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'I'd be willing to take that risk for the enjoyment of the time that I have': a COM-B influenced analysis of older people's perspectives on their alcohol consumption

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ABSTRACT

Objectives: To explore how older people understand, perceive, and evaluate the various factors which drive their alcohol consumption behaviours.

Methods: Semi-structured interviews were conducted with 33 Australian community-dwelling older adults (aged 65+ years) who drank alcohol at least once a month. Thematic analyses identified common themes which were then mapped onto the COM-B theoretical framework.

Results: Drinking behaviours were driven by a lack of capability in the form of poor knowledge regarding safe drinking behaviours and guidelines; high opportunity for consumption due to ease of accessing alcohol and its prominence in social routines; and high motivation to drink due to perceived benefits outweighing perceived risks.

Conclusion: Increasing older peoples' knowledge of the risks associated with consumption and safe drinking behaviours represents a key health promotion priority in order to reduce the burden of alcohol-related harms among this group.

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Introduction

Australia's population is ageing at an unprecedented rate, with 22% of the population (8.8 million individuals) expected to be aged 65 years or over by 2057 (Australian Bureau of Statistics, 2014, 2017). Alcohol use is a significant but often overlooked contributor to the burden of disease among this group. Older people are more vulnerable to alcohol-related harm than their younger counterparts, as ageing-related physiological changes reduce one's capacity to metabolise and excrete alcohol. In addition, older people are more likely to have comorbid health conditions that may be exacerbated by alcohol and/or to use medications contraindicated with alcohol (Crome & Rao, 2018; Nicholas & Roche, 2014). Older Australians who drink alcohol are therefore vulnerable to a range of adverse outcomes including diabetes,

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cardiovascular disease, mental health problems, obesity, liver disease, early onset dementia and other brain injury and increased risk of falls (Carvalho et al., 2021; Crome et al., 2011; Schwarzinger et al., 2018; Scoccianti et al., 2015).

Current Australian guidelines recommend that healthy adults should drink no more than 10 standard drinks a week and no more than four standard drinks on any one day (National Health and Medical Research Insititute, 2020). An Australian standard drink contains 10 g of pure alcohol (National Health and Medical Research Insititute, 2020). It has been noted that standard alcohol guidelines may be inappropriate (i.e. too high) for older age groups (Crome & Rao, 2018). Nevertheless, even utilising the standard guidelines, a large and increasing proportion of older people are drinking at risky levels, leaving them vulnerable to alcohol-related harm. In 2019, 17% of Australians aged 50+ engaged in risky drinking (Chapman et al., 2020). Nationally representative data demonstrates that while rates of risky consumption among younger people have declined over the past two decades in Australia, rates have increased among older people (Livingston et al., 2018). For example, among those aged 18–24 years, risky drinking decreased from 57% in 2001 to 41% in 2019. By contrast, rates among those aged 60–69 years increased from 12.8% to 17.4% over the same time period (Australian Institute of Health and Welfare, 2020), with similar trends noted internationally (Statistics, 2018). Increasing rates of alcohol consumption among older age groups are also reflected in concomitant increases in treatment-seeking and healthcare utilisation among this age group (Australian Institute of Health and Welfare, 2021; Bares & Kennedy, 2021).

A number of psychosocial factors have been identified which can place older people at risk of problematic alcohol consumption. These include persistent pain, insomnia, social isolation and loneliness or bereavement, retirement and having fewer responsibilities or roles to fulfil, as well as experiencing depression, anxiety, or stress (Crome & Rao, 2018). In addition to these external factors, alcohol-related knowledge and perceptions of harm may also shape consumption among older age groups. Research suggests that older people tend to view their own consumption as non-risky or 'social' (rather than 'heavy'), and often do not consider the health risks of consumption (Bareham et al., 2019; Masters, 2003). Similarly, older people who drink at risky levels often lack a clear understanding of safe drinking guidelines (Chapman et al., 2020). These knowledge gaps among older cohorts may in turn be exacerbated by healthcare professionals' own knowledge limitations regarding geriatric substance use and resultant reluctance to discuss alcohol consumption with their older patients (Henley et al., 2019; Wadd et al., 2011).

However, there is a relative paucity of research examining how older people themselves understand their own consumption, their reasons for drinking, and the ways in which they evaluate potential risks and benefits. As such, the self-reported drivers of consumption—and reasoning behind them—remain unclear. A useful framework for conceptualising how and why individuals engage in particular behaviours is the Capability, Opportunity, Motivation—Behaviour (COM-B) Model (Michie et al., 2011). Applied to an alcohol context, it proposes that a given level of consumption arises from the interaction between individuals' capability, opportunity, and motivation to drink. Capability refers to the psychological or physical capacity required to choose one's level of consumption. Opportunity refers to all factors (physical or social) external

to an individual that facilitate or inhibit consumption. Motivation refers to the thought processes that influence the energy and direction of a behaviour—i.e. towards or away from consumption. (The structure and content of these three domains have been explained in greater detail elsewhere, e.g. (Michie et al., 2014)). The COM-B model also forms the basis of the evidence-based Behaviour Change Wheel intervention design tool, which is used to identify appropriate intervention functions and policy responses for achieving targeted changes in behaviour (Michie et al., 2011). As such, it is a useful model to conceptualise the drivers underpinning older people's alcohol consumption and how these may be leveraged to develop health promotion interventions and initiatives.

The current study therefore aimed to explore how older people understand, perceive, and evaluate the various factors which drive their alcohol consumption behaviours and patterns, using the COM-B theoretical framework.

Materials and methods

Study design and procedures

Semi-structured interviews were undertaken with community-dwelling older adults (aged 65+ years) who drank alcohol at least once per month. Ethics approval was obtained from the Human Research Ethics Low Risk Panel at Flinders University (No. 4946). Participants were purposefully recruited through researchers' networks and *via* snowball sampling. Flyers/posters were posted in select locations in the community which are commonly frequented by older persons (e.g. public libraries, community centres). A wide range of locations throughout the city were targeted in order to engage participants who varied in age, marital status, socioeconomic status, education and residential area. Potential participants enquired about participation over the phone or *via* email and were screened for eligibility by a member of the research team.

Interviews were conducted over the phone between January—April 2022 by either VK or another trained interviewer. All participants provided verbal informed consent, completed the interview in English and received a $30 retail gift voucher as an acknowledgement of their time. Interviews were guided by a semi-structured interview schedule, which comprised questions regarding participants' alcohol-related behaviours, motivations for drinking, awareness of the risks involved, and help-seeking behaviours. Interviews took approximately 30 min to complete on average.

As part of a larger project, participants additionally completed an online survey concerning their demographic characteristics, alcohol consumption behaviours, health, alcohol-related knowledge and help-seeking behaviours. With the exception of demographic characteristics (age; sex; marital status; country of birth; education; household income) and current levels of alcohol consumption (quantity/frequency of consumption), quantitative results are not reported here.

Analysis

Interviews were audio recorded, professionally transcribed (verbatim), de-identified, and imported into NVivo (release 1.6.1) for analysis (QSR International Pty Ltd, 2022).

A reflexive thematic analysis approach was used, comprising six steps as described by Braun and Clarke (Braun & Clarke, 2006; 2022): data familiarisation; initial code generation; initial theme generation; theme development and review; theme definition and naming; and producing the final narrative report (Braun & Clarke, 2022). After familiarising herself with the data, VK undertook initial coding, and then grouped codes with similar characteristics and patterns together, collating preliminary patterns into candidate themes and subthemes for review by the broader research team. Analysis at this stage utilised both deductive codes derived from the interview protocol and inductive codes developed during the analysis process. Upon reviewing the themes and their underlying data extracts, AB observed that the themes aligned with elements of the COM-B model (Michie et al., 2011); after reviewing the literature around this model, the research team agreed to use the model to refine and name the themes.

Results

Participant characteristics

A total of 33 participants completed the interview. The majority were female (67%) and ranged from 65 to 88 years old. Approximately two in three were married (67%) and living with their spouse (68%). The majority (73%) were born in Australia; other countries of birth cited were the UK, New Zealand and France. Most participants (62%) had either a Certificate/Diploma or an Undergraduate Degree but were currently retired (88%). A large proportion of the sample (61%) had a combined household annual income of $60,000 or less.

Participants consumed alcohol regularly throughout the week, with 70% reporting that they drank at least four days per week. The majority (85%) reported that on the days they drank alcohol, they consumed relatively small quantities (four or less standard drinks) (Table 1).

COM-B model influences on consumption

Capability

Knowledge of risks. Participants were relatively knowledgeable about the potential risks associated with alcohol consumption in general. However, there was wide variation in the salience of different types of risks and the extent to which

Table 1. Participants' typical frequency and quantity of alcohol consumption.

Frequency of consumption	N	%
Every day	3	9.1
5–6 days a week	9	27.3
3–4 days a week	11	33.3
1–2 days a week	6	18.2
2–3 days a month	3	9.1
Less often	1	3.0
Quantity of consumption	**N**	**%**
7–8 standard drinks	2	6.1
5–6 standard drinks	3	9.1
2–4 standard drinks	21	63.6
1 or less standard drinks	7	21.2

participants perceived that they themselves were vulnerable to potential harm. When participants were asked to discuss the risks of consumption, behavioural effects and consequences were typically more salient than health-related harms. Participants discussed their negative perceptions of those who became aggressive, loud or violent after drinking (but generally felt that they personally would not act in these ways) as well as concerns that they would 'lose control,' 'make a fool of myself' or become 'obnoxious,' 'ridiculous' or 'silly.'

> *To me the biggest problem is the aggression that some people get when they get a lot of alcohol poured. To me that's, you know, the worst possible thing that can happen to somebody.*

When prompted specifically about health-related harms, most participants had a general understanding that alcohol was detrimental to one's health, but more specific knowledge of health conditions associated with alcohol varied widely. Hypertension, diabetes and obesity, disease of the kidneys, liver, brain and heart, dementia, insomnia, and weight gain were all recognised by participants to be related to alcohol. However, the association between alcohol and cancer or mental health disorders—two of the more prevalent and severe potential consequences of consumption—was not widely recognised. Similarly, the increased risks faced by older people specifically were not acknowledged by any participants.

> *I was just going to say, yes, I've heard of most of that, but I didn't think of cancer, I have to admit I didn't equate that [alcohol consumption] to cancer.*

Most participants stated that they were in good physical condition, and that therefore consumption held few dangers for them. While there was almost universal agreement that if their condition deteriorated at some hypothetical point in the future they would reduce their consumption, most participants felt that it was not currently necessary.

> *Perhaps if I was doddery on my legs perhaps, you know, but I'm not, I'm quite fit and stable. So, you know, I think I can see that [reducing consumption] could be [necessary] as I get older but it's not at the moment.*

Even among the small number of participants who drank at high-risk levels, there was typically little recognition of the harm that they may be vulnerable to. These participants would often acknowledge 'unfortunately I drink too much I know that' but nevertheless state that their level of consumption was not harmful to them.

> *Well I don't think it's harmful…I know the recommendation, I drink more than the recommendations but personally I don't care because, you know, I don't believe it's harming me.*

The risk of being, or becoming, dependent on alcohol was perceived by the majority of participants to be very low. Many stated explicitly that they were always in control of their drinking and could stop if they had any reason or desire to do so.

> *My thing is, I'm not concerned about my consumption because I know that I can stop and I have no trouble in stopping for months.*

Two participants acknowledged that their heavy consumption was placing them at risk of serious consequences and had either reduced their consumption accordingly

or were planning to do so. These participants noted particularly the effects of alcohol on their mood; the potential for chronic health problems was less salient in their decision to cut down.

Risk mitigation. A number of participants cited specific strategies that they engaged in to minimise the adverse effects of consumption. Such strategies were presented as additional evidence that they were not at risk of experiencing alcohol-related harms. Many participants reduced or completely abstained from consumption if they planned to drive. In some instances, participants would drink at home specifically to avoid having to drive.

> *We would have a soda water or a coffee because you have to drive home. I would never drink if I was out and I had to drive home. I would never have a drink.*

The importance of not drinking and driving was such that friends and family members were also actively discouraged from driving home if they had been drinking.

> *But if my friends or anyone that's here chooses to drink more, I will just say to them, 'You can, that's fine, but you either sleep here or you get a cab or an Uber home. You are not driving.'*

In addition to not driving after consuming alcohol, risk mitigation strategies typically involved drinking slowly over the course of an evening, or having a number of specifically alcohol-free days every week.

> *Yeah, I don't drink very quickly. I take my time. When we socialise, we have long nights socialising.*

> *I do think that it's probably good to have one or two nights or days without drinking.*

Some participants were aware that they did not personally tolerate alcohol very well, and as a result chose to drink less or to drink low-alcohol beverages. This was perceived to be a compromise; a way of still enjoying alcohol while mitigating the risks involved.

> *Right. I only have half, when I drink at home, I only have a glass of wine, because my body's not processing it as well. So, I might have four glasses of wine a week, but they're only half a glass.*

Among those participants who drank more heavily, risk mitigation strategies were also apparent. While those who drank at low-risk levels tended to implement strategies to prevent themselves from becoming too intoxicated, those who drank at more risky levels cited strategies to prevent themselves from coming to harm after becoming intoxicated.

> *So I've been aware that I've had too much to drink and I've taken appropriate action, which is would be to sit down or go to bed.*

Knowledge of guidelines. Participants were asked whether they were aware of the concept of 'standard drinks' and the Australian guidelines to reduce health risks for drinking alcohol. Those who stated that they were asked to describe their understanding of them. Almost all participants reported that they were aware of

standard drinks. Standard drinks were typically understood in terms of being a single glass of wine or stubbie of beer. Some noted that they used or had seen wine glasses marked with a line to indicate the level of a standard drink, but several indicated that they would typically pour more than this.

> *I couldn't tell you [what a standard drink is] but I do know when restaurants or hotels started marking the glasses for what a standard drink was, it was much less than I had thought in the past.*

Understanding of the alcohol guidelines was generally poor. While many participants stated that they knew the guidelines, most provided descriptions that were out-of-date, incorrect, or extremely broad ('drink in moderation'). The most common 'guideline' cited by participants was 'no more than 2 standard drinks per day,' with many differentiating between limits for women and for men[1]. Some participants were aware that the guidelines had changed over time, and felt that this made them less reliable indicators.

> *I become a bit cynical about that when they suddenly drop from four to two standard drinks per day for men.*

While most participants were supportive of having official guidance on the amount of alcohol that is safe to drink, some felt that the guidelines (as they understood them) were unrealistically low, or did not apply to them specifically. In general, the official guidelines had little impact on most participants' consumption levels.

> *But, yeah, the recommendations are nice but they're unrealistic for someone who's careful with their health and doesn't drink to excess. I know what they are and I choose to ignore the actual recommendations, the guidelines.*

Information from healthcare practitioners. The potential risks of alcohol consumption—and ways of mitigating them—were reportedly not often raised by participants' healthcare professionals. While most participants indicated that they would be comfortable seeking help from their GP in regard to alcohol consumption if necessary, many noted that their doctors did not typically discuss alcohol consumption with them in any context. One participant stated that even their liver specialist had never raised alcohol consumption with them.

> *…when she [the GP] prescribed them [medication] she did not mention alcohol, and certainly the pharmacist has never mentioned it, no.*

Some participants did not perceive this to be a problem, as there were warnings on medication packets and they could 'figure it out themselves.' However, others noted a desire for healthcare practitioners to be 'more proactive' in addressing alcohol consumption as well as other potential health issues that may arise in older age. One participant felt that his concerns were often brushed off or attributed to his age, rather than being addressed appropriately.

> *Well first of all the printout that comes with the medication in the box or packet always warns about the interaction…So I don't think they're afraid to mention it, I just think they realise there's no need to, I'm aware of the situation and I have to make my own judgements.*

But I wouldn't have any qualms to raise it [alcohol consumption], but I don't think he's very interested. Not talking about alcohol, but if you say, "Gee, I've got a stiff neck," the first thing they say, "Well, you're not young anymore," and that's bloody common, where you say, "Gee whiz, the knee joints are a bit creaky." "Well, you're not young anymore," and that's about the extent of it.

Opportunity

Social routines. Alcohol consumption featured heavily in social interactions, both at home (drinking with a spouse) and while out (dinner with friends, larger family gatherings). Correspondingly, many participants reported that they primarily or exclusively drank on weekends. Several participants reported that they would drink more alcohol when it was in the context of a social event, noting that the pleasure they typically gained from drinking alcohol would enhance their enjoyment of the event.

I would drink, as I say, two glasses a night when, on the nights that I drink at home. If I'm out with friends I would drink more than that.

It was noted that there was often an expectation at social events that alcohol would be present. Offering drinks to guests was seen as the 'correct' or 'hospitable' thing to do. Correspondingly, a minority of participants perceived that when they spent time with friends there was implicit pressure to consume alcohol: 'people can expect you to drink alcohol. There is that expectation in Australia.' Despite this, where such pressure existed, most participants reported that they felt comfortable resisting it, and that if they did drink more at an event the decision to do so was their own.

If I cave in and have a second one, it's my choice, not because it's pressure from anyone else.

By contrast, a number of participants reported that they commonly drank by themselves or only with their spouse. In most cases this was associated with a specific habit or routine; typically this centred around preparing or eating the evening meal.

My wife and I sit down at the end of the day usually and she has a drink and I'll have my drinks and we watch a bit of television while we're doing it, so it's just a thing we do together.

Well, I would normally pour the glass of wine while I'm getting dinner. I'm on my own, that's while I'm getting dinner. I would drink half of it while that's happening and then I'll drink the other half while I'm having dinner and after dinner.

Always with dinner at night. If I drink, it's always at dinner at night. It's always with food.

When long-standing social routines were disrupted, this could cause a similar disruption in drinking patterns, typically resulting in higher levels of consumption. A key example of this was retirement: several participants noted that having more free time and fewer responsibilities led to them drinking more frequently and in larger amounts. More transitory disruptions could also have large effects: some participants stated that the COVID-19 pandemic had had an effect on their consumption, whereby the boredom and isolation caused by lockdowns led to more drinking. However, these participants noted that they had now returned to pre-COVID levels of consumption.

I retired a couple of years back in November and I think I've just had a bit more free time, a bit more relaxed time, whereas if I was working the next day I never used to drink at all, but now like I can relax.

Availability and advertising. The extent to which alcohol was easily (and cheaply) available was noted to have a strong impact on the amount consumed. A number of participants reported that they had significant wine collections, with some working in the wine industry. Several also used online shopping, which allowed large deliveries of wine or other alcohol to their house. The ability to easily grab a bottle without leaving home was seen to encourage consumption.

It was too easy to get it. It was here…I'd usually get what I want online, so then you'd get cartons at a time and you've always got plenty.

By contrast, when alcohol was perceived to be difficult to obtain consumption levels were often lower. A small number of participants who drank at more high-risk levels reported that the cost of purchasing alcohol acted as a barrier to them consuming as much as they would otherwise want: 'It's so expensive. That's the thing, it's not so much for the health side of things, but it's the cost of it.' However, the majority of participants would actively ensure that they always had ready access to sufficient quantities of alcohol for their desired level of consumption.

The role of alcohol advertising and marketing was also highlighted by several participants, who felt that they were being actively encouraged by the alcohol industry to consume. This was noted particularly in reference to online retailers, who would send large amounts of marketing and promotional emails.

And while I was buying them, I was getting more and more and more [marketing emails], and I'd think, oh, that's a good buy, I'll buy that. Oh, that's a good buy, I'll buy that.

The general preponderance of alcohol imagery in media was similarly noted by several participants. Media portrayals were perceived to normalise drinking as the usual or accepted thing to do, as well as promoting the perception that alcohol was necessary when socialising. One participant reported that this made it difficult to reduce or cease consumption, as the large amounts of alcohol imagery could trigger cravings to drink.

And when you're trying to give it up, it's everywhere. I'm a big film person. I watch a lot of film. And every film, people are drinking. It's very difficult to get away from.

Motivation

Benefits of consumption. Typically, participants reported that they chose to drink alcohol because they received a range of benefits from doing so. The most commonly cited benefit of alcohol consumption by all participants, regardless of consumption level, was simple enjoyment. Participants reported that they enjoyed the experience of drinking and the taste of alcohol. Many noted that drinking 'a nice glass of wine' enhanced meals and social events.

I have to say that I do appreciate the quality of good wines so, if my husband and I go to a lunch, we generally would choose something really, really nice and I can appreciate something that goes well with the food, so again, it's the flavour and the celebration of it, I suppose.

Participants also noted that they enjoyed some of the effects of alcohol consumption, particularly the feeling of relaxation that accompanied it. This relaxation had two elements: alcohol was likely to be consumed at occasions that were themselves relaxing (e.g. social events, at the end of a long day, etc). In addition, the physiological effects of the alcohol also created a relaxed sensation.

…when I'm out with friends at lunch or whoever, I find it relaxing. Obviously, the alcohol has some effect on my brain, I guess (laughs) – a euphoric action or something or whatever.

A final benefit of consumption noted by several participants was that drinking alcohol helped them to deal with difficult or stressful times, mental health issues, or past traumatic events. While there was recognition that drinking may not be the most constructive way of dealing with these issues, participants nevertheless reported that alcohol was beneficial to them in this regard, and they often explicitly chose to drink for this reason.

Participants used alcohol to cope with a variety of challenging situations, ranging from minor inconveniences to severe long-term issues. Some noted that they would have a drink to relax or cheer themselves up '…if I've had a bad day or, you know, something's upset me.' Others recalled specific traumatic events that led to high levels of consumption on a particular occasion, for example 'when my dad got crook.' A smaller number attributed their chronic heavy consumption to ongoing mental health concerns.

A lot of it's connected with my past. It depends what's come up during the day, that may link me with memories that, triggered the drinking.

Weighing up risks vs benefits. Most participants did not engage in prolonged internal debates regarding the relative risks and benefits of consumption. Rather, the immediate and highly valued nature of the benefits received (i.e. pleasure, relaxation, enhanced socialisation) was perceived to far outweigh any future risks that were seen as neither likely to occur nor particularly severe. Indeed, in many cases, participants believed that there were no potential risks for their level of drinking and that they were therefore free to enjoy the benefits of imbibing.

I don't think it would hurt me. Matter of fact, I would go as far as to say I probably reckon it does me good psychologically, a sip… just have a sip of wine.

Others recognised the potential for adverse outcomes, but felt that the benefits they gained from consumption were more important: 'Well, I know it's bad for me, but it makes me relaxed, and I have fun, I enjoy it.' For many participants, this disregard of potential risks was explicitly linked to their age. There was a sense that there was no point worrying about long-term health consequences when 'you don't have that many more years, anyway.' Similarly, some felt that by their stage of life, they deserved or had earned the right to have a few drinks.

You know I think there comes a time when you sort of go well yeah, you know, I recognise the risk involved but if it gave me another two years in a nursing home, or whatever, maybe, I don't know whether that's necessarily a good thing… to me I'd be willing to take that risk for the enjoyment of the time that I have.

A smaller number of participants stated that while there were no harms associated with consumption, there were no specific benefits either. In these cases routine, habit, or social events were what spurred consumption.

It's acceptable. It's not that it's beneficial. There isn't anything there that's benefiting your body.

Reasons for limiting consumption. Although participants highlighted the many benefits they gained from their current level of consumption (which was typically below the official 'risky' threshold), there was recognition that they may be at risk of experiencing harms if their consumption increased. Consequently, there was a conscious effort among many participants to not drink above levels perceived to give rise to adverse outcomes. The adverse outcomes of primary concern to the sample were typically relatively mild and short-lived, rather than long-term severe health consequences.

Some participants limited their consumption to avoid exacerbating existing chronic health conditions: 'I've got…digestive problems, and that keeps mine fairly well in control now.' However, few cited a fear of *developing* serious health conditions as a reason for drinking less. Nevertheless, almost all participants stated that they would consider reducing their consumption if they had a major health issue, or were advised to do so by a healthcare professional.

If I had abnormal liver function tests that were brought on by alcohol or if I had another medical problem like an ulcer or something, I think it would be easy enough to say, "Well, that's it. No more."

More commonly, the adverse consequences participants sought to avoid centred around the unpleasant immediate after-effects of drinking. Many participants noted that by limiting their drinking to a couple of glasses they could still enjoy the benefits of alcohol while minimising any hangover effects: 'I don't like waking up dizzy or waking up tired.' Similarly, several participants sought to avoid the experience of being intoxicated; these participants noted that they disliked the feeling of being out of control, and limited their consumption in order to ensure that they never reached that stage: 'I don't like going beyond the point where I feel intoxicated or coordination is affected.'

Several female participants stated explicitly that they didn't drink to excess not because of any health benefits, but because they wanted to avoid putting on weight.

From my point of view I'm more concerned about the calories involved than the effect on my, I guess principally liver.

Discussion

The current study aimed to explore how older people understand, perceive, and evaluate the various factors which impact their patterns of alcohol consumption. As

per the COM-B model, analyses identified that drinking behaviours among this sample of older adults were driven by a lack of **capability** in the form of poor knowledge regarding safe drinking behaviours and guidelines; high **opportunity** for consumption due to ease of accessing alcohol and its prominence in social routines; and high **motivation** to drink due to perceived benefits outweighing perceived risks.

Poor alcohol-related knowledge (i.e. **capability**) was a consistent theme across participants and manifested in several discrete areas. Most notable was a lack of understanding of older people's vulnerability to a range of adverse health consequences as a result of drinking alcohol. In addition, participants in the current sample were largely unable to accurately describe Australia's official guidelines to reduce the risks associated with alcohol consumption. This is unsurprising given similarly low levels of knowledge found in previous research (Islam et al., 2019). However, compounding this poor understanding was considerable scepticism regarding the guidelines' rationale, validity, and utility; perhaps partially due to the aforementioned lack of knowledge of alcohol-related harms. As such, in some cases participants were not just uninformed or uninterested in the guidelines, but actively in opposition to them. A similarly poor understanding of standard drinks was also noted in the sample, albeit without the same degree of scepticism.

It is likely that this lack of awareness is at least partially due to, or exacerbated by, health professionals' reluctance to discuss alcohol with their older patients. Both the current study and previous research have noted that general practitioners and pharmacists are unlikely to raise safe levels of alcohol consumption with older people, may not note when alcohol is contraindicated with medication, and may attribute symptoms of alcohol-related disorders to the natural ageing process (Wadd et al., 2011). Consequently, healthcare professionals are not only failing to disseminate appropriate health messaging to counter the false beliefs held about alcohol consumption by some older people, but in doing so may be (unintentionally) maintaining the perception that drinking alcohol is an inconsequential health behaviour.

Opportunity to drink alcohol was a function of the Australian cultural milieu; specifically supportive social norms regarding consumption (which resulted in alcohol being strongly centred in social events) and the ubiquitous nature of alcohol advertising and imagery (which in turn reinforced the social norms). In the current sample, the consumption of alcohol was a key component of both nightly family routines and social gatherings. Its centrality to these events was partially borne of habit, but also actively promoted by media imagery and alcohol advertising. Consumption in this context was also facilitated by ease of access to alcohol in the home (which in turn was driven by alcohol marketing and online shopping).

Finally, older adults in the current sample were highly **motivated** to consume alcohol due to its high perceived benefits in combination with low perceived costs. Participants reported that they gained considerable pleasure and relaxation from consumption, and perceived any resultant harms to be either non-existent, limited in scope, or unimportant. The lack of salience of potential alcohol-related harms may again partially be related to participants' poor alcohol-related knowledge but also reflects the purposeful prioritisation of current enjoyment over long-term gains, given participants' advanced age.

Results of the current study highlight several potential intervention points to promote healthier alcohol consumption among older people. Key amongst these is the need to enhance older people's understanding of both alcohol-related risks and the safe drinking guidelines (including the scientific rationale behind them). Poor alcohol-related knowledge is a central component of older people's **capability** to drink alcohol, but also contributes to **motivation** by impacting individuals' internal cost/benefit analyses. Consequently, the dissemination of accurate health messages tailored for this cohort should be a priority going forward. To increase the perceived relevance of the guidelines to this cohort, messages focusing on the alcohol-related consequences identified as concerning to participants, such as effects on mood and enjoyment of an occasion and deleterious interactions with existing chronic health conditions or medications, could be trialled. Health professionals (particularly GPs and pharmacists) would ideally be a conduit for such messaging, however previous research (Wadd et al., 2011) and results of the current study suggest that substantial professional development and upskilling may first be required in order to enhance their understanding and work-efficacy regarding these issues. Consequently, further research is required to examine the most effective methods for wide-scale dissemination of health promotion messages to older audiences.

The present study also suggests that addressing the availability of alcohol, as well as its preponderance in media and advertising, would potentially be beneficial in terms of reducing **opportunity** to drink. Older people are far from the only social group who would benefit from increased controls in this area (Anderson et al., 2009), but implementing such reforms requires considerable political will. Nevertheless, results of the present study add to the weight of evidence suggesting that limiting the availability and marketing of alcohol in this way is a goal towards which we should continue to strive. A potentially more achievable goal in the shorter term could be tighter restrictions for online alcohol retailers specifically (including their marketing strategies), as these online stores were highlighted by participants as a key method of quickly and easily obtaining alcohol.

Limitations

There are several limitations to consider in the interpretation of this study. The sample size is relatively small and does not represent the full spectrum of alcohol consumption behaviours among older people. Similarly, older adults most vulnerable to the adverse effects of alcohol (e.g. those in very poor health, socially isolated, alcohol dependent, etc) may be less likely to participate in research studies. Caution should therefore be exercised in generalising the current results. In addition, it is acknowledged that researchers are unable to completely avoid personal bias when conducting qualitative research, and their personal characteristics may influence their observations and interpretations (Tong et al., 2007). In the present study, the team members conducting the interviews and analysing the data were substantially younger than the research subjects, and this may have impacted both the establishment of rapport and the way in which the interviews were conducted, and the data analysed.

Conclusion and future directions

Alcohol consumption among older Australians appears to be driven by a combination of poor knowledge regarding safe drinking behaviours and guidelines; ease of access to alcohol and its prominence in social routines; and high motivation to drink due to perceived benefits outweighing perceived risks. Future research is warranted to explore whether these factors remain consistent among different cohorts of older individuals; for example, those who drink at higher risk levels. Increasing older peoples' knowledge of the risks associated with consumption and safe drinking behaviours represents a key health promotion priority going forward; however, any health messages must be seen as realistic, relevant and achievable for older people. Further research is required to explore the specific messages that are likely to resonate with this group.

Note

1. The most recent alcohol guidelines were released in 2020 (12 months prior to the commencement of fieldwork for this study) and state that adults should drink no more than 4 standard drinks per day or 10 per week. Participants' reference to two standard drinks per day likely refers to the 2009 guidelines to reduce long-term risk of harm. However, this is only half of the 2009 guidelines; they also state that adults should drink no more than 4 drinks per occasion to reduce the short-term risk of harm. The guidelines have not provided different limits for women and men since 2009, however this was a feature of the 2001 guidelines.

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Data Availability statement

Due to the nature of the research, supporting data are not available due to ethical restrictions, as they contain information that could compromise the privacy of research participants.

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