted an average of 68 minutes, and focus groups lasted an average of 53 minutes. Practitioners and older adults' characteristics are presented in Tables 1 and 2, respectively. Participating older adults were aged 66–89 years. Alcohol use varied from infrequent and low level (one drink monthly or less) to frequent (drinking

several times per week). Participants are pseudonymised in reporting.

Themes

Three themes explained the findings: disregarding impersonal information about effects of drinking on health; personally relevant risks of harm — expecting symptoms from excessive drinking; and perceived gains from restricted intake.

Disregarding impersonal information about effects of drinking on health. Older people conveyed their awareness of information about positive and negative effects of health-related behaviour, and how much was considered 'safe' to drink. The transitory and seemingly contradictory nature of alcohol-related health messages encountered over time meant that they expressed scepticism about the validity of 'generic' information as a source of advice. One participant consequently disregarded health messages, instead consuming what they viewed was sensible:

'I pay a certain amount of attention to the government's rules, but if they keep changing them. I view the alcohol rules very much like all the other ones about food. We've been told not to eat butter, not to eat eggs. "Eat eggs. Eat butter. It's good for you." You're just told a load of rubbish, basically. You don't believe a word of it. 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 person [OP], Stanley, aged 69 years, male [M])

'Sensible' drinking was viewed to be low risk, and encompassed not drinking 'too much' or 'to get drunk'. This finding cut across sex and socioeconomic groups. Views about levels of drinking considered

'sensible' differed, resulting in tendencies for heavier drinking among males and those self-identifying as working class. Health risks were assumed relevant only to groups that they perceived were 'problematic' drinkers, such as 'alcoholics' and younger 'binge' drinkers. 'Moderation' in drinking was recognised by older adults as a consistent message, which many ascribed to. This did not reflect a defined level of alcohol use and many consumed at hazardous levels.

Practitioners reflected that older people were only responsive to alcohol-related health messages when they were tailored to the individual's circumstances and drinking practices. Personalising risk communications required a critical understanding of current health messages. This was not normally possible for most practitioners (except pharmacists and nurses, with established roles in alcohol intervention), who had limited alcohol-related training, understanding of age-specific risks, or time for tailoring:

'We've had very little training in the advice we need to provide. Your knowledge is limited. You think, "Oh, cut down, yeah." But that's all we've got to go on really.' (Dentist)

Personally relevant risks of harm — expecting symptoms from excessive drinking. Older adults expected they would experience symptoms if their alcohol use was excessive. Any reductions in intake motivated by health risks were prompted by perceived consequences of their drinking, rather than proactive changes to prevent harm. A female participant recognised effects of alcohol on her weight and energy levels, and made the decision to limit drinking:

Nancy (OP, aged 66 years, female [F]): *'I've lost quite a lot of weight over the last couple of years. And that's part of that. I eat more, if I'm drinking. And in itself, it's quite ...'*

Bethany Kate Bareham: *'calorific.'*

Nancy: *'Yes, so, I was drinking more. I thought, I'm falling asleep in front of the telly. Which I don't do if I don't drink. And I just thought, time has come. I think I can do it, and I did do it.'*

Others recognised negative effects on mood or when combined with medications, and restricted their intake. Many experienced decreased tolerance for alcohol with age, and restricted their intake accordingly to avoid symptoms from excess. Some reporting high tolerance to alcohol across their lives had not experienced any

Box 2. Details of focus group composition

Focus group	Participant group	Composition
Focus group 1	Older adults	Three unconnected females aged >85 years
Focus group 2	Older adults	Six male friends aged 66–77 years
Focus group 3	Practitioners	10 members of a general practice team, including GPs, practice and district nurses, and healthcare assistants
Focus group 4	Practitioners	Five members of an older adult social care team (social care practitioners)
Focus group 5	Practitioners	Three partners of a dental practice (dentists)
Focus group 6	Practitioners	Seven dentists completing training
Focus group 7	Practitioners	Two members of a domiciliary team (domiciliary care providers)

Table 2. Characteristics of older adults, N = 24

Characteristic	n
Sex	
Male	12
Female	12
Age, years	
65–69	8
70–74	5
75–79	6
80–84	1
85–90	4
Ethnicity	
White British	23
Indian	1
Living situation	
Alone	11
With partner	13
Work status	
Retired	21
Semi-retired	3
Profession (previous)	
Manager	5
Professional	7
Technicians and associate professional	2
Clerical support worker	3
Service and sales worker	3
Craft and related trades worker	2
Elementary occupation	2
Level of socioeconomic deprivation (IMD)	
Low	8
Low-medium	6
Medium	4
Medium-high	4
High	2
Living location	
Urban	18
Rural	6
Potential risks associated with participants' alcohol use identified in narratives	
Regular weekly intake in excess of UK low-risk alcohol use guidelines (≤ 14 units/week) ³⁹	5
Binge use of alcohol (≥ 6 units for females or ≥ 8 units for males in a single occasion, as categorised by UK low-risk alcohol use guidelines) ³⁹	9
Co-use of alcohol with medications or conditions that may be negatively affected by alcohol use	13
Driving following intake authors felt may have exceeded lawful limits	5-
Self-reported pattern of alcohol use (where reported)	
Frequent (several times per week)	16
Infrequent (monthly or less)	6
Binge	1
Self-reported health state, rated from 0 ('terrible') to 100 ('perfect')	
20–39	2
40–59	3
60–79	7
80–100	12

IMD = Indices of Multiple Deprivation³²

symptoms attributed to alcohol. Concerns regarding effects on health did not factor into their decisions for drinking.

Practitioners highlighted that not all harms experienced through non-dependent drinking were symptomatic. Those involved in interventions to address alcohol conveyed that it could be difficult to motivate restricted use where older people had not experienced symptoms of harm from drinking. Their older care recipients commonly cited reaching old age to indicate that their drinking was not harmful. Alcohol-related discussions were unlikely to prompt these individuals to contemplate making changes to their drinking, as social care practitioners explained:

Social care practitioner (SCP): *'You've got people who've been doing this for 50 years and 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."'*

SCP: *'There is that sort of dismissive attitude, "Well, I've done it all my life and I've never come to any harm."'*

This perspective was echoed by some older adults, particularly the oldest individuals.

Alcohol screening test outcomes could provide a concrete indicator of the (potential) effects of older adults' drinking on their bodies. Screening tests, such as alcohol-related risk scores (conveying increased chance of harm associated with use) or blood tests, were integrated within practice in many care settings. Risk scores helped convey individual risks to older care recipients in a tangible format. A dentist explained how the products of screenings supported patients to link behaviour with effects on their body:

'The DEPPAs [Denplan PreViser Patient Assessment; oral health risk screening tool, including alcohol-related risks] with them having a written piece of paper in their hand describing their risks, that's something visual they go away with. I think it helps them to make that link between, "What I'm doing to my body or what I'm putting in mouth affects..." It's easier to talk about it because it's there and it's in colour.' (Dentist)

Where screening results did not indicate harm, older adults drew on this as evidence that their drinking was not a risk, justifying continuation. Despite drinking at hazardous levels, a participant felt their normal blood results demonstrated that their drinking was not problematic:

'When I get my bloods checked every 6 months, the practice nurse will say, "Your bloods are spot on. There's nothing in your internal organs ringing bells." So I don't think [alcohol is] having a detrimental effect.' (OP, Malcolm, aged 67 years, M)

Older adults receiving care for long-term conditions, whose health was closely monitored, felt that any personally relevant risks attached to their drinking would be communicated by practitioners. They otherwise assumed their drinking was safe.

Health practitioners recognised that guiding older patients' understanding of screening results was important to avoid misconceptions that may lead to them maintaining drinking at hazardous levels. However, they explained that they did not systematically screen blood samples for indicators of alcohol-related harm, or convey findings indicating potentially harmful drinking.

Perceived gains from restricted intake. Disease and death were an expected part of late life. Older people were motivated to restrict their intake when they viewed that drinking might affect the state of their health and perceived control over their health and longevity. This view was prominent among participants self-identifying as middle class, who felt being health conscious was important, and perceived agency over their health. For example, men in focus group 2 discussed how they felt it was important to ensure their quality of life was not impeded by ill health caused by their behaviour:

Billy (OP, aged 77 years, M): *'You're more conscious of it [health, in later life].'*

Jack (OP, aged 73 years, M): *'One knows that one's quality of life is going to be severely diminished if one suffers from ill health.'*

Billy: *'You are conscious of the fact that your life is coming to an end. You end up being more conscious therefore of I better not do this, because of that stage.'*

Older adults often had particular health concerns that they looked to manage by any means. They were more open to adjusting their drinking when they perceived doing so would enhance their quality of life through alleviating health complaints. One participant's arthritis condition was affecting their mobility. They restricted their alcohol intake to control their weight, and its effect on their condition:

'I've got arthritis in some of my joints, I'm having difficulty getting about. I can't walk as much as I would like to, so it's inactivity I'm concerned about. So I'm trying to eat less and drink not necessarily every day. [It's about] making my life easier and more acceptable.' (OP, John, aged 66 years, M)

Health practitioners reported that they often conveyed the relevance of alcohol to common health concerns they were managing, including diabetes, high blood pressure, falls risk, and obesity. They reflected that framing reductions in use in terms of potential benefits, given individual concerns, represented an effective way of motivating healthier decisions:

'If they say, "I'm tired", or, "My mood is low". I'll often reflect back to them, if they've drunk a lot, "Do you know alcohol lowers your mood?" 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.' (GP)

Older adults were clear that they were prepared to limit or stop drinking if this was recommended by health practitioners because of individual health risks. As one participant emphasised:

'You should follow the doctor's advice. You just assume the doctor knows what they're talking about. If I was advised by a doctor, "Don't drink at all for health reasons." Then I could stop.' (OP, Charlie, aged 76 years, M)

Older adults broadly viewed acute illness to be incompatible with drinking. When experiencing ill health, a number of participants described having curtailed their alcohol use. In these circumstances, older adults perceived their health as vulnerable to the hazards of drinking. They were more open to recommendations to reduce intake following such health events, as described by practitioners involved in aftercare and older people who had received advice in such circumstances:

'[Nurse] said, "I can see you enjoy a drink and I don't want to stop you from drinking, but, for the first fortnight or so after you leave the hospital, could you dilute it?" So I did that with soda water I may tell you, which made quite a nice drink. But she advised me, what I thought was very sensibly due to my age and one thing and another, that I could have a drink but as long as I didn't have too much immediately

after my heart thing. (OP, Valerie, aged 88 years, F)

Older adults had also followed practitioners' advice for restricting intake when prescribed medications contraindicated for use with alcohol.

Some of the oldest participants struggled to manage their declining health, and did not feel they had control over their health state. They were not motivated to attempt to improve health outcomes through restricted drinking. The same participant conveyed that restricting their intake to avoid low energy would be pointless, as they experienced fatigue regardless of drinking:

'I just have what I enjoy, you see, sometimes, if I don't have [alcohol] at all, one day death is imminent and the next you can leap a five-barred gate. You don't know what your day is going to be.' (OP, Valerie, aged 88 years, F)

Many practitioners experienced in intervention for alcohol remarked on their oldest care recipients' apathy towards reducing their intake. These individuals were resigned to their limited remaining years, feeling drinking contributed to enjoying these. Practitioners explained this was difficult to address:

'I think older patients sometimes go, "Well, I'm 89. I haven't got long left. I enjoy it." It's hard to say anything really to that person.' (GP)

DISCUSSION

Summary

This study generated novel insights into older people's perceptions of alcohol and health by combining views of older people and practitioners. The findings suggest that the health risks of alcohol do not influence older people's decisions about drinking, unless risks are perceived to be personally relevant. Age-related illness is often a prompt for older people to acknowledge that alcohol-related risks are relevant to them, and make changes to maintain quality of life and longevity. However, if health conditions were unmanageable, older people felt there was no benefit in restricting their drinking. Older people's perceptions of the effects of alcohol on their health require careful navigation within primary care to support healthier decisions. Practitioners promoted awareness of the personal relevance of alcohol-related risks by discussing alcohol as a potential cause of specific symptoms, and emphasising

potential benefits of reducing intake for individual health concerns.

Strengths and limitations

This qualitative study produced a rich understanding of how older people perceive and manage potential effects of alcohol on their health. Practitioners' perspectives highlighted opportunities and challenges to supporting older people to make healthier decisions.

However, this study may not provide a complete account of older people's understanding of effects of alcohol on health. Participants shared experiences of health consequences attributed to alcohol, but stigma associated with 'problematic' drinking³⁹ may have had limited disclosure. The sample did not include older people living with severe frailty, and the majority were white British. This reflects the population of Northern England,⁴⁰ but limits insights into perceptions of other cultures.

A range of practitioners were involved in this study. Understanding heterogeneity in their work to support older people's decisions was not prioritised in this study, but is reported elsewhere.¹⁶

Comparison with existing literature

Common experiences of ill health in old age could motivate older people to make changes to reduce their risks from drinking. Ill health is a commonly reported context for decreased intake with age.^{22,24,41-47} Older people may be more likely to perceive alcohol as harmful to their health, and be open to contemplating changes in their drinking. Identifying alcohol as a cause of various symptoms of ill health converts abstract risks into reality. This process instigates behaviour change towards healthier lifestyle choices.³⁶ This motivation has previously been demonstrated among older people with problematic alcohol use, where significant health issues were influential.²⁴ In the present non-dependent sample, decreased alcohol tolerance with age motivated reduced intake. Older adults were motivated to make healthier choices when they perceived changes may help mitigate symptoms. Significant illness meant older people felt vulnerable to alcohol-related harm.

Older adults' symptom-focused view of alcohol's effects, and perceptions of potential benefits of a healthy lifestyle in old age, could present challenges for promoting healthier decisions. Age-related decline or medication side effects may be attributed to causing symptoms experienced by older adults, rather than

alcohol.^{43,48} Poor symptom management in the context of multimorbidity could create a sense of hopelessness about health, so that older adults felt modifying their behaviour was futile. The relevance of alcohol-related health risks to older adults' relatively 'sensible' and 'moderate' drinking²² could seem limited for the increasing numbers of older people experiencing well-managed health.⁴⁹ Resultant disregard for alcohol-related risk messages is well evidenced in older populations.^{9,24,50} Increasing media coverage highlighting harms faced by older populations from alcohol may lead to recognition that risks may be associated with their drinking.

Perceptions of potential protective effects of alcohol in the present study did not seem to affect older people's decisions, contrasting with findings from other older populations.^{22,51,52} Changes to low-risk alcohol use guidelines in the UK preceded the present data collection, which highlighted a lack of clear evidence for health benefits.³⁸ Guidelines and associated media coverage may have clarified that drinking is a health risk, or added to the uncertainty created by an 'ever-growing deluge' of conflicting messages about effects of alcohol.⁵³ Positive contributions to wellbeing, including roles in socialising and managing emotional wellbeing, can be important to older people's decisions for drinking.^{16,22} However, protecting health was prioritised among the present non-dependent group where older people perceived specific risks from alcohol use.

Primary care practitioners play an important role in supporting older people to recognise when alcohol could be affecting their health. Practitioners' functions in identifying alcohol as a potential cause of symptoms, and highlighting restricted use as an appropriate response to mitigate health concerns, are well recognised.^{36,42} Screening tests in primary care were a vehicle to convey the potential effects of alcohol. Tailored advice by primary care practitioners, highlighting individual risks associated with drinking, was central in motivating restricted use. This reflected findings of interventions to promote healthier decisions for alcohol use among older people, where such personalised approaches were most effective.⁵⁴ Framing changes in alcohol use to highlight potential gains for older individuals also reflects older people's priorities, and is known to promote other healthy behaviours.⁵⁵ Practitioners' approaches to supporting older people's decisions for drinking have focused on minimising associated health

risks.⁵⁶ Current policy for risk management in UK care systems promotes taking older people's priorities and wider wellbeing into account in lifestyle advice. Discussions should explore how risks may be managed, while maintaining contributions to wellbeing and identity.⁵⁶ Older people may not be motivated to make changes to alcohol use if its contribution to their wellbeing is not considered.

Practitioners in the present study had varying ability to highlight the individual relevance of alcohol-related risks. Little training in alcohol intervention, and limited time to discuss the issue in consultations, impede work to support older people's decisions for drinking across health and social care systems.¹⁴ Intervention to address alcohol use, and associated training, is not within the remit of some practitioners, such as domiciliary carers and healthcare assistants.^{14,17,57} Practitioners' capability to highlight age-related risks for older adults may also be limited by low awareness of age-specific risks,^{19,20} and no practitioners in the present study reported using age-specific screening tools to support discussion of individual risks. Nurses and pharmacists had dedicated time and training, and knowledge of the older person's health status, to provide individual advice.

Implications for research and practice

The effects of common health concerns on quality of life represent an opportunity to motivate older people to adopt healthier lifestyles. Supporting older people to manage their health is important, ensuring they perceive that healthier behaviour could promote improved health outcomes. Further research should explore receptivity to alcohol-related health promotion among older people with frailty, and older minority ethnic groups.

Primary care practitioners have an important role in supporting older people's decisions, helping patient understanding of potential effects of drinking on health and quality of life. Systematic screening and communication of health risks associated with alcohol use are important in later life, where individual risks may be heightened by morbidity and medicine use. Older people may otherwise struggle to identify with associated risks. The impact of such screening and personalised intervention initiatives on older people's alcohol use should be evaluated. It is important to support practitioners involved in managing older people's health, such as nurses and pharmacists, to intervene and address the

age-specific risks of drinking, ensuring older people receive support for their decisions. Integrating age-specific screening tools into care may raise practitioners' awareness of individual risks associated with alcohol use in later life, and support tailored discussion.

Practitioners should explore and take older people's perspectives of any positive impact of alcohol for their wellbeing into account when giving advice, and ensure older people's priorities are considered.

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Competing interests

The authors have declared no competing interests.

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