

Alcohol use across retirement: a qualitative study into drinking in later life

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Executive summary

Key findings

- Retirement is one of many events in a person's life which can bring a change of routine, including routines and practices around alcohol.
- Retirement can provide an opportunity for the volume of alcohol consumed to increase due to increased opportunity to drink, but it could also see a decline as social networks reduced or changed, or as the pressures of work cease.
- Processes and circumstances associated with ageing can present sudden broken routines that can be problematic in terms of periods of increased risk of social isolation and/or increased alcohol consumption, particularly for previous heavy drinkers.
- Whilst broken routines can be associated with retirement they are broader than this and include things like taking on a caring role, bereavement and loss of social networks.
- Moderate drinking amongst retired people can contribute to their engagement with 'active' and 'healthy' ageing. For this reason, alcohol need not be viewed simply as a hurdle to health and wellbeing.
- The public health message that ageing brings increased risks associated with alcohol was being received by those in our sample.
- Healthy ageing policies can learn from the active contribution older people make in creating healthy routines, in identifying for themselves the risks associated with the life-stage in relation to alcohol and help support these adaptations.
- Services should ensure the issue of older people's drinking is not missed. The participants in our sample were not 'addiction' clients so would need to receive advice from other sources. However, the needs of older people, particularly around ensuring social connections and interaction, are no different from adults more generally and care should be taken not to 'ghettoise' messages and services.

Background

Alcohol related harm costs Scotland an estimated £2.25 billion per annum (Scottish Government 2008) and is no longer considered a marginal problem with 50% of men and 30% of women drinking above recommended weekly guidelines (Scottish Government 2009). That alcohol can pose a threat to healthy ageing comes across clearly in the literature (see for example, Holley-Moore and Beach, 2016; NHS Health Scotland, 2006; Wadd *et al.*, 2011). However, so too does the need for older adults to lead active and connected lives (Christie Commission, 2011; Scottish Government, 2011a). Nevertheless, relatively little is known about the where, what and when of older people's drinking and whether or not changes associated with retirement have an impact on how people drink.

Research aims

The purpose of this study was to improve understanding about the role of alcohol use in retired men and women. To reflect potential cohort differences, three age bands were selected to focus on:

- 'younger' retirees aged 55-59 years
- 'middle' retirees aged 65-69 years
- 'older' retirees aged 75-79 years.

It should also be noted that in order to better understand the wider context and implications of alcohol use in retirement, the study focussed on normative consumption rather than those diagnosed as problem drinkers.

Consequently, the key aims of this study were to:

1. investigate how the process of retiring and ageing shapes alcohol use and its role in the lives of retired people
2. explore the meaning and uses of alcohol in retirement
3. explore the lives of older people more broadly, including social networks, interests and family life
4. capture the intersections of gender, age and socio-economic status in shaping the experience of retirement and how it relates to alcohol use. This was achieved by including men and women, three specific age groups, and those from areas categorised as 'more deprived' and 'less deprived', according to the Scottish Index of Multiple Deprivation (SIMD).
5. consider service and policy implications flowing from an enhanced understanding of alcohol use in later years.

Methods

In order to address the research aims, a qualitative methodology was employed. Data was collected and analysed in two stages. In the first stage, Key Informants with expertise in relation to alcohol policy and/or older people's services were interviewed about their perceptions of the issues surrounding older people's use of alcohol and any key areas of concern. In the second stage, in-depth interviews were conducted with a total of 40 men and women, across the three age cohorts and ten SIMD deciles. Interviews sought to explore the role and meanings of alcohol use, as well as other aspects of life in retirement including hobbies, social networks and health more generally.

Findings

Key Informant (KI) insight

Two key themes emerged from the KI interviews. The first theme related to the heterogeneity of older adults' drinking and how this related to specific concerns

around risk and ageing: older adults were often described as more 'at risk' in relation to alcohol, both in terms of the risk of alcohol dependency and an increased risk of harm related to more moderate amounts of alcohol. Retirement itself was discussed in this context but as one of many issues which related to changes in the patterning of older people's use of alcohol.

Secondly, the issue of 'constricted social opportunities in later life' were raised by our KIs. Whilst retirement was mentioned in this context, other issues such as bereavement, geographical separation from family, social isolation, boredom, and a lack of 'other things' to do were all identified. This theme of lack of opportunity was often framed as a potential 'trigger' for increased alcohol consumption (particularly in the context of the home). Throughout these interviews, KIs talked about a need for greater availability of, and access to, organised groups and clubs for older adults.

Older adults interviews

Key findings from the interviews with older adults are detailed below. These related older adults' drinking routines and practices to three key areas: routes into retirement; roles and activities in the retirement phase of life; and social networks.

- Routes into retirement could be characterised as 'traditional' or 'drift'.
- Most retirement transitions involved other influencing factors including health; changes in work environment; caring commitments and financial considerations.
- These other factors often had a more important influence on the initial experience of retirement and on the way in which alcohol was consumed than the transition to retirement itself.
- Alcohol consumption was largely framed in positive terms and was embedded within daily and/or weekly routines.
- While some participants took part in a wide range of roles, activities and pursuits, others suffered periods of relatively little involvement or activity.
- For many retired people, these roles and activities provided part of the context within which drinking took place in terms of where, when and with whom they drank.
- Drinking routines often had self-imposed rules and restrictions to avoid the risk of dependence or 'losing control'.
- Retirement was one of many events in a person's life which could bring a change of routine, including routines and practices around alcohol.
- Retirement could provide an opportunity for the volume of alcohol consumed to increase due to increased opportunity to drink, but it could also see a decline as social networks reduced or changed, or as the pressures of work ceased.
- Many participants reported drinking less as a result of health concerns, decreased tolerance for alcohol or decreased opportunities to socialise and drink.

- Processes and circumstances associated with ageing can present sudden broken routines that are problematic in terms of periods of increased risk of social isolation and/or increased alcohol consumption. Whilst broken routines can be associated with retirement they are broader than this and include things like taking on a caring role, bereavement and loss of social networks.

Discussion and conclusions

Retiring, ageing and changes in alcohol use

- A number of changes in drinking routines and patterns were evident including an increase in home drinking. This was linked to varied factors such as a growing preference for drinking at home and reduced costs, rather than a sign of 'hidden' or 'problem' drinking.
- Amongst those who did change their drinking, many had reduced their alcohol intake either as a result of deliberate action, or as the consequence of decreased opportunities to drink socially.
- Amongst those who moderated or stopped drinking, reduced tolerance, broader health considerations, avoidance of hangovers and reduction of social networks were all associated with this change.
- The public health message that ageing brings increased risks associated with alcohol was being received by those in our sample.
- A variety of circumstances and life events other than retirement or physiological ageing had a role in shaping alcohol use. These included the development or loss of interests and pursuits; changing social networks and opportunities to participate in social routines; taking on full time caring responsibility for a partner, or other close relative and bereavement.
- Although younger retirees may demonstrate higher levels of alcohol consumption than older retirees, this does not necessarily indicate a pattern that will continue five or ten years after retirement.

Meaning and uses of alcohol in retirement

- Alcohol was largely embedded within a broader set of routines and rituals in the lives of older people.
- Moderate drinking amongst retired people can contribute to their engagement with 'active' and 'healthy' ageing. For this reason, alcohol need not be viewed simply as a hurdle to health and wellbeing.

Life in retirement

- Many participants' lives were structured around various roles, responsibilities and more leisure-oriented activities.
- Age, health, mobility and the other circumstances going on in a person's life influenced the types of activities pursued and how regularly.

- Those whose time was largely taken up by caring for a dependent relative were often the most socially isolated.

Gender, age and levels of deprivation

The gender, age and SIMD sampling employed in this study was aimed at generating a broad and varied range of experiences, routines and practices rather than testing for differences based on these variables. Nevertheless, some differences could be tentatively suggested.

- More men in our sample drank in public spaces than women.
- More women in the study were full time carers than men. The caring role was often associated with increased levels of social isolation, suggesting that if the burden of care on older women increases with population change, more women will be at risk of suffering high levels of social isolation in this phase of their lives.
- Participants in the older group largely drank less than those in the middle and younger groups. However, it should not be *assumed* that this reflects a cohort difference with public health consequences – an ‘ageing effect’ was also evident that suggests more regular consumption amongst younger retirees may also decline as this cohort ages.
- With regard to levels of deprivation, little difference was found in the sample in relation to how alcohol was used. That is not to suggest that such differences do not exist, but that they simply did not figure strongly in this study.

Recommendations

The physical and social processes associated with ageing present a variety of risks and opportunities with regard to relationships with alcohol.

However, the results of this research suggest that changes in routines associated with this stage of the life-course (retirement from paid work, physical ageing and changing opportunities for sociability) can cause disruptions to established routines which has associations with alcohol use but also in relation to risk of loneliness and social isolation.

Positive outcomes appear to be associated with an individual’s ability to actively construct healthy routines which take account of needs for social interaction and other wellbeing needs. With the older population, initiatives to promote healthy relationships with alcohol should recognise social isolation and loneliness as an associated risk.

Healthy ageing policies can learn from the active contribution older people make in creating healthy routines, in identifying for themselves the risks associated with the life-stage in relation to alcohol and help support these adaptations. Practitioners can build upon older people’s own informal management strategies for alcohol risk.

These can be shared with other older people or used to start a conversation around what works for different individuals in different contexts.

The value of community spaces such as shopping centres, libraries and local parks, as sites that allow alcohol free social interaction, for older people should be taken into account in developing health ageing policies

Policies and initiatives aimed at older people's health need to be cautious of stigmatising older people's alcohol use. Alcohol can play a significant role in social and leisure activities which are important features of health and wellbeing in later life. Initiatives aimed at promoting healthy and active ageing need to ensure that physical inactivity and solitary pursuits are not inadvertently stigmatised.

Where older adults have had periods of heavy drinking in the past, they are potentially more at risk of using alcohol in response to 'broken' routines and in need of additional assistance and support to adapt and develop new routines that do not involve excessive alcohol.

Consequently, screening tools used to assess alcohol problems could be more nuanced if they included questions related to regular alcohol routines (where, when, why, how and with whom,) rather than focussing on estimates of units consumed. Simple management strategies with simple messages are more effective than advice about units.

Services should ensure the issue of older people's drinking is not missed. The participants in our sample were not 'addiction' clients so would need to receive advice from other sources. However, the needs of older people, particularly around ensuring social connections and interaction, are no different from adults more generally and care should be taken not to 'ghettoise' messages and services.

Policy initiatives such as the Change Fund that accompanies the Scottish Government's *Reshaping Care for Older People* programme (Scottish Government, 2001a) could be used to stimulate existing groups to widen their participation to include older people – providing opportunities for older people specifically or including them in existing groups.

Introduction

In the context of an ageing population, changes in retirement age, and specific concern surrounding the ageing of a generation which has positioned alcohol more centrally into leisure and lifestyle than any before it, there is a perception of a 'demographic time-bomb' in population health terms.

Nevertheless, relatively little is known about the 'where', 'what' and 'when' of older people's drinking and whether or not changes associated with retirement have an impact on how people drink. To address this, the research presented in this report examines normative alcohol use amongst retired people living in the West of Scotland. The findings suggest that drinking behaviours are routinized and woven into the daily and weekly patterns of people's lives. Whilst retirement can introduce a disruption to these routines, it is only one of many life events around which people's lives are ordered. Alongside this, evidence from this study suggests that older people actively reflect on their drinking routines and practices and often take steps to moderate and reduce their drinking to accommodate changes in their lives. This suggests that not only is there an awareness of the main public health messages surrounding alcohol use amongst older people, but that a more asset-based approach to alcohol, in which older people share strategies for coping with change in later life, could be fruitfully adopted. Furthermore, this study suggests that moderate drinking amongst retired people is often a significant component of their lives and can contribute to their engagement with 'active' and 'healthy' ageing. Thus, rather than simply viewing alcohol consumption as a hurdle to health, health professionals should be wary of stigmatising older people's drinking in a way which may have detrimental consequences to their health.

Context: Alcohol and the ageing population: Changing times

Worldwide the population is ageing as a result of improvements in life expectancy and declines in fertility rates (World Health Organisation (WHO), 2011). In Scotland specifically, the average life expectancy has risen significantly over the past century, from 40 years in 1900 to just over 77 for males and just over 81 for females born in 2014 (Scottish Government, 2015). The proportion of older adults in Scotland is expected to continue to rise and it is projected that the number of people aged over 65 will be 21% greater in 2016 than it was in 2006, and 63% greater by 2031 (Scottish Government, 2011a). This "greying" of the population raises new opportunities as well as challenges in relation to older adults' health and wellbeing (WHO, 2011a).

Alongside this, the shifting burden of healthcare towards non-communicable diseases in our society, means that harmful alcohol use has been identified as a global public health concern (WHO, 2014). When used harmfully, alcohol is a component cause in over 200 disease and injury conditions, including alcohol dependence, liver cirrhosis, cancers and injuries (WHO, 2014). It constitutes the third leading risk factor for premature deaths and disabilities (WHO, 2009) and is one of

the four most common modifiable and preventable risk factors for major non-communicable diseases (WHO, 2011b). From such figures, it is clear that when used harmfully, alcohol poses a threat to healthy ageing.

Globally, nationally and locally alcohol policies have been developed that aim to reduce the harmful use of alcohol and the associated health and social costs (WHO, 2014). In the UK, much of this focus has been on the 'safe' guidance for alcohol intake. For men, the recommendations are that they do not regularly exceed 21 units per week, and 3-4 units per day. For women, the recommendations are lower at 14 units per week, and 2-3 units per day. Both are advised to have at least two alcohol free days per week (Department of Health, 1995¹; Scottish Government, 2009).

In terms of parameters of normative alcohol consumption, cross-Europe analysis by the Social Issues Research Centre (SIRC, 1998) identifies four near universal themes associated with the consumption of alcohol: proscription of solitary drinking; prescription of sociability; social control of consumption and behaviour; and restrictions on female drinking. Typically, the pattern of alcohol consumption in the UK is celebratory, characterised by a preference for heavier drinking at the weekends with relatively little drinking taking place during the (working) week (McDonald, 1994; Plant and Haw, 2000; Parker and Williams, 2003; Measham, 2006). Alcohol has long been referred to as 'our favourite drug' (Royal College of Psychiatrists, 1986) - associated with pleasure and leisure time and socially accepted, whilst at the same time linked to a wide range of health and social problems. Thus, the consumption of alcohol has both positive and negative aspects. Generally, the positive aspects are associated with moderate alcohol intake, and problems associated with 'harmful' intake (e.g. SIRC, 1998), although that position is being challenged by more recent health advice which indicates that there is no 'safe' level of alcohol consumption (Department of Health, 2016).

Throughout the 1990s, alcohol consumption increased in the UK as alcohol became more affordable and widely available (Smith and Foxcroft, 2009). During this time Scotland experienced increases in both heavy drinking and alcohol related harm (O'Donnell, 2006; Leon and McCambridge, 2006). Alcohol was being 'consumed in larger quantities by a much wider range of age and social groups' (Independent Enquiry on Scotland's Alcohol and Drug Use, 2010, p. 7).

In particular, heavy drinking (i.e. drinking out-with the guidelines) is no longer considered to be a marginal issue with 50% of men and 30% of women found to be drinking above recommended weekly guidelines of 21 and 14 units of alcohol respectively (Scottish Government, 2009). In 2009, the Scottish Government responded by publishing *Changing Scotland's Relationship with Alcohol: A Framework for Action (2009)* outlining efforts to change Scotland's culturally engrained relationship with alcohol.

¹ This was revised in January 2016 to 14 units per week for both men and women.

In this report the Scottish Government are clear that they are adopting a whole population approach.

“Our approach is targeted at everyone, including the ‘ordinary people’ who may never get drunk but are nevertheless harming themselves by regularly drinking more than the recommended guidelines” (Scottish Government, 2009, p. 6).

Similarly, in a report to the European Commission, the Social Issues Research Centre (SIRC) (1998) also call for a focus on drinking behaviour per se, rather than problem oriented perspectives.

“The dominance of problem oriented perspectives has led to a serious imbalance in the study of alcohol whereby problems affecting only a small minority of drinkers have received disproportionate attention, while the study of ‘normal’ drinking has been neglected” (SIRC, 1998, p. 3).

Initially, therefore, older people’s drinking was considered from a risk perspective simply as one group within a wider ‘at risk’ population. Generally older people’s alcohol consumption has been lower than that of younger people and so regarded as less of a public health priority. There are, however, clear signs that this perception is changing (Bakhshi and While, 2014). Concerns have been raised about the future implications if the ‘Baby Boomer’ generation continue their levels of consumption into later life² (e.g. NHS Health Scotland, 2006; Wadd *et al.*, 2011). More recently, the Big Lottery funded ‘Drink Wise, Age Well’ programme was launched in the UK with the aim of reducing alcohol related harm amongst older people by providing an overall prevention-to-treatment programme including increasing awareness of alcohol-related harm, changing attitudes and norms around drinking, combatting stigmatisation and increasing individual and community resilience to alcohol problems amongst older people (Holley-Moore and Beach, 2016). Their initial report stresses a ‘pressing need for action to reduce alcohol-related harm in older adults across the UK’ (Holley-Moore and Beach, 2016, p.4).

Thus, against the backdrop of an ageing population, an increasing emphasis on prevention of non-communicable disease within healthcare, and a widening of the perception of risk away from addiction and dependency towards ‘heavy’ drinking over longer periods of time, studies of older people’s drinking have begun to emerge that examine drinking practices in terms of risk and harm. Despite the call for more studies of ‘normal’ drinking almost 20 years ago, these have been largely absent from public health explorations of older people’s drinking. In this study we intend to address this imbalance by complementing the risk and harm perspective on alcohol and ageing with a perspective which focuses on older people as a population group

² ‘Baby boomers’ typically refers to those born in the aftermath of the Second World War, between 1945 and 1965 (e.g. Health Scotland, 2006)

about whom more knowledge is required about the processes that shape both normative *and* problematic alcohol use.

Research aims

The key aims of this study were to:

1. investigate how the process of retiring and ageing shapes alcohol use and its role in the lives of retired people
2. explore the meaning and uses of alcohol in retirement
3. explore the lives of older people more broadly, including social networks, interests and family life
4. capture the intersections of gender, age and socio-economic status in shaping the experience of retirement how it relates to alcohol use. This was achieved by including men and women, three specific age groups, and those from areas categorised as 'more deprived' and 'less deprived', according to the Scottish Index of Multiple Deprivation (SIMD).
5. consider service and policy implications flowing from an enhanced understanding of alcohol use in later years.

Within these aims, the focus is on normative consumption (rather than 'problem' drinking) in order to better understand the wider context and implications of older adults' alcohol consumption, beliefs and practices.

Background: Ageing, retirement and alcohol consumption

Published reviews are available that examine alcohol (use and misuse) in relation to older people (e.g. Johnson, 2000; Ferreira and Weems, 2008; Coulton, 2009; Simmill-Binning *et al.*, 2009) and retirement specifically (e.g. Kuerbis and Sacco, 2012; Zantinge *et al.*, 2014; Bamberger, 2014). However, much of this literature is from a clinical perspective with less emphasis on the socio-cultural aspects of older adults' alcohol use. The next part of the report explores this further, focusing on existing literature relating to older adults' alcohol consumption and the retirement-drinking relationship (e.g. Holley-Moore and Beach, 2016; Bamberger, 2014).

It is generally accepted that older adults consume less alcohol than their younger counterparts which has contributed to them being seen as less of a public health priority up until recently (Bakhshi and While, 2014). Although older people have tended to drink less than younger people, it is not yet fully understood whether this is due to:

- an ageing effect – older people have reduced their consumption as they have aged
- a cohort effect – current cohorts of older people drank less when they were younger and have maintained that pattern into old age

- a mortality effect - heavier drinkers die earlier.

Related to this, older adults appear to have a different pattern of consumption to their younger counterparts. In contrast to younger people's 'concentrated' (binge) style of consumption, older people are associated with a 'spread' pattern of drinking i.e. consuming smaller amounts of alcohol on a more regular basis (e.g. Plant, 2008; Scottish Health Survey, 2013; Holley-Moore and Beach, 2016). The percentage of non-drinkers is also higher in older age groups (Scottish Health Survey, 2013). It should be noted that most of the surveys reporting that older people drink less such as this one, are cross-sectional rather than longitudinal and are therefore do not indicate how alcohol changes over one's life course (Gilhooly, 2005).

As the paper '*A drink to healthy ageing*' highlights, although heavy drinking by older people is a cause for concern, the majority of older people are moderate drinkers (Byles *et al.*, 2006). This is further reinforced with the findings from the 'Drink Wise, Age Well' study that found 80% of respondents who drank alcohol were 'low risk' drinkers (Holley-Moore and Beach, 2016). This was measured using a combination of weekly units consumed and the Alcohol Use Disorders Identification Test scores (AUDIT) which asks a range of questions about alcohol use and problems arising from alcohol use over the previous six months (WHO, 2001). Furthermore, some existing research suggests that moderate drinking in older people has a beneficial effect on mortality and is associated with a range of psychological benefits which may be linked to reduced stress and greater sociability (Wadd *et al.*, 2011). Using data from Wave 1 of the English Longitudinal Study of Ageing, Lang *et al.* (2007) conclude that, in comparison to abstinence, moderate levels of alcohol consumption are also associated with better cognitive health in middle aged and older adults. Moderate drinkers were found to have better subjective wellbeing and fewer depressive symptoms than their abstaining counterparts. Moderate consumption (1-14 drinks per week) in older men and women is associated with decreased mortality; older people who live in the community and consume moderate levels of alcohol have fewer falls, greater mobility and improved physical functioning compared with non-drinkers (Ahlstrom, 2008).

Nevertheless, from the late 1970s, a 'new public health' approach emerged which saw a redefining of problematic alcohol consumption; the focus shifted from the 'alcoholic' label (which applied to a minority of drinkers) to 'problem' drinking (less severe but affected more drinkers) (Thom, 1994). Therefore, in the context of this new approach, moderate alcohol consumption on a regular basis over a number of years was also increasingly constructed as problematic in public health terms.

Whilst older people have tended to drink less than their younger counterparts, there is also evidence to suggest that the present generation of older people drink more than previous generations (NHS Health Scotland, 2006; Watts, 2007; Smith and Foxcroft, 2009; Wadd *et al.*, 2011). Watts (2007) highlights that whilst it is usual for

consumption to decline with age, current cohorts of older people are experiencing wider changes that may facilitate them drinking more than previous cohorts, such as greater disposable income, better overall health, more leisure time and holidays abroad. Related to this, Smith and Foxcroft (2009) highlight that there are likely to be large income inequalities among older people, and that it is “likely to be the wealthier, better-off individuals who are drinking more and enjoying their new freedoms” (Smith and Foxcroft, 2009, p. 86).

The impact of retirement

The impact of retirement on drinking patterns has received particular attention in the literature with the suggestion that, as a major life event, it may exacerbate existing patterns of heavy drinking or indeed serve as a trigger for misuse (Bamberger, 2014). This assumption, however, is challenged where reviews of the quantitative evidence base have found some studies reporting an increase, some a decrease and others finding no change (Kuertis and Sacco, 2012; Zantinge *et al.*, 2014; Bamberger, 2014). It is therefore argued that retirement itself does not have a strong, direct impact on drinking but that aspects of the process (e.g. voluntariness) as well as individual characteristics (such as a history of drinking problem) may increase or decrease drinking (*ibid.*).

In this context, it is worth mentioning that retirement as a process and as a cultural practice has undergone significant change in the UK in recent years (Phillipson, 2004a; Phillipson, 2004b; Mein *et al.*, 2000). The impending retirement of the ‘Baby Boomer’ cohorts along with the financial implications of people drawing on pensions for a longer period of time has widely been framed as unsustainable (Price, 2007). This culminated in 2011 in the removal of the default retirement age of 60 and 65 for men and women respectively with the message that no-one should be ‘forced’ to retire (Department for Work and Pensions, 2014). Equality legislation was introduced which sought to make it illegal to discriminate against people aged over 50 in the work place. The launch of Fuller Working Lives (Department for Work and Pensions, 2014) aimed to make clear a business case for continuing to work in later life, and to address the forced market exit of people in their 50s and early 60s.

At the same time as the push towards longer working lives and later retirement, there has been a shift in perception of retirement, increasingly viewed as a celebrated ‘3rd age’ framed in terms of freedom, sustained leisure and reward (e.g. Phillipson, 2004a; Künemund and Kolland, 2007; Loretto, 2010; Loretto and Vickerstaff, 2012). Indeed, Loretto and Vickerstaff, (2012, p. 77) reflect on there being “no great appetite for working longer” (i.e. beyond state pension age) as most of the participants who were working or had retired from work talked about retirement in terms of ‘freedom’ such as from deadlines and work pressures.

From this perspective, retirement is understood as an opportunity to reach/maintain a high quality of life, rather than a stressful and traumatic event associated with the loss of work (Künemund and Kolland, 2007). What is more, this conceptualisation of

retirement as a time of “sustained leisure” has obvious implications for the way in which alcohol is positioned. However, it is important to highlight that this is one version of retirement and the literature is clear that there is great diversity in approaches to and experiences of retirement (e.g. Banks and Smith, 2006).

For example, Loretto and Vickerstaff (2012) highlight the ‘messy’ nature of retirement, noting that distinguishing between ‘retired’ and ‘non-retired’ participants in their study was not straightforward because some self-defined as ‘retired’ but were still doing some paid work. Banks and Smith (2006, p. 43) also draw attention to the fluid nature of ‘retirement’, pointing out that the term can be used in relation to three different aspects:

1. Complete and permanent withdrawal from the paid labour market.
2. Receipt of income from a pension (whether that be from the state or a private pension).
3. A state of mind i.e. one perceives of themselves as retired.

Frequent reference is made to two groups in relation to early retirement specifically. The first group is characterised as wealthy and able to retire early due to private occupational pensions (Banks and Smith, 2006). Here, retirement is framed as a positive **choice** (Lissenburgh and Smeaton, 2003). In contrast, the second group, are more likely to have been economically inactive in their 50s. Prior to drawing their state pension, they may have been receiving other sources of state support such as income support or disability benefits; thus they ‘drift’ into retirement (i.e. receive a state pension), moving ‘from one source of support to another’ (Banks and Smith, 2006, p. 53). In such circumstances - and particularly amongst low paid men – this is less about a personal choice and more about an inability to remain in employment due to health problems (Lissenburgh and Smeaton, 2003). Therefore, perceptions of retirement vary - for those with stressful and/or unsatisfied jobs it can be looked forward to as an ‘escape’ whilst for others it can become ‘a dismal burden’ (Hodkinson *et al.*, 2008: p. 174). Indeed, retirement related to health problems is commonplace and this relationship requires further attention (Hodkinson *et al.*, 2008).

It has been noted that the majority of studies into retirement focus on men (e.g. Mein *et al.*, 2000). This is problematic given that men and women may have different career routes which then have implications for how retirement is approached and experienced. Loretto and Vickerstaff’s (2012) qualitative study found evidence of gendered pathways to retirement. The men in their sample tended to take a market-driven pathway to retirement (e.g. shaped by employment policies or opportunities). In comparison, their partners tended to take a more domestic driven route, frequently bound by caring responsibilities. The researchers conclude that it is important to consider the domestic context of the household in relation to pathways to retirement, rather than focusing on the individual. Similarly, whilst the main reason for economic

inactivity in men in their fifties is being long term sick/disabled, for women, caring responsibilities at home are equally important (Phillipson, 2004a).

Therefore, despite the cultural associations between retirement and sustained leisure/ freedom from work, routes into retirement are varied and dependent on the circumstances surrounding retirement and the type of employment (or not) that precedes it. However, retired people's lives do not simply fall into a 'before' and 'after' pattern. For example, there have been calls to widen the focus of understanding life and engagement in retirement/ later life, and consider aspects other than paid, formal work (e.g. Phillipson, 2004a; Price, 2007; Loretto and Vickerstaff, 2012). Increases in life expectancy and the changing nature of family life could lead to additional responsibilities – such as supporting elderly parents/grandparents and helping with grandchildren to assist the middle generation to undertake paid work (Price, 2007). The Scottish Government (2011c) estimates that around 3,000 people aged 65+ receive more than 20 hours of paid care per week. In comparison, over 40,000 people aged 65+ provide more than 20 hours unpaid care per week.

The concept of social engagement is another important area to consider when examining the diverse experiences of retirement. In the UK, it has been estimated that around 10% of people aged 65 and above report that they often/always feel lonely – a percentage that has remained stable over the past six decades (Victor *et al.*, 2005). Research demonstrates that social isolation (the absence of contact with others) and loneliness (the subjective experience of isolation regardless of choice) are detrimental to the health and wellbeing of older people. For example, they are linked to depression and higher rates of mortality (e.g. Steptoe *et al.*, 2013) as well as increasing feelings of disconnectedness and not belonging (Hawkey *et al.*, 2005).

Thus, Bamberger (2014) calls for a shift in the conceptual framing of the drinking-retirement relationship. He emphasises that it is the process of adjustment in retirement that is important and that this process may take 10-20 years to run its course; it is not enough to focus on the short term 'before' and 'after'. Thus, it has been suggested that the value of focusing solely on the retirement-drinking relationship may be somewhat limited, leading Kuertis and Sacco (2012, p. 594) to comment:

“In this sense, research on retirement and alcohol use may be replaced by more general approaches to midlife and later life drinking where issues such as workforce engagement and other forms of so-called productive ageing are examined alongside other dynamic influences of health in the second half of life”.

Drinking across the life-course

Previous research demonstrates a growing recognition that “people experience different drinking patterns at different times in their lives” (Plant, 2008, p. 170). The significance of alcohol for younger people is often contextualised in relation to the transition to adulthood; more recently, there has also been an increase in studies examining alcohol use in relation to retirement.

With the exception of adults who develop alcohol dependence, it has been argued that alcohol consumption declines with age for most adults, and that they may become abstinent (Balsa *et al.*, 2008). Aspects related to this apparent decline have been identified as: biological ageing; decrease in socialisation; and morbidity (Moos *et al.*, 2005). The latter of these is the focus of Moos *et al.*'s (2005) study and their findings suggest that as people encounter more health problems as they age, they reduce their intake of alcohol.

Moos *et al.* (2005) also emphasise the importance of an individual's previous relationship with alcohol as an important aspect in drinking trajectories in later life; in their study, a history of heavy drinking predicted heavier drinking in later life. Platt *et al.* (2010) used data from America's Health and Retirement study to examine changes in drinking and found that generally consumption was low in older people, and declined as people aged. However they highlight that there are exceptions, such as those with a history of problem drinking, and that it is these exceptions require more attention.

Studies such as those cited above have tended to be quantitative, measuring alcohol consumption pre- and post-retirement over varying lengths of time. Whilst younger adults' use of alcohol has been explored through qualitative studies that focus on their views, experiences and the role alcohol has during that phase of life, qualitative research focusing on the alcohol use of retired adults are largely missing from the field. One of the few exceptions to this is Wilson *et al.*'s (2013) qualitative study conducted in the North East of England. Focusing on adults aged between 50-94 years, they found that drinking had positive constructions and alcohol could be a source of enjoyment when consumed in moderation. Participants emphasised their drinking as their choice; that their consumption was controlled; and that alcohol did not 'dominate'. Participants defined their relationships with alcohol in terms of self-control and propriety, rather than health considerations.

Emslie *et al.* (2012) contend that midlife heavy drinking can be positive for health because of its role in maintaining social networks:

“Heavy drinking (as a release from tension, an escape from the responsibilities of life, a means of improving mood through laughter with friends) can be seen as part of the process of maintaining good health for both men and women” (Emslie *et al.*, 2012, p. 492).

Thus research that focuses on older adults' reasons for drinking highlight the importance of the association it has with relaxation and sociability. Plant *et al.* (2009) investigated alcohol use through questionnaires with people aged 55+ and the two most popular reasons were: sociable (63%), relaxation (57%). Related to this portrayal of sociable drinking, the majority of respondents in Plant *et al.*'s (2009) study reported drinking with family and friends, at 75%, and 26% reported drinking with their partner, whilst only 16% reported drinking alone.

Other qualitative studies such as Wilson *et al.* (2013) and Ward *et al.* (2008; 2011) again highlight the perceived benefits of sociability and relaxation. This led Wilson *et al.* (2013) to conclude that drinking can help prevent older adults "from losing touch". Thus, drinking is portrayed as something that can help maintain quality of life as one ages. This type of approach lies in stark contrast to a more risk and harm approach which is beginning to dominate the study of older people's drinking. For example, despite its name, the recent 'Drink Wise, Age Well' report largely ignores the potential positive benefits for older people of alcohol's role in relaxation and socialising, and indeed makes little use of the data on the 80% of respondents who were classed as 'low risk', in preference for a more detailed examination of 'increasing' and 'higher' risk drinkers (Holley-Moore and Beach, 2016). Therefore, the implication is that the 'Age Well' dimension of the programme is straightforwardly achieved via a reduction in alcohol use.

At the same time as studies highlight older people's use of alcohol as 'sociable', older people also tend to be more associated with home based drinking, in contrast to younger people's more public and visible drinking (e.g. Plant and Haw, 2000; Valentine *et al.*, 2007; Rolfe *et al.*, 2009; Plant *et al.*, 2009). Plant *et al.* (2009) found that their respondents (aged 55+) who drink were most likely to do so in their own homes, at 69%, than restaurants (58%) with a much lower percent drinking in social clubs/pubs (11%). It has been argued that this can render older people's drinking more "solitary and discrete" (Ward *et al.*, 2008, p. 3) However, it should be noted that home based drinking does not necessarily entail solitary drinking, whilst the association of alcohol with relaxation mentioned above implies that solitary drinking at home also does not necessarily mean 'problem' drinking.

Problematic alcohol use in older people

Whilst drinking too much alcohol is associated with increased risk generally, there are specific concerns about older people's use of alcohol. Ageing is associated with biological, psychological and social changes that render older people 'uniquely' vulnerable to alcohol (Wadd *et al.*, 2011). Bamberger (2014) highlights two aspects that can render older people more at risk (than their younger counterparts) of adverse health consequences from misusing alcohol; firstly, that it can exacerbate a range of chronic health conditions that affect older people and secondly that it can adversely interact with the medication older people may be prescribed for such conditions. Furthermore, in older people, alcohol has been linked to falls, confusion,

self-neglect, low quality of sleep, increased risk of coronary heart disease, stroke, accidents, memory loss and depression (e.g. Johnson, 2000; Clough and Hart, 2004; Simmill-Binning *et al.*, 2009). Other vulnerabilities have been associated with loneliness and isolation as people get older, such as diminished mobility, bereavements as well as poor economic and social supports (Wadd *et al.*, 2011).

In relation to 'problem drinking' specifically in older adults, three types of drinkers have been identified (Institute of Alcohol Studies (IAS), 1999; Alcohol Concern, 2002):

1. Early onset (survivors) for whom an alcohol problem developed early in life and is continued.
2. Late onset (reactors) who begin drinking heavily later in life, often in response to traumatic life events such as loneliness, pain or retirement.
3. Intermittent heavy drinkers (binge drinkers) – who drink occasionally or excessively, with adverse effects.

With regard to the second group, there have also been calls for more attention to be paid to potential 'triggers' for the late onset of problems which, it has been argued, may increase with age. These include bereavement, isolation, loss of role and daily routines and structures, fear and ill-health (Clough and Hart, 2004; Ward *et al.*, 2008; 2011; Shaw and Palattiyil, 2008).

Nevertheless, the prevalence of dependant alcohol use amongst older people is small - as reported by Wadd *et al.* (2011), 3% of older men and 0.6% of older women (aged 64-74) are alcohol dependent. Further, within the Scottish Health Survey (2013), the vast majority of respondents aged 75+ were low risk or abstinent, at 96% and 100% of men and women respectively. Nevertheless, whilst the prevalence of alcohol problems appears to be relatively low in older people, alcohol issues in the older population have also been described in various ways as 'hidden', underestimated, and neglected in contrast to alcohol problems in younger people (e.g. Clough *et al.*, 2004; Ahlstrom, 2008; Shaw and Palattiyil, 2008; Coulton, 2009; Simmill-Binning *et al.*, 2009; Royal College of Psychiatrists, 2011; Drugscope, 2014; Bamberger, 2014). In addition, as noted earlier in the review, there has been concern that the prevalence of alcohol use disorders in older adults may increase alongside the ageing population (e.g. O'Connell *et al.*, 2003; Drugscope, 2014). There have been calls for this to be addressed urgently with references made to a "silent epidemic" (O'Connell *et al.*, 2003, p. 667), and "the time to act is now" (Clough *et al.*, 2004, p. 1).

More than a decade on, these sentiments remain, with reports entitled 'Our invisible addicts' (Royal College of Psychiatrists, 2011) and 'It's about time' (Drugscope, 2014) and the claim that there is a "pressing need for action" (Holley-Moore and Beach, 2016). This concept of 'silent epidemic' is significant in that, in the absence of

evidence to back up the anticipated rise in problem drinking amongst older people, there is a danger of stigmatising and problematizing older people's drinking. Social engagement, as outlined below, is an important consideration for optimising older people's health and wellbeing and alcohol has a strong cultural association with socialising and leisure time. Khan *et al.* (2006) contend that health promotion and education about the potential negative health outcomes of alcohol should be delivered in the context of 'ensuring appropriate engagement' in later life. In a similar vein, Van Wersch and Walker (2009) call for more research on the health consequences of alcohol that "acknowledges psychosocial contextual factors and avoids generalisations made on isolated biomedical data" (p. 132); they urge that public health warnings should not be ignored but critically assessed.

Healthy and active ageing agendas

As elsewhere in the world, changing demographics and the implications this may have in terms of demand on public services have provoked much attention in Scotland. This is particularly the case because the "greying" population is occurring in a climate of constrained resources (e.g. Christie Commission, 2011; Scottish Government, 2011a).

In 2007, the then Scottish Executive published *All Our Futures: Planning for Scotland with an Ageing Population*, casting the demographic shift in a positive light. In this report, specific reference is made to the WHO's (2002) conceptualisation of 'active ageing' as the process of optimising opportunities for health, participation and security to enhance quality of life as people age. It is worth noting that the WHO's definition of active ageing states explicitly that "activity" is not just about physical activity, but is about continued participation in social, cultural, spiritual and civic affairs.

However, declining health can influence a person's ability and desire to engage in activities as they age. For this reason, active ageing and healthy ageing are closely related concepts. Healthy ageing has been defined as:

"Maintaining the elderly in good health and keeping them autonomous and independent over a longer period of their remaining years" (Oxley, 2009, p. 6).

Many research studies have found evidence that maintaining social engagement and physical activity improves people's health outcomes as they age. Nevertheless, returning to the WHO definition of active ageing, "activity" can be very broadly defined and can encompass activities which older people with declining health are still able to participate in. For example, home-based, contemplative leisure activities such as book reading or TV watching are far more prevalent activities amongst the oldest-old and amongst those with poorer health, than are sports, travel, and participation in club life (Jacobs, 2005), but could be argued to denote "active"

ageing nonetheless. Similarly, interview studies have shown that older adults themselves do not view health as a prerequisite for ageing actively (Clarke and Warren, 2007; Katz, 2000).

One of the criticisms of the active ageing approach is that it implies a moral imperative which promotes a “busy ethic”; staying active is deemed morally virtuous (Ekerdt, 1986). This therefore has the potential to add guilt and stress to older people as they struggle to avoid idleness and engage in busy activities and this is a theme explored in the data from this study.

Ultimately, the goal for the Scottish Government is to optimise the quality of life for older people. Four long-term outcomes are identified within this which are to optimise:

1. physical health and function
2. independence
3. positive mental health and wellbeing, and
4. quality of end of life.

According to the reshaping care programme, this includes aspects such as making sure older people feel safe, that they have opportunities to meet and support each other, ensuring no-one is socially isolated or lonely, staying as healthy as they can, being free from discrimination and stigma, and being listened to and having a say in the services they receive (ibid.).

Overall, therefore, a commitment to valuing older people remains clear in the current Scottish Government’s strategies alongside a move towards prevention. This is important in the context of research into older people’s use of alcohol in that it implies a preference for an asset-based approach to alcohol use and one that maximises older people’s role in sharing their strategies of ‘ageing well’.

Research methods

The study was carried out in two stages. The first consisted of in-depth qualitative interviews with 22 Key Informants with expertise in relation to alcohol policy and/or older people's services. Participants were identified by the Project Advisory Group (see Appendix 1) and included individuals from alcohol and drug partnerships, local councils on alcohol, specialist alcohol services, older adults' services in the statutory and voluntary sector, academic institutions and relevant national charities.

Participation was confidential: therefore names are not included anywhere in this report. The purpose of this was three-fold:

1. To augment the desk-based literature review.
2. To influence the subsequent study design to ensure the concerns of practitioners and decision-makers were reflected in the interview schedule.
3. To establish relationships with end users of the research in order to maximise opportunities for knowledge exchange and uptake of findings.

The themes which emerged from the analysis of this data were used to construct an interview schedule for the larger second stage of the research. This second stage involved qualitative interviewing of retired men and women carried out between August 2014 and June 2015. The interviews explored the role alcohol played in their lives, and the influence of retirement and ageing on their alcohol consumption. The meaning and uses of alcohol for retired men and women were explored in three age cohorts: 'younger' retirees aged 55-59 years, 'middle' retirees aged 65-69 years and 'older' retirees aged 75-79 years. In addition, the proposed sampling framework (see Appendix 5) was designed to gain a diverse sample in terms of gender and socio-economic status. For the latter, The Scottish Index of Multiple Deprivation (SIMD) was used as this is an area based measure of deprivation; Decile 1 relates to areas categorised as 'most deprived' and Decile 10 relates to areas categorised as 'least deprived'.

Procedure

The interviews were semi-structured and followed a visual topic guide covering:

1. Employment
2. Stopping work
3. Home and family
4. Friends
5. Things that you like to do
6. Life events
7. Health
8. Having a drink
9. Policy relating to alcohol
10. Alcohol and medication

The topic guide is detailed in Appendices 5 and 6.

Sample

In total, the sample recruited comprised 40 participants across the three age cohorts; ten in the younger cohort of 55-59 years, 16 in the middle cohort of 65-69 years and 14 in the older cohort of 75-79 years. The sample included 23 females and 17 males ranging in age from 56 – 81 years³. With regard to the Scottish Index of Multiple Deprivation, 19 participants lived in areas categorised as ‘less deprived’ (i.e. deciles 6-10) and 21 lived in areas categorised as ‘more deprived’ (i.e. deciles 1-5).

Data analysis

Thematic data analysis was conducted following Braun and Clarke’s (2006) approach and with the use of NVivo to assist the coding process (see Appendix 4 for a more detailed account of data analysis).

³ Recruitment focused specifically on the three age cohorts. However one participant lay outside of this, being slightly older than the upper limit of the oldest age band. All other participants were within the three age bands.

Insights from Key Informants (KIs)

Two major themes emerged from the interviews with Key Informants that were especially relevant to our analysis of drinking in retirement.

The first theme related to the heterogeneity of older adults' drinking and how this related to specific concerns around risk and ageing: older adults were often described as more 'at risk' in relation to alcohol, both in terms of the risk of alcohol dependency and an increased risk of harm related to more moderate amounts of alcohol. Retirement itself was discussed in this context but as one of many issues which related to changes in the patterning of older people's use of alcohol. This was therefore accommodated in our subsequent interview schedule.

Secondly, Key Informants from across the professional spectrum highlighted the issue of 'constricted social opportunities in later life'. Once again, whilst retirement was mentioned in this context, other issues such as bereavement and geographical separation from family were also discussed. This theme of lack of opportunity was often viewed as a 'trigger' for increased alcohol consumption, particularly in the home, and was often framed in terms of a need for greater availability of, and access to organised groups and clubs.

Heterogeneity of older adults' drinking

The extent to which older adults' drinking was viewed as a public health problem was a contested area amongst the KIs interviewed. On one hand, there was a positive framing of older adults' alcohol consumption and we were encouraged not to overly problematize alcohol use in older adults. Participants highlighted that, despite recent increases, consumption in older people is generally lower when compared with younger people. They also pointed to a lack of firm evidence about what happens to levels of consumption when one retires and a need for better understanding about both protective and risk factors. All of this was contextualised within the wider picture of drinking as a social and leisure activity that is considered normal and socially accepted for adults across the age spectrum. The current 'Baby Boomer' generation were described as "redefining old age" in various ways, including their leisure choices and their alcohol use was seen by some as a mere reflection of those wider changes.

On the other hand, with KIs drawn from areas such as addiction services, social work and the health and social care sectors, inevitably many framed older adults' alcohol consumption in a more negative way, pointing to an increased vulnerability related to alcohol as people age. In addition, there were concerns about the implications that increased consumption in middle aged and older adults may have for health and social care services in the future if they continue to drink at the same levels in later life.

This dual construction of alcohol as both a positive leisure pursuit associated with sociability and a negative threat to individual and public health mirrors the wider

themes within the literature. Nevertheless, there were specific issues raised amongst KIs related to older people's drinking.

Increasing 'risk' as we age

There was a general consensus that there could be *increasing 'risk'* associated with alcohol consumption as we age. These risks were grouped into: physiological changes, interactions with medications, and falls/injuries. Social isolation was also mentioned in relation to increasing risk as we age. This is explored in the latter part of this section. Changes associated with the ageing process were described as making an older person's body 'more at risk to alcohol use'.

That older adults are more likely to be on various medications (both prescribed and over the counter) was also identified as an important consideration in relation to how this could interact (intentionally or unintentionally) with alcohol.

"...The trouble is they have four or five or more different conditions and thus they end up with 15, 20 medications and you add heavy doses of alcohol on top of that and that must be a concern... compromised function being further compromised by relatively heavy doses of alcohol and poly-pharmacy with alcohol added into the interactive mix" (KI 8; academic).

A further challenge in the context of older people specifically was that the consequences of alcohol use in older adults can be hidden and/or difficult to detect. For example:

"Alcohol can lead to loss of balance if it's used in a particular way but...loss of balance is also one of the physiological features of ageing so it might not be easily detected by a GP..." (KI 10; national older adults' charity).

Because of these additional considerations, some of our informants echoed suggestions that the limits/guidance should be reduced for older people:

"We obviously know there is the government unit guidelines, but in all of these reports and in particular, The Royal College of Psychiatry there is mention of how, you know, those units wouldn't be suitable for someone older but there is nothing new come out yet" (KI 19; alcohol and drugs health improvement).⁴

⁴ At the time of writing, new guidance has just been issued which recommends men and women do not regularly drink more than 14 units of alcohol per week. Thus, the weekly limit for men has been reduced to match the guidance for women. However, no age differentiation has been brought in.

However, others raised a challenge with setting generic advice for older adults, emphasising that they are not a homogenous group and people do not all 'decline' at the same rate as they age:

"You may have a very healthy 70 year old who can still drink at the same level as a younger person. You may have somebody in their 60s who has multiple health problems and so they can't and I guess one of the difficulties with that is setting recommended drink limits" (KI 5; academic).

Participants also highlighted that, especially with increasing life expectancy, 'older adults' as a group are becoming increasingly diverse. Gender and socio-economic status were also identified as sources of difference in older adults. Some Key Informants emphasised that health and social inequalities remain a concern in later life:

"The pattern of alcohol use and alcohol harm is likely to be socially patterned because there's this paradox that you must be aware of, I'm sure that in the, in the general adult population the most affluent seem to drink as much if not more but with much less harm and it may be that that, that pattern is continued into older age" (KI 8; academic).

'Falling through the net' and concerns for the future

A repeated concern raised by practitioners – as in the existing literature - was that alcohol could be a 'hidden' issue for older adults. There was a clear sense amongst Key Informants that it was difficult to gauge the extent of older adults' alcohol use. The idea of older adults 'falling through the net' was another aspect of the complexity involved in discussions about alcohol and ageing. Many of the quotes here point to a hidden and/or under detected issue:

"I think it's hidden problems really. I think it's manifesting itself usually too late when the, through either mobility, frailty or cancer, or other you know, so we tend to intervene when there's a huge issue" (KI 12; social work).

This hidden nature was described in terms of older adults drinking more at home, out of sight and away from social controls that may help to monitor and moderate consumption. Stigma for those for whom alcohol is a problem (especially amongst women) was also pointed to; people may hide any issues because of embarrassment, guilt or shame.

Added to this, participants who worked in social work reported experiencing difficulties with the language used to diagnose and refer older adults with alcohol issues – the focus appeared to be on whether there was an alcohol dependency issue rather than other aspects such as safety in the home.

"Where's the line, where do you cross the line to become addicted or where is it just problematic?'... we need more support and older people

need more support to help them and us recognise what the issues are and how we can help motivate them to manage that” (KI 15; social work).

The need for service provision to become more strategic in light of the changing demographics of the population and tightening resources was frequently talked about. For some, this meant more consideration of older adults’ alcohol use generally and the potential implications for their health. Others talked specifically about a need for more attention to be paid to older adults with alcohol problems.

It is worth highlighting here that, as found in the literature, participants talked about different issues related to the early onset of alcohol problems compared to problem drinking which begins much later in life. This distinction is important because, as KI 5 explained, a preventative approach may mean different things. She highlighted that prevention is not merely about stopping new problems from arising, but also preventing the ‘escalation of drinking’ and the ‘relapse’ of those who have had alcohol problems earlier in life. She continued to explain that needs of these groups may be different, and that for the latter:

“It’s about helping them deal with the transitions and losses that are very common in older people...so resilience focused interventions may be improving people’s coping skills, boosting their self-esteem, making sure they’re having plenty of social interaction perhaps relaxation techniques, all of those different things so they’re going to make people more able to cope with adversity” (KI 5; academic).

Thus issues associated with ageing, such as physiological and/or cognitive decline, as well as transitions associated with things such as loss of role and bereavement, were all framed as potential risk factors associated with older people’s drinking. Alongside this lay the perception that problem drinking amongst older people was a largely hidden phenomenon with a lack of dedicated services available to intervene. These concerns and considerations helped shape the topic areas for the interview schedule for retirees (see Appendix 5 and 6).

Constricted social opportunities in later life

The second main concern Key Informants highlighted related to changes and life events encountered in later life and the way in which these were often accompanied by a constriction of social opportunities. There was concern about the impact these could have on older adults’ health and wellbeing generally, as well as the potential impact it could have on their alcohol consumption specifically. Key Informants talked about a set of issues relating to adapting to changes associated with getting older including loss of social roles, reduced social networks and bereavement.

Social isolation was identified as a concern and this was often linked to bereavement, but as KI 2 highlights general changes could also be significant:

“[It could be] people maybe... moving away or busy with grandkids you know and you’re just... suddenly your circle of people that you had 10 years ago is much reduced so it could be isolation not even down to one specific event. It could just be getting older” (KI 2; national alcohol charity).

There was wide recognition that lack of contact with others could be an issue for older adults also related to mobility issues and lack of transport. Closely linked to this theme of isolation was the way in which the higher incidence of drinking at home amongst older people was framed as contributing to potential risk of dependence. For example, KI 15 talked about some older adults that she worked with:

“I think it creeps up on a lot of people like that, you know who were social drinkers and then they shifted to the house and they have been more active but then they’re spending more time in the house so it slowly becomes more of a habit, it creeps up on them and then it’s a problem before they recognise it” (KI 15; social work).

A lack of pro-social activities was identified as well as a ‘gap of resources’ for older adults. There was a concern that there were relatively few opportunities for people to do structured, organised activities or to come together to spend time with others in the period following retirement, but before their health needs brought them into contact with care services such as day centres:

“Basically we don’t have the resources...so we have a kind of a gap and that kind of leads to people being bored and you know “I used to have a wee drink so I’ll just have another wee drink now”” (KI 23; third sector community worker).

Men were portrayed as particularly at risk of this lack of alternatives. Many of the Key Informants felt that the traditional provision of older people’s clubs and activities catered more to women who were described as “more clubbable, sociable” (KI 24; third sector community worker). Related to this, some Key Informants talked about the pub as positive for older men, providing a space for them to come together and be in the presence of others in a way that is familiar to them.

Another important issue in this regard was when older people did not have family living locally. This was not considered unusual for older adults and was highlighted as a consideration for provision of care particularly within the ‘Reshaping Care’ (Scottish Government 2011a) context, as KI 6 described:

“Older people are going to be supported to live in their own homes for as long as possible. Well hey, that’s fantastic but if the only people that are coming in are home carers, if you don’t have a family, you’ve certainly not got this fabulous extended community around you, you’re on your own, the door’s closed, you know you’re on medication and we’re saying

to you 'but don't drink cause that's bad for you'. What would you do? It's so difficult" (KI 6; older adults' organisation).

Consequently, Key Informants raised questions about what life is like in retirement, including how older adults spend their time (given the absence of work), and how they respond to other changes they may encounter. Questions were also asked about the nature and role of alcohol consumption within the context of their wider lives:

"What are they going to do with their lives basically?" (KI 15; social work).

"My sense is that alcohol is a great reliever of boredom" (KI 8; academic).

As mentioned earlier, Key Informants pointed to a lack of evidence about what happens to alcohol consumption when one retires and this was a relationship that they felt could be better understood in terms of the risks and protective factors:

"It's really about understanding why, what is it about retirement, is it about loneliness, is it about their sense of lack of purpose once people have retired, what really is it that makes some people start drinking more as they retire and what also are the protective factors, why do some people deal with that in ways that don't involve drinking?" (KI 5; academic).

These questions subsequently formed a significant part of the interview schedule that was implemented with retired men and women within this study (see Appendices 5 and 6).

Findings: Drinking styles in retirement: roles, routines and networks

One of the more obvious associations surrounding the transition from work to retirement is the assumption that it marks the beginning of a period of increased leisure time. For some in our study this was indeed the case and some of that increased leisure time could be spent drinking alcohol.

“Almost everybody’s talking about the fact that they drink a bit more because there’s more time to drink and my brother, for example, is slightly concerned that when he retires he’ll start drinking earlier in the day. So I mean it’s like a big topic” (G313 – younger cohort, female, SIMD 9).

“I think possibly it’s tempting to drink more when you retire... I go out more for lunch and go out more with friends because I’ve got time to do it, so possibly linked to that yes [I drink more]” (OCL302 – younger cohort, female, SIMD 3).

However, what we found was that, beginning with the transition to retirement itself, the pattern of people’s lives in retirement and the manner in which alcohol was used were highly varied and complex. What emerged as most significant in shaping people’s relationship to alcohol was the way in which they drank prior to retirement and the manner in which alcohol was embedded into the routines of their lives.

This section discusses the main findings of this study, based on an analysis of the interviews with retired men and women. Firstly the circumstances surrounding retirement are examined in terms of the varied and ‘messy’ nature of the transition. The section will then go on to examine the relationship between retirement and alcohol in the context of the roles, routines and networks which make up retired people’s lives.

Routes into retirement

The participants in this sample displayed a range of routes into retirement which were categorised into two types:

1. ‘traditional’ as in the end of paid work within a long term position, and
2. ‘drift’ where retirement is entered into after a complex employment history including periods of unemployment, full time caring and/or disability.

These two categories broadly map onto the different types of retirement outlined in the literature (see for example, Lissenburgh and Smeaton, 2003; Banks and Smith, 2006). Nevertheless, most retirement transitions involved multiple influencing factors including health; changes in the working environment; caring commitments and financial considerations. Thus decisions surrounding retirement were often complex and the outcome of competing demands and factors. It was often these associated factors and influences, rather than the retirement transition itself, which determined

how the early years of retirement were experienced in broad terms and the role played by alcohol within that.

For example, health issues figured prominently for many in the decision to retire. These included issues with the participant's own health (accidents and injuries as well as diagnoses of chronic conditions or life threatening illnesses) as well as health problems for partners, parents or children. In this context, early experiences of retirement and attitudes towards the transition were shaped by these health issues.

“The main thing that made me absolutely stop [working] was my dad became very sick...and my mum had already died two years previously so I was the sole carer for my dad” (OCG313 – younger cohort, female, SIMD 9)

For this participant, the transition from paid work did not signify the start of a new era of leisure, but rather the adoption of the demands of a full time caring role. This was often also especially evident for those (most often women) whose route into retirement was characterised as ‘drift’. For these women, periods of full time (often low paid) employment were interspersed with periods where they were the sole carer for children, partners, parents or grandchildren. Therefore, retirement was not a watershed or significant event in and of itself. Instead, it involved the self-application of the ‘retired’ label or a change in state benefit.

There are two points of significance here – firstly, retirement did not necessarily indicate an increase of leisure time and therefore an increase of ‘time to drink’. Secondly, retirement transitions were dependent on a number of different, influencing factors and it was these surrounding factors, rather than the retirement process itself, which would influence how people experienced retired life and their opportunities to socialise and use alcohol.

Drinking routines

For the current drinkers in this sample, their drinking of alcohol was a practice that was framed in largely positive terms associated with leisure time, health and wellbeing:

“I feel that it's much better than pills and some people that don't take a drink, sometimes you think it would do them the world of good to take a drink” (OCA307 – older cohort, female, SIMD 2).

“It takes your mind off your problems and stuff like that” (OC001 – younger cohort, male, SIMD 1).

“It loosens you up a wee bit” (OC107 – older cohort, female, SIMD 7).

“I find it pleasant and I find it pleasurable” (OCL311 – younger cohort, female, SIMD 7).

What was also evident was the routine and ritualised nature of most drinking styles. Whether social or solitary, drinking was largely embedded into the everyday rituals and routines of the participants' lives. For example, participant OC118's drinking was framed as part of his daily preparations for his evening meal:

"I drink two drinks every day before my dinner. We always have dinner at six o'clock or thereby. I just think it's an appetizer, just gives you that wee boost for eating your dinner, aye" (OC118 – older cohort, male, SIMD 4).

Other participants also talked about rituals around using alcohol in the home. Participant OCA307, for example, talked about having one drink with her meal every night and differentiated between this, her usual (and long established) routine, and when she had company:

"If you are on your own you're only just having maybe the one drink. I usually just have a drink with my meal or just before it. I don't really sit and drink... That's only if you've got company I suppose maybe occasionally you would have another drink or and special occasions or you know" (OCA307 – older cohort, female, SIMD 2).

These rituals were influenced by the context and company in which they took place. In another example from the older cohort, participant OC143 and her husband have continued into their retirement a pleasurable and ritualistic pattern around wine consumption built up in their pre-retirement lives:

"I particularly enjoy, I like cooking, to get the right wine with the right dish. My husband was very interested in that too and he's got a couple of books about it and we look up what's the right thing with you know different kinds of fish even. So it's a pleasure. We get, well, we get the most out of it without letting it dominate" (OC143 – older cohort, female, SIMD 7).

With routine and ritualised drinking in the home like this, the volume of alcohol was usually relatively small and the idea that alcohol was 'adding' to the experience was constructed as central. In the example above, having a set structure to their intake seemed important in terms of presenting their consumption as controlled and/or moderate.

For other participants, daily routines related to alcohol involved a larger volume. One of the female participants in the younger cohort talked about a solitary routine of consuming just under half a bottle of wine per day. Again, there was an imposed routine order to this in the form of a time restriction (not before 6pm) and her consumption of alcohol was a routine that marked the shift from her working day in the garden to her leisure time in the evening:

“I drink pretty much every day and I would usually not start before six o’clock as I’m often out in the garden so I mean I’ll have a drink the minute I come in from the garden essentially” (OCG313 – younger cohort, female, SIMD 9).

Similarly, participant OC131 talks about typically sharing a bottle of wine with her husband of an evening. This appears to be a continuation of the participant’s pre-retirement ritual:

“I think when I used to work it was part of the kind of ritual of being home you know, you came in you know sort of like you know kiss the cat and kinda opened the fridge and you know poured a glass of wine, made dinner and what have you and that was, that was kind of you know ah, day’s over, that’s quite nice ... into the evening, relax, have a glass of wine, cook dinner” (OC131 – middle cohort, female, SIMD 10).

The embeddedness of alcohol in home routines was framed within the wider changes in the accessibility and availability of alcohol, as captured in the following quote from one of the females in the middle cohort:

“It’s so much easier just to have a glass of wine than making a cup of tea...I just think it’s the way we are nowadays that’s it’s quite just a part of life isn’t it, it’s become part of life really” (OC088 – middle cohort, female, SIMD 10).

There were examples of participants drinking more (although not necessarily heavily) in later life than they had previously done and this was framed as part of these wider changes. For example, OC234 and his wife now have a glass of wine every day with their evening meal, commenting that they therefore drink more than they did when they were working when they would not have had wine during the week. This was often framed in terms of being cheaper than going ‘out’ and easier in that they did not need to consider how they would get home:

“We probably drink more at home because you don’t have to think about going home, you are home and it’s quite easy to, uh huh, have another one or finish the bottle if you wanted” (OC088 – middle cohort, female, SIMD 10).

“I mean you go to some places you will probably pay as much for a glass of wine as you would for a bottle of wine at home, you know so cost would come into it” (OCA304 – middle cohort, male, SIMD 5).

By far the main place participants bought their alcohol was supermarkets. Looking for deals and bulk buying were common patterns in this sample:

“I would look for a good wine at a reduced price. I would do that and I am quite particular about the kind of wines I like” (OCL302 – younger cohort, female, SIMD 3).

“We can go through phases that we spend quite a lot because we are affected by the price of something so if it’s on offer and it’s one we like, we could buy four or half a dozen and there’s always wine in the house. We’ve got quite a lot of bottles in the house but it wouldn’t stop us buying another bottle that was on offer” (OCG314 – younger cohort, female, SIMD 8).

However, although many participants reported an increase in home drinking as they got older, drinking in social environments was also evident and for some (mainly male) participants, was the only environment in which they consumed alcohol. Once again, this was characterised by routines and rituals. For men in particular, going to the pub often had a highly regularised pattern to it in terms of when they went and what alcohol they consumed. A key part of the experience was the opportunity for social interaction: there was a clear sense that this was an opportunity to ‘see familiar faces’ and enjoy the company of others. Both OC023 (middle cohort, male, SIMD 1) and OC172 (middle cohort, male, SIMD 2) also talked about going to the pub as something they had enjoyed prior to retirement as well which suggests a continuation of the work/leisure distinction into retirement. This is particularly evident with weekend drinking where alcohol was often used to mark the passage of time from the (working) week to the weekend:

“Normally I just go out on a Friday night with my friends, go along to the local club along the road and sometimes five of us, sometimes six, usually about a round each over the course of the night and that’s it” (OC114 – older cohort, male, SIMD 6).

Social drinking in pubs/social clubs regularly applied to men in our sample more than women. However, having regular ‘nights in’ with friends also came across in the sample and was more common amongst women drinkers. Participant OC088 talked fondly about her ‘wine appreciation club’ which takes place every Friday evening and in which they each take a turn hosting:

“So we get together and we just love our wine appreciation and we chat, sometimes we laugh, sometimes we cry and we say “it’s better than taking a pill” and “it’s therapeutic wine drinking”” (OC088 – middle cohort, female, SIMD 10).

Overall, therefore, amongst those participants who drank during their retirement, normal drinking styles were embedded into daily, weekly and occasionally monthly

routines. There was an identifiable regularity and set pattern to when, where and with whom they drank alcohol. Whilst there were variations in this – special occasions and holidays were frequently discussed as times when more alcohol would be drunk or drinking would be more frequent - in general, normative, terms alcohol was woven into the routines of people's lives. What is important is that these routines were evident regardless of the amount of alcohol normally consumed, whether it was consumed at home or in public and whether it was done alone or in company. In order to explore what factors may have shaped these drinking routines, it is necessary to look at the broader context of participants' lives in retirement - at the varied roles and responsibilities, leisure pursuits and activities that provided the context within which drinking took place.

'Keeping busy': work and leisure in retirement

Although many in the sample displayed full, active and busy lives, there were also those who struggled (or had struggled) with loneliness and social isolation. In terms of alcohol there is, in essence, a dual risk here. As highlighted earlier by Key Informants, social isolation can lead to unhealthy drinking at home for older people and indeed the classic construction of problem drinking in older people is framed around the solitary drinking of excessive amounts in private. However, the ready availability of alcohol in social settings means that even those with very active social lives may be at risk of consuming potentially dangerous levels of alcohol if many of their activities are framed around places and occasions where alcohol is consumed.

On the other hand, living alone and/or having large periods of time marked by solitary pursuits and activities does not necessarily equal problematic social isolation, whilst those who appear to have rich social lives may still be experiencing loneliness and isolation. There is therefore no straightforward way to differentiate those at risk (either of isolation or of potentially problematic drinking) based solely on their level of social interaction.

However, what did emerge strongly from this study was the emphasis participants placed on 'keeping busy' and 'doing something'. Work, for example, played a significant role in many of the participants' lives, usually in the form of part time and/or casual employment. Whilst paid work brings the obvious financial advantage of additional income, very few of those who had access to this kind of income mentioned it as the main reason for choosing to work. Instead, as with those who undertook voluntary work, they highlighted work as an opportunity to 'get out' or 'do something':

"I knew I was going to have, going to have to work after retiring because I couldn't sit about the house" (OC118 – older cohort, male, SIMD 4).

"When I retired spot on the age of 60 I moved into another career, voluntary work and I was a guide at [a local] gallery in Glasgow for about ten years and that was sort of a second career which I greatly enjoyed... I

had a very happy social time and built up my knowledge of fine art so that was a great, great interest” (OC143 – older cohort, female, SIMD 7).

Taking on these roles allowed participants to experience many of the benefits associated with employment more generally such as social interaction with others, a sense of purpose and contribution, and an opportunity to use their skills. Implicit in their accounts, however, was the theme that not ‘being busy’ was by comparison a negative thing. Many mention the desire to ‘get out’ ‘do something’ and not ‘just sit around’.

Another way that those in the sample avoided ‘doing nothing’ was through a myriad of leisure pursuits. These included reading, baking, cooking, gardening, socialising with friends and family, social groups, exercise and hobbies.

“I don’t like being in the house. I think it’s just I’m, I’m not into that mind-set yet and I’m worried that when I get up in the morning if I don’t have a plan then I will start to regret retiring, so I’ve got to do things” (OCL302 – younger cohort, female, SIMD 3).

Once again, implicit in the desire to avoid being idle is a negative association with inactivity. Being out of the home, socialising and mixing with others and being busy were constructed as positive to the extent that they were pursued as goals and effort was to be made to achieve them. On the other hand, inactivity and idleness were understood negatively and associated with fear and guilt:

“I used to apologise and feel guilty if hadn’t achieved anything in a day....I kept saying to [my husband] “oh, I’m really sorry, I don’t think I’ve achieved anything today” (OCL301 – younger cohort, female, SIMD 4).

“Well what I decided when I stopped was that I wanted to have a structure to my week, a routine because I think it’s very easy to just fall into bumbling along and not doing very much” (OCL311 – younger cohort, female, SIMD 7).

This type of pro-active determination to ‘do things’ and avoid idleness suggests that activities and pastimes that on the surface appear as simple leisure pursuits arguably had an element of work associated with them. The choice to join a club or group, to go to the gym more regularly or to meet up with friends more often was frequently shaped as much by a need to avoid guilt associated with being idle, as a desire to engage in that particular activity as part of a larger embracing of leisure and freedom.

“I joined a gym weeks after I retired and I have been going to the gym five days a week ever since. Every morning unless other circumstances dictate, I go to the gym. I do a couple of hours every morning in the gym so really my morning’s sort of killed. I come home here back of 12, have lunch and then I’ve got the afternoon. I don’t have a lot of time to sit and

reflect. I keep going. I'd rather be doing something than, than be sat here" (OC190 – older cohort, male, SIMD 9).

Furthermore, routines included both private individual activities around things like shopping, housework, reading etc. and social routines involving meeting friends, taking trips, participating in group activities.

"[W]ell [housework] it's part of the routine. I mean you do develop a routine without realising it. ...for some reason we started going shopping on a Thursday and now it's always a Thursday" (OC149 – older cohort, female, SIMD 8).

This leads to a sense of fluidity between activities related to tasks, chores and work and activities associated with leisure. Indeed, there was often no neat or clear distinction between leisure time and necessary tasks or responsibilities. Several explicitly mentioned the idea that 'leisure time' was not necessarily 'free time'.

"I seem to have got busier. I think at first I seemed to have had more time, I just feel just now as if almost every day there's something." (OCG309 – middle cohort, female, SIMD 10).

What was also evident was the way in which tasks, roles and activities were highly routinized. Yet again, implicit in many of these routines was a desire to 'keep busy' and to provide structure to daily life.

"I get out every day no matter what the weather's like and I, I, sometimes I just go to the town centre. I hate the town centre but I go there because you can get a good walk round it, you know and be dry, so it's getting a bit of exercise. So no, I make sure I go out every day." [OC214 – older cohort, female, SIMD 4).

Overall therefore, participants' lives - their activities, tasks, responsibilities and pursuits – tended to provide a routine pattern to their day and it was the nature of this pattern that would provide part of the context to their drinking routines in terms of opportunities to drink and with whom, as well as how alcohol was being used. Having a glass of wine to mark the end of chores and the start of leisure time (e.g. OCG313); spending time with colleagues after performing a voluntary role (OC143); having a lunch with wine while meeting friends (OCL303) and so on.

However, underlining many of these activities and pursuits lay a clear desire to keep busy and 'get out and about' stemming from an unspoken guilt or possibly fear association with 'idleness'.

The one group of participants for whom a desire to 'keep active' was not present, were those who were full time carers for dependant relatives. Assuming a full time caring role in later life can mean taking on heavy, physically demanding tasks as well as long hours with little respite.

“My whole life was turned upside down when my husband had a serious stroke and I'm now a full time carer... my life is completely constricted. I can't leave the house except for about 20, well about ten minutes in the morning to walk down to get the paper and sometimes I find that very frustrating and depressing” (OC143 – older cohort, female, SIMD 7).

“My husband took ill and I nursed him for four and a half years. He couldn't be left and didn't want to put him in a hospital. Your sitting room was basically a hospital ward, tanks of oxygen and it was just 24 [hours a day]...and not much help. Very little outside help, family included. You were left to get on with it” (OC089 – middle cohort, female, SIMD 2).

The difficulties faced by those who were carers, underlines the argument made in the literature that although an ageing population is associated with an increasing care burden on a societal level, older people themselves, and older women in particular, bear most of the burden for care in contemporary society. For most of the carers in our sample, leisure time was rare and opportunities to mix with others outside the home were rarer still. What is more, the constant demands of this role when it is performed at home, brings a heightened risk of social isolation both during the time in which they are carers as well as when that role is no longer performed but existing social networks have been disrupted.

Adapting to changing social networks

Retirement can have a dual impact on people's social networks. On the one hand, it can lead to the gradual loss of work colleagues as a source of social opportunities:

“I don't miss [working] now, I miss what, what I had at that point in time...the kind of routine, the companionship and the feeling and belief that you were doing something positive and helping.” (OCG314 – younger cohort, female, SIMD 8).

On the other hand it can free up time to spend with friends and family and to pursue new social groups. However, once again, it is important to note that social networks change across the lifespan and that other key life events – bereavement, ill health, new responsibilities associated with caring – can all have a more significant effect on a person's social connectedness than retirement:

“There [was] the woman next door but she died, and then there [was] me and then there [was] the woman on this side, she's 81 now and she can't walk and then there [was] another one next block up, but her husband's ill now so she can't go and another one round the corner and she's not been very well and we all went out every Friday...but now we don't do it because there's none of us fit” (OC0001 – middle cohort, female, SIMD 1).

Some participants talked about going out (drinking) as less of a feature of their routines as they got older. For participant OC190, drinking had reduced over time

and also shifted towards home drinking which appeared to have been a response to shift in his social networks. When he was younger and still working, Friday and Saturday nights were associated with going to the pub with friends. However, that group has reduced significantly over time and he comments that there are only three of them still alive:

“You know as the group got smaller and smaller the need to go to the pub got less and less, so I think that, that is another reason that I don’t go to the pub as much, there’s, there’s not many of us left” (OC190 – older cohort, male, SIMD 9).

Participants’ drinking routines were also influenced by the health of others. For the participants in the sample who were responsible for caring for spouses in ill-health, there was a clear sense that this role had a moderating effect on their consumption of alcohol. Participant OC143 for example cares full time for husband and she highlighted that because she has responsibility for her husband, alcohol does not feature in her routine as significantly as it did in the past:

“I wouldn’t be sufficiently able to cope. It’s a, you know it’s really quite a demanding job” (OC143 – older cohort, female, SIMD 7).

However, the caring role can have a significant and powerful effect on social connectedness. One of the clearest examples of this was the experience of participant OC089 (middle cohort, female, SIMD 2) who had cared for her husband and then her mother when their health declined up until they passed away. After the death of her husband, the participant described how she began to drink heavily:

“I mean 24 hours wasn’t enough when my hubby was here and all of a sudden, although that’s no excuse, but all of a sudden you’ve got this time on your hands and you’re thinking, “what am I getting up out my bed for”, you know?” (OC089 – middle cohort, female, SIMD 2).

“Well you were just, as I say, sitting on your own all day. I’d have my breakfast, do my housework and then, “what do I do now? Och, I’ll have a drink”” (OC089 – middle cohort, female, SIMD 2).

Loneliness and social isolation were highlighted for this participant. One of the things that come over strongly in examples like this is the complex nature of the interrelation between social embeddedness and potential social isolation. Living with others does not necessarily insulate a person from being isolated or lonely. Participant OC089 for example lives with her daughter and her grandson and yet she currently struggles with isolation and loneliness. This is partly related to increasing isolation associated with caring for her husband before he died but also to changes

in the lives of others. For example, she used to spend time every week socialising with a group of friends:

“A Thursday night we’d take week about, there was four of us, but they’ve all got married. ... So that bit, stopping our nights out, their men wasn’t want to have women sitting so I can understand it...” (OC089 – middle cohort, female, SIMD 2).

Social networks and social connectedness, therefore, provide another important context to people’s drinking. Nevertheless, caution should be exercised when attempting to generalise from this. Social isolation in itself did not necessarily lead to problem drinking nor did solitary drinking at home correlate to social isolation or problem drinking. Rather, it is perhaps more useful to frame this in terms of broken routines: changes which caused a break in routine or a period where there were no regular routine activities in the person’s life were associated with a lack of purpose and potential social isolation. Often this was framed in relation to ‘loss’, such as a bereavement (and loss of the caring role) or indeed exiting from paid employment. Similarly routines can also be broken through friends taking on caring roles and no longer being available or reduction in existing social circles through illness, losing touch and bereavement. For any of these reasons, the pattern of someone’s life and their social networks may be broken. Within this sample, these broken or lost routines emerged as very obviously associated with the risk of isolation and loneliness.

Amongst participants, there were some concerns about the impact this could have on drinking. However, it is worth noting that there was also evidence that for some, cutting back on drinking/giving up altogether could itself contribute to broken routines. OC095, for example, had given up alcohol three years before the interview and talked about how he had formerly gone drinking at his local club with a group of friends:

“The same group, every Friday without fail. There was eight of us and well, there’s seven go now because I don’t go up [since I stopped drinking] and they’ve said to me, “oh, come up, we miss the, sort of, banter and all that sort of thing...” but, yeah, as I say, I miss the company more than I miss the drink” (OC095 – middle cohort, male, SIMD 7).

This speaks to fact that changing drinking patterns at this stage of life can have an effect on opportunities to socialise and engage with others, which adds further complexity to the relationship between social connectedness/isolation and drinking.

Processes offering protection: Adapting drinking routines

Some participants had adapted their alcohol routines in retirement in response to what they viewed as the 'dangerous' or 'negative' consequences of drinking. Whilst some of these related to general negative associations (such as weight gain, general health, avoidance of hangovers), some were specifically related to ageing or to factors more likely to affect older people. In response, whilst some stopped drinking altogether, others adapted by either cutting down or consciously moderating their consumption.

For participant OC190, for example, drinking less as he got older was the result of a combination of factors. As well as his social circle reducing and his networks becoming more family oriented, he talked about the 'danger' involved in consuming alcohol, referring to 'extreme situations' in the past involving heated arguments:

"alcohol is a dangerous thing, you can get yourself into some horrible, let's say debates, but debates that in some cases, they're the wrong subject at the wrong time at the wrong place" (OC190 – older cohort, male, SIMD 9).

As a result, this participant had now enforced rules and regulations on his drinking in order to moderate his consumption. In this sense, the ritual and routine element of his drinking appears to safeguard him from overindulging:

"So I said right, so I don't drink during the week and at the weekend I, I do not drink before ten o'clock at night, if I'm here I do not drink before ten o'clock at night and then I only have three, I only drink whisky really (in the house)" (OC190 – older cohort, male, SIMD 9).

Cutting down for health reasons associated with weight gain was also mentioned by some of the other participants in the younger cohort and framed as part of a joint decision with their spouses:

"We just felt for our health sake because one thing, you know apart from the effect of alcohol, one thing leads to another, you then start snacking inappropriately and you know, it's a combination of all of that together" (OCL301 – younger cohort, female, SIMD 4).

For participants who drive, a need to adapt their drinking routines in light of the recent change in drink driving policy was frequently mentioned. Although some participants seemed to have mixed views on the impact, desired effect and fairness of this policy change it had led to a change in their behaviour. How participants adapted to this varied, some continued to drink in the same way and used taxis or public transport. For others, particularly those who felt public transport was an issue,

there appeared to be a shift in the balance of their alcohol consumption towards being more home based:

“I probably drink more at home ‘cause, as I say, most times we’re out, if I’m out with all the girls we’ve got the car now, so we wouldn’t now.”
(OCL303 – younger cohort, female, SIMD 3).

There was also talk about “taking it in turns” to drive so as to alternate who could have an alcoholic drink. The change of law also impacted on drinking in terms of concern over driving the next day. Participants in this sample were keen to ‘not risk’ driving over the limit:

“I would be conscious well I’m driving the next day let’s not take any chances here you know” (OCA304 – middle cohort, male, SIMD 5).

Whilst these reasons for curbing alcohol consumption could have occurred at any age, some were more specifically tied to ageing. One of the few examples of a participant who stopped drinking because of prescribed medication is participant OCG313 (a heavier drinker). She described “always checking” the instructions and highlighting “the moderation aspect” as important; she continued:

“I think I had something, I’m trying to think back with my labyrinthitis I was taking steroids...you’re not supposed to take alcohol with them so I didn’t take alcohol. If it says specifically don’t take alcohol with it I wouldn’t take it but fortunately the medication I take, I can take it” (OCG313 – younger cohort, female, SIMD 9).

There were also a small number of examples of participants being advised (recently or longer ago) not to drink on the medication they were on but who continued to do so on the basis of their subjective assessment of risk. For example:

“Aye, amitriptyline I’m advised not to take a drink with it but I have the odd glass of wine even with that and I got, oh yes the amitriptyline was for my back, my back injury” (OC214 – older cohort, female, SIMD 4)

The majority also did not recall having a conversation with a health professional about potential interactions and others said it did not say anything on the packet. However, we did not find any examples of those who had adapted their drinking because of the risks of interaction with long term medications. This slightly unexpected finding may in large part be due to the low numbers of heavier drinkers in our sample. Some participants, for example, felt that their GP would know enough about them to know whether they needed to advise about drinking and potential interactions for medication.

However, other factors associated with getting older, particularly changing tolerance for alcohol, were regularly mentioned as reasons for adapting drinking routines:

“Nowadays my tolerance level is probably about a pint and a half of beer or two malt whiskies. Any more than that and I'm not going to sleep well and I'm going to feel an energy crash about eleven o'clock the next morning... I could've coped with more than that, years ago when I was a young person. Not, not that I ever had a huge tolerance but I could've coped more” (OCA306 – male, middle cohort, SIMD 3).

Even in the youngest retired cohort, participants talked about a reduced capacity to drink. Participant OCL311 described drinking less (in terms of volume) than she did ten years ago because:

“Well (a) I don't like getting up in the morning and not feeling great and (b) I physically can't take the volume. I find I just can't, you know I feel bagged up” (OCL311 – younger cohort, female, SIMD 7).

This examination of the way in which participants adapted their drinking to various changes associated with aging, health or changes in the law highlights the way in which rules and regulations were applied to their alcohol consumption. For example: not drinking before a certain time of day, not drinking until a certain day of the week, limiting the volume consumed and not drinking if driving the next morning. When added to pre-existing restrictions (such as for example those who only drink outside the home or those who will not drink alone) it is possible to frame these kinds of rules as part of imposed routines – a way of accommodating and acknowledging the negative associations and dangers of alcohol. Behind some of these imposed routines lies the real fear of the 'slippery slope', of drinking too much in an unhealthy way. For many this is epitomised by solitary drinking:

“I would hope not to want to drink myself...I think if you go down that route then you're opening a can of worms regarding that aspect...but sitting in the house, never drink yourself, no. No, I don't think I would ever do that” (OCG315 – younger cohort, male, SIMD 2)

Summary

- Routes into retirement could be characterised as 'traditional' or 'drift'.
- Most retirement transitions involved other influencing factors including health; changes in work environment; caring commitments and financial considerations.
- These other factors often had a more important influence on the initial experience of retirement and on the way in which alcohol was consumed than the transition to retirement itself.
- Alcohol consumption was largely framed in positive terms and was embedded within daily and/or weekly routines.
- While some participants took part in a wide range of roles, activities and pursuits, others suffered periods of relatively little involvement or activity.
- For many retired people, these roles and activities provided part of the context within which drinking took place in terms of where, when and with whom they drank.
- Broken routines could represent periods of increased risk of social isolation and increased alcohol consumption as a response.
- Drinking routines often had self-imposed rules and restrictions to avoid the risk of dependence or 'losing control'.
- Retirement was one of many events in a person's life which could bring a change of routine, including drinking routines and practices.
- Retirement could provide an opportunity for the volume of alcohol consumed to increase due to increased opportunity to drink, but it could also see a decline as social networks reduced or changed, or as the pressures of work ceased.
- Many participants reported drinking less as a result of health concerns, decreased tolerance for alcohol or decreased opportunities to socialise and drink.

Discussion and conclusions

The key aims of this study were to:

1. investigate how the process of retiring and ageing shapes alcohol use and its role in the lives of retired people
2. explore the meaning and uses of alcohol consumption in retirement
3. explore what life more generally is like in retirement, including social networks, interests and family life
4. capture different experiences of retirement and later life by including men and women, three specific age groups, and those from areas categorised as 'more deprived' and 'less deprived', according to the Scottish Index of Multiple Deprivation (SIMD)
5. consider service and policy implications flowing from an enhanced understanding of alcohol use in later years. This last point is discussed in the Recommendations section.

Retiring, ageing and changes in alcohol use

A number of changes in drinking routines and patterns were evident in this study. For example, an increase in home drinking – both socially and privately – was discernible. Whilst many of our participants had switched to home drinking (solely or as their main drinking location) this did not necessarily indicate 'hidden' or problem drinking and was related to a number of different factors such as decreased opportunities to socialise, a growing preference for drinking at home; the reduced costs; a greater tendency to drink mainly with family and before or during a meal at home. Furthermore **the context of other factors which influenced the decision to retire were often more significant in shaping people's initial retirement experience and their drinking routines, than the transition to retirement itself.** These included things like the need to take on a full time caring role, personal health problems or injuries, bereavement, experiences in the workplace towards the end of their working lives and financial considerations.

In addition, **the way in which participants drank prior to retirement emerged in our sample as a more important indicator of post retirement drinking than the manner of their retirement** (i.e. traditional or drift). Whilst we did find examples of new drinking routines after retirement, many people in the sample simply adapted their drinking routines around the new patterning of their lives. Furthermore, whilst we found examples of people who felt they were drinking more following retirement, which was attributable to increased opportunities to drink and increased leisure, we also found that the opposite was the case – many participants had reduced their alcohol intake either as a result of deliberate action, or as the consequence of decreased opportunities to drink socially. Amongst those who moderated or stopped

drinking, reduced tolerance, broader health considerations, avoidance of hangovers and reduction of social networks were all associated with this change.

In relation to the idea of increased individual risks associated with ageing, it is worth noting that these were recognised by most of our participants. For example, fear of the 'slippery slope' to alcohol dependence was observable in the many ways in which participants imposed limits on their drinking and where decisions were made to reduce consumption, and it was often implied in more general efforts to 'keep busy' and 'be active'. Further, with one exception⁵, where participants were, or had been, drinking more heavily or in a way they themselves felt was problematic there was recognition that this carried additional risks associated with their age. Therefore, it is worth noting **that the message that ageing brings increased risks associated with alcohol was being received by those in our sample**, although admittedly not all participants adapted their drinking in light of this.

Nevertheless, **a variety of circumstances and life events other than retirement or physiological ageing had a role in shaping alcohol use** – the development of new interests and pursuits; reduction of pre-existing social networks and opportunities to participate in social routines; taking on full time caring responsibility for a partner or other close relative; and bereavement could all play a more pivotal role in shaping alcohol use, either in terms of a change of location or pattern or an increase, decrease or cessation of quantity consumed. Therefore, drinking patterns and routines in the immediate post retirement period often did not remain static and many later circumstances and events brought change to the way in which alcohol was consumed. Thus, although younger retirees may demonstrate higher levels of alcohol consumption than older retirees, this does not necessarily indicate a pattern that will continue five or ten years after retirement.

Overall, when examined through the prism of routines, retirement represented one of many possible life events which could disrupt or break the routines around which people's lives were ordered. The pathway to wellbeing appears to be shaped as much by how people re-constitute order and routine as much as the effects of physical ageing.

Meaning and uses of alcohol in retirement

Alcohol was used in a variety of ways by those in the sample. Both in terms of drinking at home and in public spaces, alcohol was often a vehicle for socialising and interacting with others and was associated with relaxation, leisure and the sharing of experiences with others. For others, drinking took place largely alone at home; nevertheless this was often done in the context of low to moderate amounts being consumed and in a way which served to demarcate leisure time. There was, for

⁵ One participant felt that his tolerance for alcohol had increased and that his drinking style was no more problematic than when he was younger.

example, often an association of alcohol with meal times, with many participants drinking before, during or after meals. Similarly alcohol was used in the context of a more relaxed, quieter period of the day.

Furthermore, alcohol was largely embedded within a broader set of routines and rituals in the lives of older people which were collectively used as a way of marking the passage of time or of filling the day or week. Thus alcohol use was largely woven into the daily and weekly patterns of people's lives.

Overall, **the findings from this study suggest that moderate drinking amongst retired people is often a significant component of their lives and can contribute to their engagement with 'active' and 'healthy' ageing.** The emphasis on social connectedness in particular suggests that socialising with others, at home or in public spaces, on a routine or regular basis is a significant feature of healthy ageing. Similarly, the enjoyment of periods of leisure time – alone or with others – needs to be promoted. For this reason, whilst we would not advocate the promotion of alcohol consumption by health professionals, we would nevertheless argue that alcohol need not be viewed simply as a hurdle to health and wellbeing. Absence of alcohol does not equate to healthy ageing. Instead, we would suggest that constructing alcohol use amongst older people as inherently more risky or problematic negates the wide variety of experiences, routines and tolerances that exist amongst older people and risks stigmatising older people's drinking in a way which may have detrimental consequences to their health if it results in the limiting of their activities and interactions.

Life in retirement

In order to understand the various meanings attached to alcohol and the role it played for retirees, drinking behaviours were examined in the wider context of people's lives in retirement. In this way, alcohol consumption became a lens that allowed us to explore retirement more generally.

One of the most striking findings was the number of retired people whose lives were extremely busy and for whom there was not an abundance of 'free time' (or indeed boredom) in retirement. Many participants' lives were structured around various roles and responsibilities other than, although sometimes including, forms of 'work'. These roles included volunteering (formally and informally); caring for relatives and a range of regular responsibilities to friends and neighbours. Whilst not contradicting the idea of retirement becoming an 'extended age of leisure', caution needs to be exercised not to over-generalise: for some in our sample leisure time was very rare.

Added to these roles and responsibilities, was a plethora of more leisure-oriented activities (individually or in groups, provided by local groups or services, or organised

amongst friends and family). Once again however these activities need to be placed in context: age, health, mobility and the other circumstances going on in a person's life all had an influence on what types of activities were pursued and how regularly. In particular, those whose time was largely taken up by caring for a dependent relative were often the most socially isolated with very few opportunities for leisure pursuits of any social kind.

Furthermore, there was a clear sense of the importance to older people of a 'busyness' ethic and the avoidance of being 'idle'. This came over very strongly in the efforts people made to develop routines to fill their time and was especially evident for those who didn't have work and/or caring commitments. There is perhaps a warning here for policy efforts to engage older people with healthy and active ageing agendas. Leisure time (spent alone or with company) and solitary strategies for 'getting out and about' or for 'keeping busy' such as reading and walking need to have as significant a role in constructions of healthy ageing as group activities and pursuits. Pressure to 'join in' could potentially deepen the 'busyness' ethic in a way that adds guilt to those not inclined to group activities and becomes detrimental to health. We would suggest that allowing older people to relish leisure time without guilt needs to be considered as a part of the goal of healthy ageing.

It is also worth highlighting that the two recruitment routes used in this study (via GPs and via local community groups) allowed us to include people who do not take part in many activities outside of home/family, as well as those who were more actively engaged in organisations like Opportunities in Retirement. Therefore, our sample achieved a broad mix of experiences of retirement.

Gender, age and levels of deprivation

It is worth reiterating that with a qualitative study such as this, broad population trends and differences cannot be addressed directly. For this reason we have avoided making direct reference in the findings to gender, age cohort or deprivation differences. The gender, age and SIMD sampling employed in this study was aimed at generating a broad and varied range of experiences, routines and practices rather than testing for differences based on these variables.

Nevertheless, with reference to gender, the main suggestive difference in drinking styles related to where drinking took place. **More of the men in our sample drank in public spaces than women and women's public drinking tended to be more infrequent. Women were more regular domestic drinkers both amongst friends or family and individually.** There were also more women in the study who were full time carers than men and for some this provided the context for solitary drinking at home, whilst for others their caring responsibilities led them to stop drinking or cut down significantly. More importantly, **the caring role was often associated with increased levels of social isolation. This is worth noting, as it suggests that if**

the burden of care on older women increases with population change, more women will be at risk of suffering high levels of social isolation in this phase of their lives.

It is also possible to discern in this small sample a suggestive cohort difference with participants in the older group largely drinking less than those in the middle and younger groups. In the context of an increased availability of alcohol and a wider cultural role for alcohol as an acceptable drug associated with celebration and leisure (both at home and in public spaces) it is tempting to suggest that our sample reflects a wider population level increase of consumption, with potential future health consequences. However, whilst bearing in mind that we cannot generalise from a qualitative sample such as this, we would suggest that this should not be *assumed* – the drinking histories of those in our sample suggest change over time following retirement is also important. Indeed, we found evidence of an ‘ageing effect’ whereby as people aged, they reduced their drinking to take account of things like lowered tolerances or in an attempt to deliberately improve health. Therefore, more regular consumption of moderate amounts of alcohol amongst retirees in their fifties and sixties does not *necessarily* suggest the continuation of this drinking pattern into older age.

With regard to levels of deprivation, we found little differences in the sample in relation to how alcohol was used. That is not to suggest that such differences do not exist, but that they simply did not figure strongly in our study.

Limitations

There are limitations to this study which should be acknowledged. Recruitment relied upon participants responding to the research team to express their interest in taking part; thus participants were self-selecting. People who felt less at ease with the way they used alcohol may have been less inclined to put themselves forward for a study into alcohol use. In addition, the focus on 'retirement' in the information sent out may also have impacted upon the sample gained. Although examples of varied experiences of both work and transitions out of work were provided, those who had never worked or not worked for a long time may also have been less inclined to respond to a study that focused on experiences in retirement. Another limitation of the sample, is that it included relatively few younger men and no men living in areas categorised as 'less deprived' according to the SIMD (see Appendix 4 for a full discussion of this).

It is also important to note that the screening process undertaken by GPs in our first recruitment wave, may have meant that people with (known) addiction problems were not invited to take part in the study. Also of relevance here is that those with a recent bereavement or recent diagnosis of ill-health may also have been excluded which will have impacted upon the sample gained. Thus, the experiences of those currently trying to come to terms with such news may not have been captured by this study, although we did hear from some people who were undergoing tests/treatment and whose lives remained effected by bereavement. Ultimately, the intention was to focus on normative drinking and capture a broad range of drinking styles which we believe has been achieved in this sample.

Recommendations

The physical and social processes associated with ageing present a variety of risks and opportunities with regard to relationships with alcohol.

However, the results of this research suggest that changes in routines associated with this stage of the life-course (retirement from paid work, physical ageing and changing opportunities for sociability) can cause disruptions to established routines which has associations with alcohol use but also in relation to risk of loneliness and social isolation.

Positive outcomes appear to be associated with an individual's ability to actively construct healthy routines which take account of needs for social interaction and other wellbeing needs. With the older population, initiatives to promote healthy relationships with alcohol should recognise social isolation and loneliness as associated risks.

Healthy ageing policies can learn from the active contribution older people make in creating healthy routines, in identifying for themselves the risks associated with the life-stage in relation to alcohol and help support these adaptations. Practitioners can

build upon older people's own informal management strategies for alcohol risk. These can be shared with other older people or used to start a conversation around what works for different individuals in different contexts.

The value of community spaces such as shopping centres, libraries and local parks, as sites that allow alcohol free social interaction, for older people should be taken into account in developing health ageing policies

Policies and initiatives aimed at older people's health need to be cautious of stigmatising older people's alcohol use. Alcohol can play a significant role in social and leisure activities which are important features of health and wellbeing in later life. Initiatives aimed at promoting healthy and active ageing need to ensure that physical inactivity and solitary pursuits are not inadvertently stigmatised.

Where older adults have had periods of heavy drinking in the past, they are potentially more at risk of using alcohol in response to 'broken' routines and in need of additional assistance and support to adapt and develop new routines that do not involve excessive alcohol.

Consequently, screening tools used to assess alcohol problems could be more nuanced if they included questions related to regular alcohol routines (where, when, why, how and with whom,) rather than focussing on estimates of units consumed. Simple management strategies with simple messages are more effective than advice about units.

Policy initiatives such as the Change Fund that accompanies the 'Reshaping Care for Older People' programme in Scotland (Scottish Government, 2011a) could be used to stimulate existing groups to widen their participation to include older people – providing opportunities for older people specifically or including them in existing groups.

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APPENDICES

1. Members of the Project Advisory Group

Name	Organisation
Lorna Angus	Seniors Together (lay member)
Ken Barrie	University of the West of Scotland
Anne Berney	Seniors Together (lay member)
Julie Breslin	Addaction
Christine Calder	Seniors Together
Jennifer Curran	Alcohol Focus Scotland
Carol Emslie	Glasgow Caledonian University
Angela Fowlis	Scottish Pre-Retirement Council
Mark Gallagher	North Ayrshire Alcohol and Drug Partnership
Lucie Giles	Lanarkshire Alcohol and Drug Partnership
Lauren Johnston	STRADA (Scottish Training on Drugs and Alcohol)
Stevie Lydon	Glasgow Alcohol and Drug Partnership
Louise McCabe	University of Stirling
Tracey McFall	STRADA (Scottish Training on Drugs and Alcohol)
Iain McPhee	University of the West of Scotland
Faye Murfet	South Ayrshire Alcohol and Drug Partnership
Naomi Richards	University of the West of Scotland (now University of Glasgow)
Betsy Thom	Middlesex University
Liam Wells	East Ayrshire Alcohol and Drug Partnership

2. Example of Participant Information Sheet



ALCOHOL USE ACROSS RETIREMENT

AN INVESTIGATION OF CHANGING EXPERIENCES OF AGEING & LATER YEARS

Participant Information Sheet

We would like to invite you to take part in a research study. This information sheet provides information about the study and what would be involved if you decide to take part. Before you decide, we would like you to understand why the research is being carried out and what it would involve for you. Take time to think it over, discuss it with family, friends, and your GP if you wish. Ask us if there is anything that is not clear or if you would like more information, contact details are included at the end of this document, and a member of the research team would be pleased to discuss the project with you.

Who is doing the research?

The research will be carried out by staff from the Institute of Older Persons' Health and Wellbeing at the University of the West of Scotland who are working with staff from Brunel Institute of Ageing Studies, Brunel University, NHS Ayrshire and Arran, and the Glasgow Centre for Population Health. The project has been funded by the Glasgow Centre for Population Health.

What is the evaluation about?

We are interested in ways in which retirement from paid employment and getting older shapes alcohol use and its role in the lives of retired people.

Why have I been invited to take part in the project?

We hope to speak to forty-eight people who are no longer in paid employment and fall into one of three age bands 55-59, 65-69, 75-79. Your name was been picked at random from people registered with your GP surgery in one of these age bands.

What would taking part in the study involve?

If you decide to take part in the study you will be invited to take part in an interview with a member of staff from the University of the West of Scotland. A member of the research team will contact you to arrange a time that is suitable to visit you in your home, or another place of your choice; interviews should last approximately one hour. During the interview you would be asked about your life in retirement, the activities that you are involved in, including any activities or social events that involve alcohol, e.g. meeting friends and having a drink. We are also interested in participants' perceptions of government advice or legislation relating to sales and consumption of alcohol. In order to facilitate note-taking, we would like to record interviews and would seek your permission to do so at the time.

Should you disclose any information during the interview which suggests that you or anyone connected to you is at risk, we would discuss this with you, and with your permission refer you to an appropriate source of support.

What are the benefits or disadvantages in taking part?

It is unlikely that you would benefit directly from taking part in the project. However, if you do decide to take part you will be given a £15 voucher from Marks and Spencer or another store/supermarket of your choice in order to thank you for your time. Any travel expenses will also be reimbursed.

Do I have to take part?

No, it is up to you to decide whether or not to take part. Participation is entirely voluntary and you would not have to answer any questions that you were not happy with - you would also be free to withdraw at any time without giving a reason. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Should you wish to withdraw from the study at any time, you may request that anything you have said is excluded from the analysis.

What will happen to information collected in the study?

All information collected during the course of the study will be kept strictly confidential. No individual will be able to be identified in the study report or any other publication. We may wish to use some word for word quotations to illustrate specific points. Any information used in this way will be anonymised. Audio recordings will be destroyed once they have been transcribed. All participants will be provided with a copy of the final report. The findings will be made available to health and social care professionals, voluntary organisations, and other key stakeholders working with older people. The findings will also be presented at conferences and written for publication.

Who should I contact if I have a complaint about any aspect of the study?



If you are unhappy about any aspect of the study and wish to make a complaint, please contact the researcher in the first instance but the normal NHS complaint mechanisms are also available to you. Details of the process can be obtained from your GP practice. In the unlikely event that something does go wrong, you have the right to pursue a complaint and seek any resulting compensation through University of West of Scotland.

What will I do if I would like more information and/or wish to take part in the study?

You can contact a member of the research team by telephone, email (please see contact details below), or by returning the attached sheet with your contact details in the reply paid envelope. If you have any further questions and wish to speak to someone not closely linked to the study, please contact Margaret Brown, Senior Lecturer, School of Health, Nursing and Midwifery, University of the West of Scotland, Hamilton Campus, Hamilton. ML3 0JB: margaret.brown@uws.ac.uk, 01698283100.

Further information about this research study:

Members of the research team will be pleased to answer any question you may have and can be contacted at The School of Health, University of the West of Scotland, Hamilton. ML3 0JB

Contact	Telephone	Email
Fiona Edgar 	01698 283100 Ext 8690	fiona.edgar@uws.ac.uk
Dr Naomi Richards 	01698 283100 Ext 8690	naomi.richards@uws.ac.uk

Thank you for reading this information sheet

3. Example of Participant Consent Form



ALCOHOL USE ACROSS RETIREMENT AN INVESTIGATION OF CHANGING EXPERIENCES OF AGEING & LATER YEARS

Participant Consent Form

Participant ID:.....

Date:.....

Principal Researcher: Dr Tim Duffy

Please initial

I confirm that I have read and understand the information sheet dated 12 th February, 2015 (version 3) for the above research study.	
I have had the opportunity to think about the information, ask questions, and have them answered satisfactorily.	
I understand that my participation is voluntary and I am free to withdraw at any time without giving a reason.	
I am happy for the interview to be recorded and transcribed, and for word for word quotations to be used in reports with the understanding that they will be anonymised.	
I agree to take part in the above study.	

Name of Participant

Date

Signature

Name of Person taking consent

Date

Signature

When completed, 1 for participant: 1 researcher site file (original)

4. Research Methods

The meaning and uses of alcohol for retired men and women were explored in three age cohorts: ‘younger’ retirees aged 55-59 years, ‘middle’ retirees aged 65-69 years and ‘older’ retirees aged 75-79 years. In addition, the proposed sampling framework (Table 1) was designed to gain a diverse sample in terms of gender and socio-economic status. For the latter, The Scottish Index of Multiple Deprivation (SIMD) was used as this is an area based measure of deprivation; Decile 1 relates to areas categorised as ‘most deprived’ and Decile 10 relates to areas categorised as ‘least deprived’.

Table 1 – Proposed Sample for Retired Interviews

Level of deprivation	Younger retirees 55-59		Standard age retirees 65-69		Older retirees 75-79		Totals
	Male	Female	Male	Female	Male	Female	
SIMD deciles 6-10	~4	~4	~4	~4	~4	~4	~24
SIMD deciles 1-5	~4	~4	~4	~4	~4	~4	~24
<i>Totals</i>	~8	~8	~8	~8	~8	~8	~48

Recruitment

Participants were purposively recruited in line with the sampling framework set out above. The first wave of recruitment was facilitated by the Scottish Primary Care Research Network (SPCRN). Through the Network, four GP practices agreed to participate by granting access to their patient databases (two in Glasgow, one in Ayrshire and one in Lanarkshire). Searches of the databases identified patients fitting the selection criteria (in terms of their date of birth). These lists were then screened by GPs to exclude anyone they believed it would be inappropriate to send the invitation to. Potential reasons for excluding at this stage included: recent cancer diagnosis, palliative care, recent bereavement, mental health issues, addiction issues, housebound, learning difficulties and stage 4/5 kidney disease. Invitations were then sent to a random sample of patients remaining on the list. In total, 280 invitations were sent (60 to patients from each of the first 3 practices, and 100 from the fourth). Reminder letters were sent to non-responders. This led to 25 interviews.

The second wave of recruitment aimed to target cells of the sample that were under-represented through alternative channels such as community groups and organisations including Seniors Together, Opportunities in Retirement Ayr and the Renfrewshire Children’s Panel. The project advisory group also provided contacts. This led to a further 15 interviews bringing the total to 40.

Informed consent was gained before the interview (see Appendix 2 and Appendix 3 for copies of the participant information sheet and consent forms respectively) and participants were given a £15 high street voucher in recognition of their time. Most interviews were conducted at participants' homes. The remainder took place at the University of the West of Scotland campus or Glasgow Centre for Population Health premises, depending on the participants' preference. The interviews were audio-recorded and transcribed with the participant's permission.

Table 2 - Sample Achieved for Retired Interviews

Level of deprivation	Younger cohort 55-59		Middle cohort 65-69		Older cohort 75-79		Totals
	Male	Female	Male	Female	Male	Female	
SIMD deciles 6-10	0	4	4	4	3	4	19
SIMD deciles 1-5	2	4	4	4	4	3	21
<i>Totals</i>	2	8	8	8	7	7	40

Sample

In total, the sample recruited comprised 40 participants across the three age cohorts; ten in the younger cohort of 55-59 years, 16 in the middle cohort of 65-69 years and 14 in the older cohort of 75-79 years. The sample included 23 females and 17 males ranging in age from 56 – 81 years. With regard to the Scottish Index of Multiple Deprivation, 19 participants lived in areas categorised as 'less deprived' (i.e. deciles 6-10) and 21 lived in areas categorised as 'more deprived' (i.e. deciles 1-5).

The sample achieved is smaller than the target of 48. This was mainly due to the low numbers of male participants in the younger cohort. In both strands of recruitment, retired men aged 55-59 were difficult to access. The first wave of recruitment (GP route) led to one participant in the younger cohort (male). The second wave (community groups and networks etc.) led to one additional younger male participant and all eight of the younger female participants. Neither recruitment wave led to any younger males living in areas categorised as 'less deprived'. There are a number of potential reasons for this including the recent push in the UK for people to remain in employment for longer and delay the age at which they retire, the recent increases in the state pension age; and the fact that they may not have identified with the 'retired' label. Another contributory factor could be the methods of recruitment pursued. In the first wave, invitations to participate were sent to patients whose dates of birth matched the three specific age cohorts, and therefore those who received the invitations were not necessarily retired. This could potentially have been more of an

issue for the younger cohort where a smaller proportion of those contacted would have fit the study's inclusion criteria.

For these reasons it was decided that to pursue other recruitment routes in order to specifically target this younger male cohort risked creating an additional bias that might render comparisons between cohorts more difficult. For similar reasons it was decided not to exceed the original targets for the other cohorts in order to achieve the original target of 48 participants.

Sample characteristics (domestic arrangements, work prior to retiral & drinking status at time of interview)

The majority of the sample (26/40) lived with a spouse and eleven lived alone. The remaining three did not live with a partner but lived with one or two other members of their family (predominantly grown up children). These participants were all widows.

There were more people living alone in the older cohort than in the younger cohort. Of the eleven participants who lived alone, seven were in the middle age cohort and four were in the older cohort. In terms of their SIMD classifications, eight of those living alone resided in areas categorised as deprived, which although based on a limited sample is suggestive of the wider association between increasing age and declining income.

Participants worked in a variety of jobs prior to 'retiring'. Among the 23 female participants, almost half were teachers/lecturers or nurses (seven and four respectively). Others were managers within Human Resources (two) and the care sector (one), as well as home carers (two), shop workers (two), a technical clerk, an administrator within education and one worked for the council in organisational development. One female participant had her own business prior to retiring and one was a partner in her husband's business. Among the 17 males involved, three were in management roles in different sectors (including the NHS), two were engineers and two policemen. Five were manual workers (including builders, joiners and factory workers) and one had worked mainly in retail. The remaining four worked in traditional middle class occupations within higher education, the church and politics.

Drinking status at time of interview

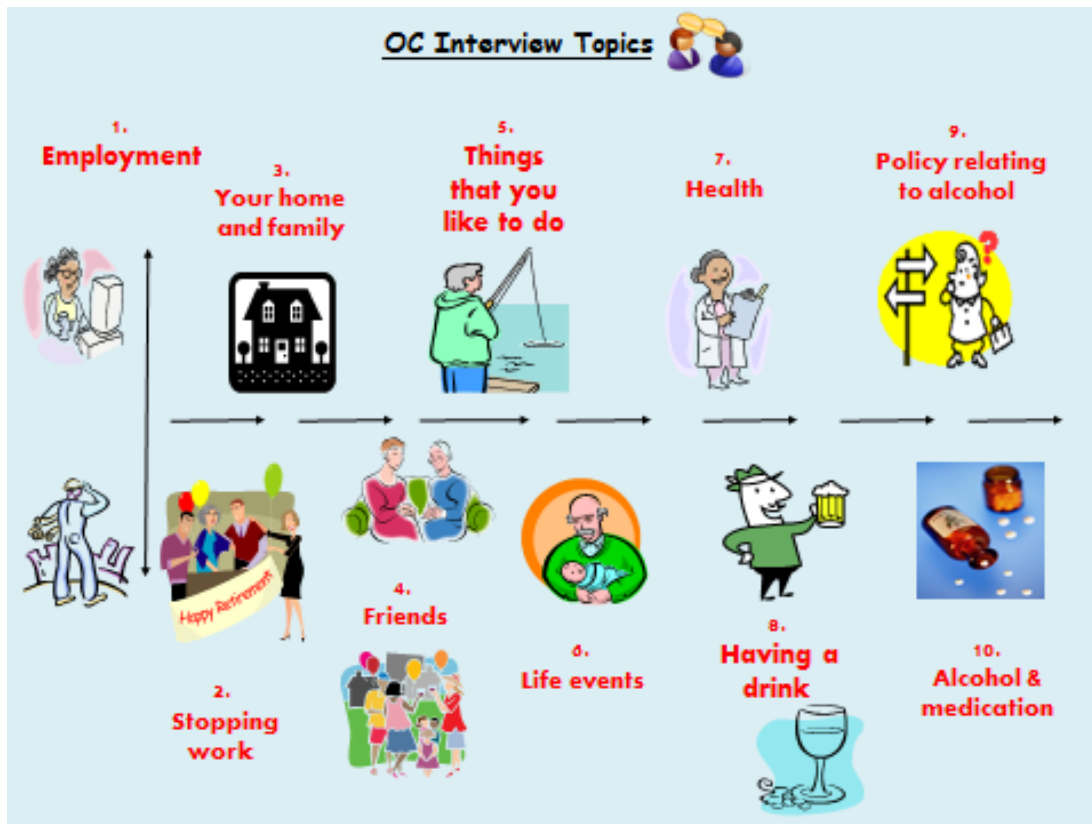
At the time of interview, 34 participants were categorised as current drinkers and 6 as non-drinkers (i.e. not currently drinking). Of the six participants who were categorised as currently not drinking, four had recently made this change (up to three years prior to the interview) whilst two were long-term abstainers (i.e. had not drunk since they were teenagers/early twenties). Of the non-drinkers, five were in the middle age cohort of 65-69 years. The long-term abstainers were both females in the middle age cohort and living in areas categorised as deprived. None of our participants in the younger cohort (55-59) were categorised as non-drinkers.

Of the 34 participants categorised as current drinkers, drinking patterns varied. Nine described themselves as 'occasional' drinkers and this often related to social, celebratory occasions (seven females and two males). Others had a more regular pattern to their consumption. Eleven participants talked about drinking most or every day (six females and five males). This was slightly more common in the older cohort than the younger cohort. Often this would involve alcohol (mainly wine) as part of meals. It should also be acknowledged here that the volume participants consumed varied, with some having very small amounts of alcohol and others having more. The remaining 14 participants described drinking at least once within a typical week; for some this was weekend orientated and for others this depended on specific social activities they had.

Data analysis

In conducting this research, we made use of the approach developed by Braun and Clarke (2006). This approach involves six phases: (1) Familiarisation with the data; (2) Generating initial codes; (3) Searching for themes; (4) Reviewing themes; (5) Defining and naming themes; (6) Producing the report. To ensure rigor, two members of the research team were involved in the analysis process and QSR NVivo was used to assist the coding process. Early transcripts were analysed separately by the two researchers and comparison of notes from these transcripts produced initial codes around four central themes: experiences of retirement; before and after retirement drinking experiences; solitary and social time (including leisure pursuits and other activities); and health. These themes were then refined as data analysis proceeded. Simultaneously, short biographies were written for each respondent which were used in conjunction with the data extracted from NVivo.

5. Visual Topic Guide for Interviews



6. Extended Interview Guide



ALCOHOL USE ACROSS RETIREMENT AN INVESTIGATION OF CHANGING EXPERIENCES OF AGEING & LATER YEARS

Interview Schedule

Introduction:

- We're interested in how the process of retiring and ageing shapes alcohol use and its role in the lives of retired people.
- You have been invited to take part in an interview because you have retired from paid employment
- Your name was picked at random from your GP practice
- What you say is confidential, we won't be feeding back what you say to your GP
- No right or wrong answers, just interested in hearing about your experiences
- Remember you don't have to answer anything not comfortable with

Diagram

- This diagram covers some of the topics that I would like to ask you about during the interview
- Firstly I am going to ask you about your job when you were in paid employment, and how long ago you retired.
- We are interested in when you stopped work and the impact it had on your life, for example on your home and family.
- I will ask you about the things that you like to do like meeting friends and hobbies, and any significant life events since your retirement, for example the arrival of grandchildren or someone being ill.
- As you know the main focus of the research is use of alcohol, and we are interested in your use of alcohol, for example if you have a drink when you meet friends, if you like to have a drink in the house etc.
- We are also interested in the impact of government policy, for example minimum pricing, and health messages relating to the number of units of alcohol people can safely consume.

- Your health generally
- Any medication that you're on

Interview Questions

1. EMPLOYMENT

- ◆ Can you tell me what you did when you worked?
 - part-time, full-time
 - location
 - how long worked there
 - circumstances around decision to leave (e.g. redundancy, poor health)
 - age, how long ago

2. STOPPING WORK & 3. HOME AND FAMILY & 4. FRIENDS

- ◆ What changed when you stopped work?
 - impact on home and family, who they lived with, where
 - friends, balance between work related and locally based friends if they travelled
 - financial situation

4. FRIENDS and 5. THINGS YOU LIKE TO DO

- ◆ What sort of things do you do with your time now that you are not working?
 - meeting friends, hobbies, holidays
 - has there been a change over time since retirement (esp older cohort)

6. LIFE EVENTS

- ◆ Have there been any significant events since you retired?
 - Bereavement, birth of grandchildren, moving house, illness.

7. HEALTH

- ◆ How is your own health?
 - Any ongoing conditions, use of medication

8. HAVING A DRINK

- ◆ If and when you are likely to have an alcoholic drink? (what, when, why)
 - researcher will have some info from previous questions re meeting friends etc,
 - try to get a picture of drinking activity over time e.g. a week, holiday periods etc
- ◆ Do you think that the amount of alcohol that you consume as changed over time since your retirement?
 - Do you drink more than before you retired?
 - If pattern has changed since retirement, what has caused this, e.g. time available, social activities, health, finance, life events

- ◆ When you do drink alcohol, would you say that you drink more in your own home, or do you like to go out for a drink?
 - If drinking at home, is this what they have always done?
 - Where do they buy alcohol, how much do they spend?
 - Reason for home consumption? E.g. legislation on smoking in public places, discount and happy hour bans, perception of women going to pubs.

9. POLICY RELATING TO ALCOHOL

- ◆ Are you aware of the government guidelines about how much people should drink?
 - What do you think about them? Do they mean anything to you?
 - How would your level of consumption compare to the guidelines?
 - Do you understand why they are there?
- ◆ You will be aware that the Government wants to introduce minimum unit pricing, what are your feelings about this?
 - How do you think it would impact on you personally?

10. ALCOHOL & MEDICATION

Participants who have indicated that they are taking medication and that drink more than a sherry at new year:

- We talked a bit earlier about the medication that you take - are you aware of any interaction between your medication and having a drink?
 - does it say anything on the prescription label, if so what
 - how do they react to it?

General: all participants

- The Government is concerned about the level of drinking across all age groups in Scotland, what do you think about the current health messages? Have you noticed anything targeted at you/your age group? (e.g. GP)
- Do you think that they are correctly targeted to people of your age?
- How do you think they could be improved for people of retirement age? How could they best get information out to people like you?
- Thinking about people you know of, do you think there is a need for health warnings?
 - What might they look like, where would they be?

7. Older people and alcohol practitioner engagement event

Tuesday 15th December, 2015

Delegate list

Amanda Tracey	Social Worker, East Ayrshire
Betsy Thom	Professor of Health Policy - Middlesex University
Fiona Taylor	North Lanarkshire Council
Janet Rennie	Social Worker, East Ayrshire
Julie Breslin	Addaction - service manager
Ken Barrie	Senior Lecturer in Alcohol and Drug Studies - University of the West of Scotland
Matthew James	Social Worker, East Ayrshire
Michael Robinson	Glasgow City Alcohol and Drug Partnership
Odette Landsburgh	Voluntary Action South Ayrshire
Paul Campbell	NHS Lanarkshire
Pauline Izat	North Lanarkshire Council
Susan Macaulay	Galston CC team, East Ayrshire
Lorna Kelly	GCPH

Comments, queries and suggestions arising from table discussions

Comments:

- Alcohol use is not always a negative in someone's life. It can be a pleasure for older people, but is often frowned upon, especially in care settings. Also pubs are sociable spaces, which is good for health, loneliness and social isolation – but is there are reluctance to allow pubs to be used in such a way? Also, older people's services are often a 'one size fits all' e.g. daycare centres for the very old, but little for those that does not suit.
- People are 'falling through the net' in terms of resources and services available to them. The participants in the current sample are not 'addiction' clients – so where would they receive advice, support and information from? And what is the relationship between wider population health initiatives/services and addiction services?
- 'Authority' issue – older people don't always want to take advice from younger people or certain professions (e.g. health visitors). But they will often listen to advice from GPs and consultants, etc.
- 'Problem drinking' often has to be accepted as an individual's 'choice' by services, even if they can see it is doing harm, as treatment cannot be forced upon anyone.
- Keeping busy and having a work ethic is related to alcohol consumption.

- This research is good because it shows older people's own informal 'management strategies' for their alcohol consumption. These could be shared with older people, or used to start a conversation about what works for each person and what they can learn and share with one another.
- All services that are in contact with older people should be able to raise issues around alcohol and not stigmatise or exclude because of alcohol use.
- Alcohol use is only really noticed/spoken about when it becomes a problem or costs public services.
- Loneliness is a massive issue and should be included in the discussion/recommendations.
- Big Lottery funding is geared towards supporting resilience, peer support and outreach in terms of older people's services but often alcohol and/or people are not seen as policy priorities in general.
- Chronic diseases are often concurrent with alcohol problems/addictions, so either addiction services should 'up-skill' to be able to support/advise on chronic conditions and/or older people's services should 'up-skill' to be able to support/advice on addictions. This will stop older people with alcohol and/or chronic conditions 'falling between the gaps' or being passed around from service to service.
- Simple management strategies with simple messages are more effective than speaking about units – e.g. having two alcohol free days per week. Other simple recommendations could also be made specifically for older people.
- The research findings and recommendations should be targeted towards GPs, breweries and charities (e.g. Age UK) as well as health and older people's services.
- There are clearly two different populations/discourses being discussed – population level drinking vs addictive drinking. We need to make clear what any recommendations made geared towards.
- Older people are still just adults – their messages and services shouldn't be 'ghettoised'.
- Learning should be sought from good practice – e.g. in Ayrshire there is an addictions and falls officer who could share learning on best practice and what works etc.

Questions:

- Methods: Did you use a screening tool for participants?
- Did you get a sense of whether people's alcohol use had increased or decreased in retirement?
- Did you measure amounts and types of alcohol consumed? And were there any 'class' differences in behaviours/preferences?
- Can the research challenge attitudes in terms of providing an assets focus and striking a balance between problematic and 'healthy' drinking? I.e. a reframing?
- What activities can replace alcohol use, especially for men?
- When does 'normal' drinking become 'problematic drinking' and who defines this? Is it related to units (which are not widely understood) or could there be

other proxies which help older people measure their own alcohol use? E.g. can they be encouraged to ask themselves (and seek assistance) if they are drinking to block out emotions etc. but be supported if their alcohol use is sociable and not adversely affecting their health?

- Can social media be used to support and promote relevant services for older people? Also, could GPs surgeries etc. be used for health improvement messages? And why not take services to where people are (e.g. pubs)? Breweries etc. have corporate social responsibility remits so could be supportive of setting up clubs etc.
- What is the real impact of gender on behaviours etc? Has this been fully explored in terms of different preferences and routines etc?
- What have the changes in drink/driving levels meant for older people?
- What is the potential impact of alcohol taxation changes and minimum pricing etc. in relation to older people?

Summary of key recommendations:

- There are clearly two different populations/discourses being discussed – population level drinking vs addictive drinking. We need to make clear what any recommendations made geared towards.
- When does ‘normal’ drinking become ‘problematic drinking’ and who defines this? Is it related to units (which are not widely understood) or could there be other proxies which help older people measure their own alcohol use? E.g. can they be encouraged to ask themselves (and seek assistance) if they are drinking to block out emotions etc. but be supported and not judged if their alcohol use is sociable and not adversely affecting their health?
- This research is good because it shows older people’s own informal ‘management strategies’ for their alcohol consumption. These could be shared with older people, or used to start a (facilitated) conversation about what works for each person and what they can learn and share with one another. Perhaps follow on focus groups could be used as a starting point?
- Loneliness is a massive issue and should be included in the discussion/recommendations. What can resilience research tell us about the role of alcohol or licensed premises and loneliness if used in a ‘healthy’ way?
- All services that are in contact with older people should be able to raise issues around alcohol and not stigmatise or exclude because of alcohol use.
- Chronic diseases are often concurrent with alcohol problems/addictions, so either addiction services should ‘up-skill’ to be able to support/advise on chronic conditions and/or older people’s services should ‘up-skill’ to be able to support/advice on addictions. This will stop older people with alcohol and/or

chronic conditions 'falling between the gaps' or being passed around from service to service.

- General *population-based* messages and services for older people should take an assets and resilience based approach when speaking about alcohol, as well as focussing on any problems and risks.
- Social media and GP surgeries should be used to support and promote relevant services for older people. And why not take services to where people are (e.g. pubs)? Breweries etc. have corporate social responsibility remits so could be supportive of setting up clubs etc.
- GPs, Local Authorities, Health Boards and Charities (e.g. Age UK) are key audiences to share the overall report and findings with.