Alcohol consumption in old age - A Norwegian perspective

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Abstract

“Older adults” (≥65 years) covers a large age span and includes a mixed group of individuals. Alcohol intake may vary due to socio-demographic conditions, health situations and culture. In the Nordic countries, the inhabitants and health care workers have viewed alcohol consumption as a private matter. It is only in the last decade that health politicians and researchers have focused on older adults’ alcohol intake and its relationship to health and aging.

A recent Norwegian population-based study found the prevalence of weekly alcohol intake (≥ 1 day/week) to be 28%, and among those who drank weekly about 45% drank more than once a week. In recent decades, alcohol intake has increased among older adults in Nordic countries, while in Europe it has been generally stable. It is likely that the number of older adults who consume alcohol regularly and the number who have alcohol-related problems will increase as the population ages.

Alcohol is seen as a symbol of the good life, and after retirement, a glass of wine may be taken for pleasure. It is nice that older adults may enjoy their good life, but it is important to know that alcohol intake in old age should be moderate and lower than in younger days due
to decreased tolerance. Furthermore, the intake of alcohol does not improve your health, as many believe due to misleading media headlines over the years.

For other groups of older adults, increased alcohol consumption in old age is related to coping with negative situations and episodes in life. It may be that they or someone in their close family have a disease, or it may be a reaction to loss of life-partner, social network or work and social-status related to work. Thus, alcohol is used as a painkiller, to reduce tension and to cope with their situation.

**Introduction**

Older adults (≥65 years) covers a large age span and includes a mixed group of individuals. Both the health and life-styles of older adults may vary considerably. Habits and the use of alcohol may also differ a great deal.

**What is elevated drinking in old age?**

Various terms may describe consumption of alcohol in old age, and the intake of alcohol may include dependency, harmful consumption, misuse, risky consumption or elevated consumption. Here the term elevated consumption will be used to illustrate this type of intake. The definition of elevated consumption of alcohol in the Diagnostic and Statistical Manual of Medical Disorders, the Fifth Edition (The DSM-5) (from 2013) is broad and there is no standard definition of elevated consumption from the literature (Simoni-Wastila & Yang, 2006). Nonetheless, one alcohol unit per day for adults 65 years and above, both for men and women is often set as a suggested limit for this age group (Dufour, Archer, & Gordis, 1992; Moos, Brennan, Schutte, & Moos, 2004). In recent years, guidelines have been established in order to reduce the risk of unhealthy intake of alcohol in older adults in several countries (National Institute on Alcohol Abuse and Alcoholism, 2018; Lang, Guralnik, Wallace,
& Melzer, 2007; Moos et al., 2004), but not in Norway (Frydenlund, 2012). The usefulness of such guidelines has been discussed (Frydenlund, 2012), partly since problems due to alcohol consumption have also been reported among those with alcohol consumption below the suggested limit (Moos et al., 2004). Clinicians in Norway recommend that older women not drink more than five alcohol units per week (Knutheim, & Rahm, 2016). In addition, they add that for older adults it is not wise to drink every day or more than 2 alcohol units in the same day, if they want to avoid the risk of alcohol-related health problems.

**Change in metabolism and tolerance in old age**

With increasing age, the tolerance for alcohol is reduced due to the aging process. The aging process contributes to altered metabolism and volume distribution in the body. These changes will give higher alcohol concentrations in the blood, and alcohol effects will last longer than the same amount of alcohol in younger people. This is information that older adults in Norway and Nordic countries do not have (Johannessen, Helvik, Engedal, & Sorlie, 2016). They either do not know that with aging the organs tolerate less alcohol before damage may occur. It is important to spread information about changed metabolism and decreased alcohol tolerance in old age. This to reduce health risks due to alcohol consumption.

**Drinking frequency and volume**

In Norway and other Nordic countries, the intake of alcohol is decreasing with increasing age (Bjork, Thygesen, Vinther-Larsen, & Gronbaek, 2008; Moore et al., 2005; Moos et al., 2004; Støver, Bratberg, Nordfjørn, & Krokstad, 2012). However, the decrease in alcohol consumption with age among older persons of today is less prominent than it was among older persons in the 1970s and the proportion of older people abstaining from consumption of alcohol is lower than before (Aira, Hartikainen, & Sulkava, 2005; Moore et al., 2005; Moos
et al., 2004; Strandberg et al., 2007; Støver et al., 2012). Data from a large Norwegian population-based study (the HUNT study) suggests a marked change in the drinking frequency and volume in the population in 2006-08 (HUNT3), compared to 1995-97 (HUNT2) and 1984-86 (HUNT1), with a lower prevalence of abstainers and an increased consumption in old age (Støver et al., 2012). In summary, alcohol intake has increased among older adults in Nordic countries. However, in Western Europe, the intake of alcohol has generally been stable (Hallgren, Högberg, & Andreasson, 2009).

A newly published Norwegian study, using data from a population-based study from the early 21st century, found the prevalence of weekly alcohol intake (≥ 1 day/week) to be 28% in older adults, and among those who drank weekly about 45% drank more than once a week, but few were drinking four days or more a week (Tevik et al., 2017). Among older men and women, the proportion of those abstaining from alcohol increases with increasing age. For example, in men the odds for being an abstainer were about three fold higher in those age 85, than in those 65 to 74 years (Li, Wu, Selbaek, Krokstad, & Helvik, 2017). In addition, the proportion of those drinking once a week is negatively associated with age (Slagvold & KA, 2014; Tevik et al., 2017). The mentioned studies do not say anything about the amount of drinking per occasion for those who drink alcohol. From other studies it is found that, alcohol consumption among older Norwegians is highest in the age group between 66 and 79 years, like it is in other western European countries (Hajat, Haines, Bulpitt, & Fletcher, 2004; Lang et al., 2007; Støver et al., 2012). When it comes to epidemiological studies, it is suggested that the older adults who participate are those without the most serious chronic diseases, and this includes those with alcohol problems (Langhammer, Krokstad, Romundstad, Heggland, & Holmen, 2012).
How alcohol is tied to culture and socio-demographic conditions

The consumption of alcohol is tied to regulations and rules. The regulations reflect each country’s culture and alcohol policy (Nordlund, 2012), and the written or unwritten rules includes the norms of the society (Nordlund, 2012). The Norwegian regulations cover areas such as drinking age, homemade alcoholic beverages and when or where alcoholic beverage can be sold and served (Karlsson & Österberg, 1998).

The reasons for being an abstainer may be a combination of different factors, including the society and religious norms, regulations, socio-economic conditions and other factors.

Older adults in urban areas seem to be more likely to be current drinkers, compared with those living in rural areas (Li et al., 2017; Slagvold & KA, 2014; Tevik et al., 2017). Differences in drinking patterns between rural and urban people have been reported from other countries (Booth & Curran, 2006; Borders & Booth, 2007; Dawson, Grant, Chou, & Pickering, 1995). For example in a recent Irish study, they found that those living in rural areas drank less frequently (Holton et al., 2018). In a recent Norwegian study, we found that those living in rural areas in Norway had 30% higher odds to be abstainers from alcohol intake than those living in urban areas (Li et al., 2017). We do not know for certain, but the higher prevalence of abstinence in rural areas may be partially due to conservative religious beliefs (Borders & Booth, 2007) or to cultural norms, but also partially to access. In rural areas of Norway, public transportation is scarce and the municipality centers are far away. These factors may limit access to buying alcohol. In a study comparing drinking (yes or no) in Norwegian and Chinese older adults we found that the relationship between alcohol consumption in rural/urban living areas were reversed in Chinese men. Older Chinese men living in rural areas drank more often than those in urban areas did. This was explained by the
fact that Chinese men in rural areas had access to low cost, homemade alcohol (Li et al., 2017). In addition, according to traditional medicine, Chinese men would drink alcohol to improve health (Li et al., 2017).

Alcohol consumption often is reported to be more common in populations with higher education and better economic status (Li et al., 2017; Slagvold & KA, 2014; Tevik et al., 2017). We have performed an adjusted analysis of consumption of alcohol (versus no consumption) including place of living (urban/rural) and found that both older men and women with college and university educations had twice the odds of consuming alcohol than those of the same age who finished only elementary school (Li et al., 2017). In Nordic social democratic countries with a welfare system, education is normally covered by the socio-economic status in older people. Thus, Norwegian people with higher education are more likely to have a better socio-economic status, and are able to afford alcohol (Hajat et al., 2004; Jiafang, Jiachun, Yunxia, Xiaoxia, & Ya, 2004; Rao, Schofield, & Ashworth, 2015). According to the most recent WHO data, greater economic wealth was broadly associated with higher levels of alcohol consumption and lower abstention rates (Organisation, 2014).

We do not have information about total alcohol volume consumed per week or the proportion of heavy drinking occasions (high amount of drinking when drinking, also called binge drinking) related to level of education. However, an Irish study reported recently that both a higher frequency and total volume of drinking per month in those with higher education, while the number of occasions with heavy drinking (binge drinking) was higher in those with only elementary school education (Holton et al., 2018).

From a gender perspective, older men are less often abstinent from alcohol, and drink more often than older women. This seems, not only to be a Norwegian or Nordic, but a worldwide
phenomenon (Balsa, Homer, Fleming, & French, 2008; Kirchner, Sayette, Cohn, Moreland, & Levine, 2006; Li et al., 2017; Støver et al., 2012; Tevik et al., 2017).

**Drinking is often tied to relaxation and social events**

In Norway, it is reported that older adults living with a spouse or partner more often than those without a partner, drink alcohol regularly. Those having a spouse or having a cohabitant of the same age range almost doubled the odds for consuming alcohol (versus not consuming alcohol) than those being widowed or single (Li et al., 2017). These results were supported by the results of a previous German study (Weyerer et al., 2009). The drinking pattern in older adults may possibly be related to the Northern European culture and norms. In the previous mentioned collaborative Chinese study, marital status was not associated with alcohol intake (Li et al., 2017). It may be due to the different drinking cultures. Norwegian older adults may drink a glass of alcohol and enjoy time together with their spouse or partner at home as well as in other social settings, parties and celebrations. Chinese people drink more frequently at special social occasions such as festivals, weddings and business interactions, but not with their spouse or partner at home (Li et al., 2017). In Norway and in other Nordic and North European countries, consumption of alcohol is often not only linked to social events and special occasions, but also to leisure time (Knutheim, 2015).

A glass of wine may also be a symbol of success in life, enjoyment of life or just enjoying being with friends. Alcohol may be linked to social activities and having a social life. For example, we may see alcohol used as such symbols for in grey magazines, novels and newspapers. However, being satisfied with life was not associated with whether older adults drank alcohol or not in a Norwegian population-based study (Li et al., 2017). It remains to be studied to see if satisfaction with life is associated with frequency or volume of drinking.
It is also yet to be explored if older adults with a fairly active and sociable lifestyle are more likely to consume alcohol than those with a less active lifestyle. However, it could be expected since alcohol consumption in general may be more often consumed in connection with social events rather than when being alone. Even so, the drinking patterns are complex and may differ within the Norwegian country, Nordic and European countries. In a population study from Great Britain, it is reported that those more socially active are more likely to consume alcohol (Hajat et al., 2004).

A life course transition from employment to retirement may influence the drinking pattern. A recent publication from the English Study of Aging (ELSA) reported an increase in alcohol volume and frequency after retirement (Holdsworth et al., 2017). However, a recent Irish study did not find the transition from employment to retirement associated with increased total alcohol consumption, but those retired had more episodes of heavy drinking occasions than those still employed (Holton et al., 2018). In a Norwegian population-based study, they found no difference in the drinking pattern among older adults who were newly retired from employment and those still employed, but the study was cross-sectional (Skogen, Knudslen, Mykletun, Nesvåg, & Overland, 2012). Thus, it is left to explore transition to retirement using a longitudinal design and to see if transition to retirement is associated with a change in alcohol intake, either in volume or in frequency. The drinking pattern may also be associated with the type of transition they had, whether the entry to retirement was voluntary or forced due to health or loss of employment. Others have reported that some years after retirement the pre-retirement drinking pattern is re-established (Holton et al., 2018). It may be that after a voluntary transition to retirement (due to high age and good finances, but not poor health)
people have less responsibilities and social occasions more often which may affect their drinking behavior (Britton & Bell, 2015).

**Self-reported health and alcohol consumption**

In the repeatedly mentioned population-based study, we found that men and women of old age perceiving their health as good were more likely to consume alcohol than those with poor health (Li et al., 2017). Even if our study was cross-sectional, the result is consistent with an international longitudinal study which found the association between onset of illness and a reduction from regular alcohol consumption to special occasions drinking (Ng Fat, Cable, & Shelton, 2015). Behavioral changes may be because of concerns for their health. Recent studies have identified health precautions as one of the most commonly cited reasons for reducing alcohol consumption among older adults (Khan, Wilkinson, & Keeling, 2005). It might also be because their physician had advised quitting or reducing alcohol consumption. A recent study found that General Practitioners (GPs) in Norway lacked procedures for assessing alcohol use of their old patients (Johannessen, Helvik, Engedal, Ulstein, & Sørlie, 2015), thus it is less likely that this is the reason in Norway.

**Health consequences of elevated alcohol consumption**

Norwegian media, in recent decades, have regularly written that a glass of wine or moderate alcohol intake is good for your health. However, it is not scientifically proven that alcohol consumption may improve your health. On the other hand, epidemiological studies have found that those not drinking have or report poorer health, are more often hospitalized, and die earlier than those drinking a glass of wine regularly (Bobak et al., 2016). This is in line with the suggestion above that older adults reduce or quit alcohol intake when they experience failing health (Khan, Wilkinson, & Keeling, 2005).
Chronic elevated alcohol use in older persons is associated with multiple diseases, and covers increased risk of cardiovascular problems, diabetes, hepatic injury, lung disease, reduced immune response, falls and bone fractures, cancer in several organs, impaired brain function and dementia and mortality (Schwarzinger, Pollock, Hasan, Duil, & Rehm, 2018; Wood et al., 2018; Caputo et al., 2012; Lang et al., 2007; Strandberg et al., 2007). However, women compared to men are more exposed to the negative health consequences of alcohol consumption, possibly due to differences in the metabolism of alcohol (Epstein, Fischer-Elber, & Al-Otaiba, 2007; Gomberg, 2003).

Taking future demographic changes into account, including an increasing part of the population being older than 65 years, elevated alcohol consumption can be of great importance for the costs of health services and the care sector.

**Alcohol-drug interactions**

Many drugs commonly prescribed to older people (such as anti-hypertensive drugs, anti-diabetic drugs, analgesics, sedatives, anxiolytics and anti-depressants) interact with alcohol. Nine of ten Norwegians 70 years or older use prescribed drugs (Folkehelseinstituttet, 2011). The combination of alcohol consumption and use of these drugs may increase the risk of adverse effects such as falling, hospital admission and death (Barnes et al., 2010), i.e. increasing health care costs and health decline. Lately, an increased awareness of the risk in combining alcohol and cholinesterase inhibitors used in anti-dementia drugs (cholinesterase inhibitors like donepezil - N06D A02) has risen, because of the side effects and risk for health decline with such use (Legemiddelindustrien, 2017).
The only Norwegian study regarding the potential risk for interaction between drugs and alcohol in older adults explored not the potential risk between alcohol and cholinesterase inhibitors, but the risk between alcohol and opioids, and alcohol and addictive psychotropic drugs, in older adults in community living situations. In addition, other commonly used drugs with a potential alcohol interaction risk need to be explored in the Nordic and European countries (Tevik et al., 2017). A study from the US reports the risk for potential alcohol-drug interactions to be high in this age group (Qato, Manzoor, & Lee, 2015), but the knowledge is spare.

The Norwegian alcohol-drug interaction study reported that among those using addictive psychotropic drugs versus not using these drugs the frequency of alcohol consumption (weekly or four times a week or more) did not differ much (Tevik et al., 2017). Thus, those who use addictive psychotropic drugs drink as often as those not using such drugs, and there is a potential risk for alcohol-drug interaction that may affect their health.

Commonly, older adults do not know about the danger of using alcohol when using specific drugs, and they do not see it as a problem that they combined, for example, alcohol and a sedative or anxiolytics. Often they were not informed about the danger, and felt that as long as the physician had not warned them, there was no danger in combining the drugs (Johannessen et al., 2016).

**Alcohol consumption as a private matter in a difficult time**

In Norway, consumption of alcohol is seen as a private matter both among older abstainers and drinkers of alcohol, and if alcohol consumption is spoken about it is mostly done in
general terms (Johannessen et al., 2016). Moreover, older people with an elevated consumption are more often more ashamed about their consumption than younger adults.

However, the life situation of many older adults is difficult. They may be a vulnerable group with several health difficulties. Several feel lonely and pushed aside, and this is partly caused by changes in society (Johannessen, Helvik, et al., 2015). The GPs have found that many older people have existential needs and mental health problems, needs that are not necessarily met or handled adequately by them, their next of kin or society (Johannessen, Helvik, et al., 2015). For those, alcohol may become a way to cope.

**Alcohol as self-medication**

Older people belong to a generation less open about their life situation and psychological problems than younger people (Johannessen, Helvik, et al., 2015). Thus, some use alcohol to handle anxiety, depression, life’s worries and loneliness. However, elevated alcohol consumption over time may increase psychological health problems in older adults. Even so, it is not always easy to tell what came first, i.e. the illness or the increased alcohol consumption (Caputo et al., 2012). Even so, there is a relation between elevated alcohol consumption and suicide (Caputo et al., 2012).

In women, consumption of alcohol in everyday life is reported more often due to isolation and loneliness (Epstein et al., 2007), but this is debatable (Gomberg, 1995). Furthermore, international studies have reported that elevated alcohol consumption is linked to psychological problems more often in women than men (Epstein et al., 2007; Gomberg, 1995). In Norway, we do not have information of whether there is a gender difference in the use of alcohol to cope with psychological difficulties in old age.
Some may use alcohol to improve sleep (Johannessen et al., 2016). Small doses of alcohol may generate drowsiness, but they do not improve sleep quality (Ebrahim, Shapiro, Williams, & Fenwick, 2013) and they may increase the risk of alcohol dependency.

Others may experience psychological pain because of loss of their spouse, life partner or a close family member or because of having to care for severely diseased family members. It may also be a consequence of involuntary transition to retirement and loss of a social network and social status related to work that causes such pain. Thus, alcohol is used as a painkiller, to reduce tension and to cope with their situation. Another motivation for alcohol consumption could be to reduce physical pain. However, alcohol as a painkiller may actually increase the physical pain over time (Aira, Hartikainen, & Sulkava, 2008; National Institute on Alcohol Abuse and Alcoholism, 2013).

None of these reasons for alcohol consumption are recommended, and such use should be discovered before the consumption becomes difficult to change and health declines. However, the knowledge regarding the effect alcohol consumption to improve sleep and reduce pain and psychological issues are limited.

The extent of elevated alcohol consumption in older adults

In Norway, we do not know the extent of elevated alcohol consumption and the addiction it creates in older adults, but we regularly have patients hospitalized because of injuries and diseases related to alcohol consumption. A study from central Norway found that a high proportion of older adults with an emergency referral to hospital for a physical disease, had alcohol and psychotropic drugs in their blood tests (Bakke, Bogstrand, Normann, Ekeberg, &
Bachs, 2016). In addition, we have found that a high proportion of older adults receiving treatment in old age psychiatry departments in Norway reported elevated alcohol consumption (Johannessen, Engedal, Larsen, Lillehovde, Stelander, & Helvik, 2017a). In the metropolitan areas of Norway, the community health care service now experiences more older adults receiving domiciliary care have alcohol problems (Rusfeltets samarbeidsorgan, 2017).

**How to uncover elevated alcohol consumption**

To uncover elevated alcohol consumption or consumption interacting with drugs is the first step in avoiding increased health difficulties. This may be done in the specialist health care setting or the community health care setting including the home care service and GPs work.

**Specialist health care as a source**

Until now, few of the older adults with an emergency referral to hospital for either a physical or psychological disease were asked about their consumption of alcohol (Johannessen et al., 2017a; Vederhus, Rysstad, Gallefoss, Clausen, & Kristensen, 2015). In a Norwegian study, it was estimated that about 10% of those hospitalized for a physical disease had an elevated level of alcohol consumption, and only 10% of those with a potential elevated use were asked about their consumption and advised to reduce alcohol consumption (Vederhus et al., 2015). In old age psychiatry units, it was found that a high proportion of the participants self-reported an elevated level of alcohol consumption, but there was a poor correlation between elevated consumption reported by the patients and what was written in the referral from the GP (Johannessen et al., 2017a). In this study, ten of Norway’s old age psychiatry units participated. Prior to the study, the professionals were educated in how to screen and ask questions about alcohol consumption. Approximately a year after the study ended, we
performed a qualitative study asking about how screening of alcohol consumption was going in new patients. Most of the participants continued to screen alcohol consumption after the study ended and they found it important for giving adequate treatment to new patients. This is telling us that attention and education is important for screening (Johannesen, Engedal, & Helvik, 2017b).

In the new health directives for the specialist health care service procedures are now recommended to uncover elevated alcohol consumptions of in-patients (Tonnesen, Nielsen, Lauritzen, & Moller, 2009). Thus, hopefully screening to uncover alcohol consumption causing negative health consequences will increase.

**In-home community health care as a source**

In a quite recent study conducted in Norway, we found that the community health personnel found it demanding to talk about alcohol consumption with their older patients and their relatives (Johannesen, Engedal, & Helvik, 2015). This is partly because the patients and relatives see the situation as a private matter, but in general, health personnel do not pay much attention towards alcohol consumption as a possible contributor to poorer health (Johannesen, Engedal, et al., 2015). In addition, they have somewhat limited competence and knowledge regarding consequences of alcohol consumption when health is fragile and age is high. In general, there is a lack of procedures of assessing alcohol consumption when elevated or unhealthy use were suspected and there is a lack of formal structures for collaboration with other departments in the community health services and the GPs when indicated (Johannesen, Engedal, et al., 2015).
In order to be a source to uncover alcohol problems or use of alcohol in combination with drugs creating interactions causing health risks the community health care service needs to increase the competence of their nurses and other professionals. There is a need for more knowledge and competence in observing symptoms of elevated alcohol use, and a protocol of asking questions in a systematic way about alcohol consumption. Screening is a useful way to uncover elevated use, but also to uncover potential risks for alcohol-drug interactions. In addition, formal structures to collaborate with need for treatment is uncovered.

The General Practitioners as a source

In a previous study of GPs, we found that the GPs had little focus on assessment of alcohol use of their older patients (Johannessen, Helvik, et al., 2015). They asked often about tobacco use, but did not feel they could ask about alcohol consumption. The lack of assessment routines of alcohol consumption was partly because GPs considered the topic a matter of privacy. They felt it was disempowering and insulting to ask about alcohol consumption (Johannessen, Helvik, et al., 2015).

For the GPs, screening is a useful way to uncover elevated use (Mobæk & Nesvåg, 2015) and when the screening is combined with information of the consequences of elevated use related to the individual’s health, it is an effective intervention to change alcohol behavior. However, more brief interventions like talking about alcohol use and the difficulties they may cause in more general terms has less effect in uncovering and changing elevated consumption of alcohol (Mobæk & Nesvåg, 2015). Some GPs argue that a pragmatic case finding and intervention could be used instead of systematic screening (Lid, Nesvag, & Meland, 2015). This means that the GP has a special focus on alcohol when patients have diseases more closely related to alcohol consumption.
Furthermore, the GPs thought screening and talking about alcohol use would have been easier if the negative consequences of alcohol use in older persons were more widely discussed as a topic in society, like nicotine use has been (Johannessen, Helvik, et al., 2015).

**Alcohol in old age as a topic in society**

Over the last five to 10 years Norwegian health authorities have expressed concerns about increasing alcohol consumption in old age (Stortingsmelding30, 2012) and expressed that those with alcohol problems should be given priority (Stortingsmelding30, 2012). In the last few years, there has been some focus on wise drinking in one project. In a new project, volunteers visit senior centers to talk and inform residents about alcohol consumption and precautions to take. The media, too, has lately been interested in the topic (Knutheim, 2015).

**Conclusion**

Alcohol consumption is tied to our culture. In Norway, alcohol may be seen as a symbol of the good life, and a glass of wine may be taken for pleasure. It is nice that older adults may enjoy their good life, but it is important to know that alcohol intake in old age should be moderate and less than in younger days due to decreased tolerance. However, this is not common knowledge either in the Norwegian society or among the older adults themselves. Furthermore, it is not generally known that alcohol must not be combined with several drugs and that alcohol does not improve sleep or reduce pain or psychological problems over time.

We need to focus on elevated alcohol consumption in older adults since such drinking is expected to increase. Adequate steps toward healthy aging should be taken in the years to come. Awareness should be put upon the health consequences of elevated drinking, and health authorities have an important role to play. Health professionals of all kinds need, not
only knowledge about what is elevated alcohol consumption, and consequences of and symptoms related to such use, but also they need to pay attention towards such use and ensure competence in screening alcohol consumption.
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