# Wet eldercare facilities for older persons with substance abuse problems and complex needs – promising care practices or institutionalized ageism?

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**Abstract** (The extended abstract that was submitted to the conference appears last)

Wet eldercare (care home) facilities constitute a type of harm reduction arrangements that aim for safety, increased dignity and wellbeing. The fact that residents are acknowledged as being active in their abuse results in challenges; not only will harmful activities be witnessed by the staff, the grouping of people with similar problems makes it difficult for residents who wish to drink less to actually do so. The aim of this article is to explore approaches and strategies that address challenges associated with the lenient approach of wet eldercare facilities. Data for the study consists of 12 interviews with managers and staff at five eldercare facilities with different sizes, organizational styles, and approaches. Qualitative content analysis was used to identify strategies that were used to handle the presence of alcohol and drugs under a “cap of acceptance” deemed to be necessary for a low-threshold facility. A “*looking away” strategy* meant that staff focused on care and regarded the consumption of alcohol and drugs as a private matter of residents. An *intervention and prohibition strategy* was used to establish social order and reduce harm through regulations. An *intervention and distribution strategy* meant that staff negotiated with residents on how much alcohol (and tobacco) they could afford and these products were then bought and distributed by the facility in order to even out the consumption. In the final analysis, findings are brought into a typology for strategies, based on the two variables of acceptance and control, and the use of different strategies is critically discussed.

Keywords: Alcoholism, Care, Harm Reduction, Older People, Substance Abuse

## Introduction

In this article we investigate strategies that address the use of alcohol and drugs in low-threshold facilities for persons with long-term alcohol problems. During interviews that we conducted at five low-threshold facilities in Sweden and Denmark, managers and staff stated that they provided residents with a good life, but mentioned a number of problems: harmful consumption of alcohol and drugs, peer-pressure to drink, drug-dealing, parties, disturbances, conflicts, unwelcome visitors and bedbugs. In the analysis it became clear that the presence of harmful and destructive activities was a major concern and when using Carol Bacchi’s “What’s the problem? approach”, we could identify several strategies that addressed problems relating to these challenges.

In modern society, compulsory treatment has been used as a last resort alternative for persons who do not have the will or ability to break away from a destructive pattern of substance abuse (Runquist, 2012). In Sweden, this type of arrangement constitutes the extreme version of a general aim in policies on alcohol and drugs, to quit or reduce the consumption (Bodin & Romelsjö, 2007; Ekendahl, 2011). Such aims are also expressed in the Social Services Act (Chapter 5 §9) stating that municipal social services should ensure that addicts receive the help that they need in order to stop using alcohol and other drugs. At the same time, a person’s age plays a vital part in professional decisions about substance abuse treatments. Substance abuse problems are often seen as gradually developing over a period of time making it important to “focus on the young ones” before problems become “permanent” (Mattsson, 2018; Selseng, 2015).

As an alternative to sobriety, and sometimes as part of a critique against hard-line policies on alcohol and drugs, Sweden has a history of interventions that primarily aim to reduce the harm of drug use (Fugelstad, Stenbacka, Leifman, Nylander, & Thiblin, 2007) and alcohol use (Karlsson & Gunnarsson, 2017; L. Lindgren, 2008; Mørk & Simic 2010; Ågren, 1999). In policy debates, harm reduction remains controversial and has been criticized for “sending the wrong signals” (Johnson, Richerts and Svensson, 2017:312), but among alcohol and drug researchers the view is generally positive (Andersen & Järvinen, 2007). Non abstinence-oriented interventions has been justified as humane and pragmatic, but also as means to improve health for substance users (Aceijas, 2012; Stenius, 2007) and as ways to reduce societal costs (L. Lindgren, 2008; Maremmani, Cibin, Pani, Rossi, & Turchetti, 2015). This positive view is particularly present in relation to older individuals with a long-standing history of abuse problems and homelessness (Blinded). Social service officials have argued that compulsory treatment for this population is costly and pointless and that low-threshold facilities that provide care rather than treatment constitutes a better solution (Palm, 2009). Low-threshold facilities for older people are nursing homes and the like, where goals of abstinence are abandoned in favor of goals of increased dignity and wellbeing (McCann, Wadd, & Crofts, 2017). Typically, residents are above the age of 50 (in this study up to 93 years old), with a long career of substance abuse, often combined with mental illness and homelessness. No treatment is provided, and residents are accepted as being active in their abuse.

A decision to give priority to the goal of providing care and a decent life *with* alcohol (and additional drugs in some instances) raises a challenge that we refer to as *the challenge of presence and visibility*. Staff at low-threshold facilities are present 24/7 and may witness residents’ consumption of destructive, sometimes lethal, amounts of alcohol and drugs, but their role is to provide care and accept residents as being active in their abuse. The accepting approach may not only pose a moral challenge for the staff, but also clashes with policies of social services, according to which staff generally are regarded as having a legal imperative to act if they are aware that destructive behavior is going on. Low-threshold facilities are therefore inherently vulnerable to criticism and may even be part of media scandals, if activities are described as illegal, immoral or out of control (Blinded).

Research on wet facilities in a Nordic context is rare, with Lindgren’s socio-economic evaluation of a facility in Sweden (2008) and Thiesen’s and colleagues’ descriptive articles on Danish facilities (Thiesen, 2007; Thiesen, Tanderup, Stavad, & Hesse, 2017) as exceptions. Little attention has been devoted to the moral problems that facilities and their staff face when working in harm reduction contexts. A partly similar situation has been studied within the field of home care, where staff who are employed to provide care and service encounter intoxicated care users, living in misery but refusing treatment (Karlsson & Gunnarsson, 2017). Although the choice to provide home care for people who would benefit from treatment constitutes a similar situation, the difference is that in the case of wet eldercare facilities, the context where the harmful activities occur has in fact been created by social authorities.

Wet eldercare facilities are interesting objects in their own right, but they could also be regarded as critical cases of how professionals balance the rights to self-determination that are stressed within allowing approaches with the risks of becoming a passive bystander and even facilitating destructive lifestyles of vulnerable individuals (Eliasson-Lappalainen, 1995). In order to contribute to the knowledge on this balancing act, the aim of this article is to explore approaches and strategies that address the challenge of being present at a facility where destructive behavior consumption of alcohol and drugs are part of everyday life.

Theoretically, our study is positioned within a tradition that focuses on the way controversial standpoints are explained and justified with reference to the characteristics of problematic individuals, moral frameworks and potential outcomes (Holstein, 1992; Runquist, 2012; Scott & Lyman, 1968). In particular, we will focus on how the concept of the “last-resort” (Emerson, 1981) is used as a rhetorical tool that justifies the type of non-preferred activities that are accepted at wet eldercare facilities. Whereas first resort decisions typically are presented as what ”ought to be done”, for instance to offer counseling or treatment, last resort decisions are framed as a non-preferred case of necessity (Emerson, 1981, p. 1). In Sweden and Denmark, local guidelines as well as newspaper articles have portrayed wet facilities in a favorable light by implicit referrals to the lack of real alternatives (cf. Andersen & Järvinen, 2007) (Jönson & Harnett, 2019), for instance by stating that they target people with “long-term alcohol problems” who are “unable to live in their own home” (Bryggergården 2018) and need “long-term accommodation with care provision” (Göteborgs stad, 2018). These accounts are part of a justification repertoire proving that a wet facility is the last and only solution for people who have been through the entire system of treatments and failed and when it is impossible simply to "do nothing" about the situation (Emerson, 1981).

Since Emerson’s seminal work, the concept of last resorts has been widely used to describe decision logics and unconventional solutions for a variety of problem groups (Bower, 1997), (Rincón et al., 2014), (Hulatt, 2014). In studies on substance abuse, the concept has been used to analyze methadone maintenance programs (Järvinen & Miller, 2010) and rhetoric on compulsory treatment (Runquist, 2012). Our study adds to this research, by investigating how different approaches address morally problematic issues that last resort solutions tend to be associated with.

## Data and method

There is currently no established definition of what a wet eldercare or care home facility is and no statistics are available from Nordic countries. Some larger cities have wet eldercare facilities that are entirely for older persons with alcohol abuse problems, but there are also small units dedicated to this population in regular nursing homes. Facilities also differ regarding the age of target groups in that the lower age limit ranges from 50 to 65 years.

The article is based on an explorative study of five wet eldercare facilities in Sweden and Denmark. Twelve semi-structured interviews were conducted with 17 interviewees, five managers and 12 staff members. The managers’ educational backgrounds were social work (2) and nursing (3). The staff members were social workers (2), nursing assistants (9) and nurse (1). Two managers were men, all other interviewees were women. We conducted eight individual interviews and four mini-group interviews with two to three participants. Interviews lasted between 52 and 85 minutes and were conducted in staff rooms at the wet facilities. Eight interviews were conducted by the first author and four by the second author. The interview guide covered questions about a) the characteristics and needs of the target group, b), the goals and approach of the facility, c) everyday life, d) rules and routines, e) moral dilemmas and f) main gains and challenges.

The sampling in this study was strategic, aiming to include facilities with different approaches and with different populations of “older people”. This was also the reason for including the Danish facility for people with alcohol dementia. The other four facilities were located in Sweden and all were placed in relatively large cities (150,000 to 600,000 inhabitants). Organizationally, four facilities belonged to the eldercare administration and one, Glenwood in Sweden, belonged to the homelessness administration (but specifically targeted older people with long term alcohol problems). While the first four facilities were open for visitors to enter and very much resembled regular nursing care homes, Glenwood was a locked facility (visitors had to be registered by a security guard) with few communal areas except for a TV-lounge and kitchen on each floor. An overview of the facilities is included below.

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| --- | --- | --- | --- | --- | --- |
| **Facility** | **Number of residents** | **Interviews and interviewees** | **Target group** | **Staff on site** | **Meals** |
| Mountainview | 129 | 2/5 | +50 with long term alcohol problems | 24 hours | Three meals a day, including snacks.  |
| Cloverdale | 72 | 2/3 | +50 with long term alcohol problems | 24 hours | Three meals a day, including snacks |
| Glenwood  | 45 | 2/5 | +50 homeless, with long term alcohol problems | 7-16 Weekdays | No meals served. Residents are expected to cook their own meals. |
| Victoria Lodge | 16 | 2/2 | +65 with long term alcohol problems | 24 hours | Three meals a day, including snacks |
| Bayside (DK) | 40 | 2/2 | +55 with long term alcohol problems & alcohol related dementia | 24 hours | Three meals a day, including snacks |
| **Total** | **302** | **12/17** |  |  |  |

Interviews were recorded and transcribed verbatim and read independently by both authors. The first author made the initial coding and themes were then discussed during a series of four meetings. The analysis was inspired by Bacchi’s (1999) “What’s the problem? approach”, in the sense that we actively searched for problematic conditions that the approaches and strategies of the facilities aimed at solving, as well as problematic conditions that were omitted in the descriptions of strategies. During the process of analysis, it became clear that the approaches to alcohol and drugs described by interviewees could be regarded as attempts to address the challenge of their presence and visibility through strategies that were associated with different levels of intervention and control. Following this, the process of coding became selective, focusing on how different strategies served in relation to this challenge. Three main control strategies were identified and below, we will refer to them as a) looking away, b) intervention and prohibition and c) intervention and distribution.

## Results

In the first section we will present arguments that were used to justify a *cap of acceptance* – the choice to accept that residents continued to use alcohol and other drugs in a destructive manner. Following this, we will describe the three strategies that were identified under this cap and in the final part of the article, we will provide outlines for a typology that relates strategies to the variables of acceptance and control.

### The cap of acceptance

The mission of the facilities was to provide residents with accommodation, food, care, and a “good life” or a “decent life”. Interviewees used words like safety, dignity, comfort, quality of life, and argued that acceptance of continued intake of alcohol was necessary in order to reach these goals. Last resort logic (Emerson, 1981) was used to describe the facilities and their residents. Justifications of the allowing approach was based on claims that the facilities were exceptional; they were options for persons who continued to abuse alcohol and drugs despite previous treatment efforts. Answering a question about treatment, deputy manager Katie at Mountainview argued that “we don’t have that ambition here”. Attempts to provide treatment or goals to reduce residents’ alcohol consumption was not realistic, and would only result in failure she argued:

To succeed [in becoming sober] is not the goal, because this operation would be marked by failure if that was a goal. The goal is to make everyday life as good as possible for our residents and our residents have, sort of, a history, I mean, almost all have gone through the entire system with different treatment efforts. And the basic idea with this type of facility, that I think is very nice, is that somewhere… we try to approach the human being based on who that persons is, not with a pointer or a stethoscope… because everyone knows that it is harmful to smoke, harmful to drink and harmful to take drugs.

Residents were described as individuals that would not benefit from treatment, since all previous attempts had failed. Severe substance abuse was the very reason for moving to a wet facility and to accept this abuse was a way to approach residents “based on who that person is”.

The character and history of residents was also used in comments on the outcome of the stay. Interviewees at all facilities stated that their residents had a “good” life, thereby indicating the presence of a contextualized definition that differs from the characteristic for a good life that has been debated among policymakers and researchers on “ordinary” eldercare (Martin et al., 2014):

We know that these people still have a good life here. And had they not lived here, but lived outside, then they would not have been alive today… because still it’s this thing that they like here, they really care about their apartments here… (Erica, Manager, Glenwood).

The statement established comparisons between “here” and the streets and between living at Glenwood and being dead. The cap of acceptance was often justified with reference to the history of untreatable residents and to the alternative of being homeless or dead.

While several interviewees stated that their work was very rewarding, the challenge of being present as a witness was indicated in comments on frustration about activities that were harmful or destructing. This could concern single residents, or the facility itself. A typical problem concerned the community among residents. Interviewees described a vast majority of the residents as unwilling to reduce their drinking, and those who wanted to abstain or quit found it difficult to do so in the company of others (Glenwood):

But then, AA there you have the community to quit but here, there is almost a community to keep on [drinking]. Because many times you hear in the corridor that it is like this, "Won’t you come in and have a beer?" And then there is a person who is sober and trying, I can really see how they try to fight "No, no", but "Come on now, come in to see us later when you've finished talking to her, come in now", and “No, no, no”. And then you see that they go in there. Because there is this community again. Because then maybe there are three in the apartment that sit and drink and you will be standing alone sober... So, in the same way as with the AA, where they are sober and if you come drunk then you will be the outsider… then maybe they can help and say, "but what the hell, stop drinking, come on, try to be sober again”. So here, the community is strong but it points in the other direction.

Comments on the troublesome situations that were actually created and witnessed by the facility were present in phrases like “you hear in the corridor”, “I can really see” and “then you see that they go in there”. The staff and the facilities offered safety and comfort, but the inevitable presence of drinking buddies resulted in moral doubts about the approach among staff. Several interviewees reflected on the way the facilities themselves facilitated continued destructive behavior as an ethical dilemma, as providing safety but “in some way, we encourage their abuse… we make it possible.”

### Looking away

To look away might appear as a sort of denial, but in this article, it signifies policies and activities that were applied in order to *not* make drinking or drugs the focus of attention. To some extent the strategy is built on the same idea as the policy “Don’t ask, don’t tell” previously used by the US Military, in that it involved both “not looking” and “not showing”. The high degree of acceptance inherent in this response was facilitated by staff not looking for problematic behaviors or asking what was going on in residents’ rooms and residents not showing too much of what was going on. This was facilitated by rules (see section on intervention and prohibition), in order to keep residents from drinking and taking drugs in front of the staff.

The strategy followed directly upon the commonly described aims of the facilities to “shift the focus” away from drug abuse to care and to the functional aspects of everyday lives: “we don’t focus on the abuse at all at the facility, it is a secondary issue” (Staff-member Annie, Mountainview). The looking away strategy involved a complex navigation between acceptance and control. In all but one facility residents could drink and use drugs in their own apartments. This policy was justified through references to the private character of the residents’ home. Staff member Annie at Mountainview described a clear distinction between what residents were allowed to do “outside” and inside their apartments:

The apartments are their own so in principle, they are free to do whatever they want. Just like you and me in our apartments. If you are a drug addict, it is likely that you abuse [alcohol/drugs] at home and that is also where you are allowed to do it, but never in the common areas, like the corridor or outside [the apartments] or so. No, they get to do it at home and handle it themselves.

In line with the official policy of the facility, the staff-member established a distinction between the private apartments and the common areas, to which the accepting attitude should not be expanded. In doing so, she referred to the concept of the “home” and the statement that any intake of substances should be handled by residents themselves strengthened the claim that apartments were places for out of focus activities. If residents were accepted as active addicts, their homes and areas outside the facilities were the places where their abuse realistically would take place.

A decision not to intervene when a person injects amphetamine or drinks alcohol despite a serious liver condition could be considered a type of rule violation among social workers, or health care professionals. Showing awareness of this, the interviewed staff portrayed passivity as somewhat problematic; they used disclaimers (cf. Hewitt & Stokes, 1975) and expressed practices in vague or unfinished sentences. Staff-member Pam at Cloverdale provides an example when commenting on the use of illegal drugs at the facility.

So, this is a very… it’s a tolerant facility. To say the least. When considering that they are allowed to drink and so. Drugs are of course prohibited by law, so that is not allowed here but that is done to… they use drugs, yes…

Even though rules regarding alcohol and drug consumption were in existence, staff at several facilities were reluctant to verify if these rules were followed. This became obvious when the interviewer (TH) visited Glenwood and asked why someone had written “drug tests” on the whiteboard. The staff explained that at Glenwood residents were officially supposed to use alcohol only. But drug tests were not an option, staff explained, as this would reveal that many residents used drugs and this could result in eviction. Eviction would mean homelessness; the individual would be back to square one and therefore staff turned a blind eye to drug use and abstained from testing residents.

The limited gaze of staff was acknowledged by the manager Erica at Glenwood, in response to a question if any particular guidelines applied to drug taking. Erica explained that detailed guidelines did not exist since “my staff don’t really have contact with the residents in that way, because this is about something that goes on in the apartments.” This position about apartments as places out of sight was challenged by the fact that staff-members visited residents in their apartments to provide care. Catharine, a staff-member at Cloverdale, described the problem:

I have entered rooms where they sit with their hashish and it’s just fuming. In the arm there is a needle and it’s “please can you help inject me?”, so no, that’s when those blind… [blinders] come on. But it wears on you, when you see that.

This quote illustrates an attempt to literally look away in order to uphold the idea that drug use in residents’ rooms should be outside visibility and the presence of staff-members was narrowed down to missions that excluded action against the use of drugs. In Goffman’s (1974) terms the staff member struggled to uphold her *framing* of the main activity of “providing care” by trying not to get involved in the drug taking activity of the resident.

The strategy implied an ambivalent approach to residents’ autonomy. On the one hand, clients were considered irrational “slaves to their substance use” (cf.Andersen & Järvinen, 2007) and as unable to resist the social pressure when someone offers them a drink. On the other hand, the looking away response meant that residents were viewed as autonomous subjects responsible for their decisions and “free to do whatever they want. Just like you and me in our apartments” (staff member Annie, at Mountainview).

### Intervention and prohibition

The fact that the policy of some facilities was stated as “there are no limits to how much a person can drink because self-determination is applied” (Staff-member Diana, Mountainview) did not mean that interventions were totally absent. Interviewees stated that they encouraged residents to take breaks, and to drink less. The manager at Mountainview said that staff tried to reason with residents who totally lost control over their consumption and eventually, in very rare situations, a report according to the Social service act could be sent and a caseworker could act and suggest detoxification.

Prohibition might appear as being at odds with an allowing and accepting approach, but various types of prohibition were applied at all facilities. The typical case would be to ban alcohol during social and common activities. The prohibition of illicit drugs constitutes a second case, although the staff often turned a blind eye when this rule was violated.

Prohibition and control was used to keep the social order but could also act to help residents stay sober. At Glenwood, a staff member had her three dogs on site five days a week and accompanying the dogs during walks was a popular activity among residents. The dogs and the possibility to walk them were perceived as beneficial for residents who needed physical exercise, daily structure and the social and psychological gains associated with walking dogs:

I also thought that with the dogs that I have, that it will also be a little motivator to try and give them a daily life and structure on the whole, that you can get out with them and there I can also stop them and say that you are too drunk, because that’s not the way (Anne, Staff Glenwood).

The prohibition – not being “too drunk” – had a practical and ethical basis, relating to the possibility to walk and being in the company of a dog, but was also described as a way of motivating residents to have short periods of abstinence. Social activities at Cloverdale and Mountainview were offered according to the same logic, for reasons of order and solidarity being drunk was not allowed during such activities and they were an incentive to stay sober for a few hours.

Strategies of prohibition were most prominent at Victoria Lodge. This facility differed significantly from the others in that residents were not allowed to drink alcohol neither in their apartments nor in any other place inside the facility:

What we have is that they can’t drink within the facility. On the other hand, if they feel like they want to go out to a restaurant or meet friends or so and drink with them, they'll do it. And they may come home drunk. But they are not allowed to stay down here in communal areas. Partly for their own sake, but also for the sake of others so that it does not become a trigger to, well… “but now I will also go out and drink”. (Sophie, staff member, Victoria Lodge)

The staff confiscated any alcohol found in residents’ apartments and a breathalyzer was used before meals to ensure that no resident had been drinking. The system of prohibition and control was, according to the manager, part of a voluntary contract that had been initiated by residents who wanted to have a sober environment and who were provoked by the smell of alcohol during meals.[[1]](#footnote-1) The prohibition response that was applied in Victoria Lodge was still different from the type of all-embracing prohibition response that may be applied in prisons and in in-patient treatment programs (Ekendahl, Karlsson, & Månsson, 2018; Giertsen, Nylander, Frank, Kolind, & Tourunen, 2015). In treatment facilities, patients who use alcohol or drugs may be discharged and treatment is thus labeled as “unsuccessful”. In Victoria Lodge, the “permeable” nature of prohibition made it possible for residents to drink alcohol outside of the facility, some drank in the nearby park or went to a restaurant and others were absent for days. Residents at Victoria Ledge were accepted as being active in their use of alcohol – outside the facility – and the response of the facility for being drunk was that residents had to have their meals inside their apartments, not in the dining area. The manager at Victoria Lodge argued that their approach worked well since the facility was a small unit with only 16 apartments.

To provide a quiet and sober environment was not the only motive for prohibiting alcohol at the facility. Referring to his medical knowledge as a registered nurse, the manager stated that the use of alcohol for people who are on medications was a health risk:

We justify this because we have a medical drug treatment here and so on, and we don’t feel… or it is not compatible to take medicines that are prescribed by doctors along with other drugs. Because that compromises medical safety. (Matthew, Manager, Victoria Lodge)

It is well-known that the combination of alcohol and medications can be harmful and that older persons are at higher risk (Moore et al., 1999). However, alcohol is equally harmful if consumed in or outside of a building, but staff chose to regard drinking outside as a problem that should be accepted. The manager stated that residents were “welcome to go out in the park as long as they leave the bottle outside”. Prohibition at Victoria Lodge was in this sense combined with a looking away strategy that was deemed as necessary under the cap of acceptance.

The strategy at Victoria Lodge shows how the cap of acceptance prompts the merging of prohibition and looking away strategies. A similar logic appeared in comments on the demand to be sober during common meals and social activities at Glenwood, Cloverdale and Mountainview. Residents at Glenwood could accompany the dogs if they were not “too drunk”, and staff-member Amanda at Mountainview explained that some residents were somewhat “shop drunk” but did not bother anyone so they were allowed to join the common meals. Contemplating on social activities staff-member Pam explained that some residents were “super-nice” and therefore allowed to come along on social activities even when they were affected by amphetamine:

I can tell you that we have some… here, that I have felt sometimes, that I see, I know that he or she is high, but behaves sort of. Social, nice, kidding in every way and all that. Then I find it really hard to say that ’you can’t come along because I see that you are high’.

Staff-member Catharine added that for some residents, taking amphetamine was a form of self-medication for attention deficit disorders. These residents could “function” better when they were high. Allowing residents that were affected to join in on social activities was a clear breach against the rules of the facility, but it was based on pragmatic reasoning and made possible by the looking away strategy. Staff-members focused on the functioning of residents, not on their level of intoxication.

### Intervention and distribution

The Danish facility, Bayside, differed significantly from the others in that the staff assisted residents in purchasing alcohol and tobacco on the internet and then distributed the goods evenly during the course of the day, week and month. The distribution response framed the residents’ problem in terms of uneven and uncontrolled alcohol consumption, i.e. binge drinking followed by periods of abstinence and suffering. This problem representation served as a justificatory decisional logic with the goal “of achieving a more balanced alcohol consumption” (Vivian, Staff-member, Bayside). The strategy could be seen as a version of the type of managed alcohol programs (MAPs) that have been used internationally to control and reduce the alcohol consumption of homeless alcoholics (Evans, Semogas, Smalley, & Lohfeld, 2015; Podymow, Turnbull, Coyle, Yetisir, & Wells, 2006). But whereas it is the professionals who regulate the distributed amounts within managed alcohol programs, it was the residents themselves who decided their daily amounts at Bayside.

Based on resident’s monthly income, staff made voluntary contracts with residents on how much to drink and smoke per day. Alcohol and tobacco were kept in a storage room and handed out several times a day, from early in the morning until the late at night. Residents’ daily consumption varied greatly. Some residents drank six liters of wine per day, whereas others only drank non-alcoholic soda.

When the staff at Bayside described the distribution response they often did so by referring to similar kinds of narratives (Riessman, 1993). A typical narrative introduced an old person with a long history of alcohol abuse problems and with a recurring monthly pattern of a couple of days of binge drinking after pension payment was paid out. When the money was gone, the person suffered from withdrawal symptoms until the next pension payment was paid and then the same pattern started all started over again:

And he went down to the pub and drank his entire salary ... his pension in 2-3 days. And then he was very drunk and affected by alcohol, and maybe for 27 days he had no money, no food, no cigarettes – all his needs… (Vivian, Bayside).

A central factor for the distribution response was that staff presented cigarettes and alcohol as a *need*. Vivian talked about food, cigarettes and alcohol as “all his needs” which constitutes a sharp contrast to how alcohol and tobacco was talked about in other facilities (although similar ideas were visible in comments on amphetamine as self-medication).

Following the logic of needs, the manager at Bayside claimed that the facility had an obligation to “come up with an alternative to having fourteen days out of a month where they have a terrible situation.” The pattern of binge drinking followed by withdrawal was described as extremely painful, but also as a health hazard, according to the same manager:

The healthiest way to drink if you drink a lot, it's drinking evenly ... so drink evenly over the day and over the month. This when you go on like that [binge drinking], that is what hurts the brain most. [-] I'm a nurse, but it's actually the healthiest way to drink alcohol - it's evenly.

The claim that uneven drinking causes the most harm for the brain was backed by referrals to the manager’s status as a registered nurse. On the one hand, the medical danger in binge drinking was emphasized, but on the other hand the suffering caused by withdrawal problems was presented as the main concern for the category of residents that lived at Bayside. The distribution strategy was presented as a way of harm reduction, by lowering residents stress levels and anxiety:

So, if that's how it is, I'll make sure that you get your beer every day instead of having all your beers in two days and none for 28 days, then you've got it hugely difficult. So maybe my careful, long-term goal is to make you drink evenly for your sake, because then you feel peaceful. So, I can help you ... everything is on a voluntary basis, everything is something that the resident has allowed me to work with. It's a close dialogue - a collaboration - where we like to write down the agreements and show that at eight o'clock you get two beers [laughs lightly] and at twelve you get four, or you get twenty cigarettes ... you get ten, you get twenty. So, it's on a paper and it's alright, so we make sure you have cigarettes all day and if you wake up at night, your cigarettes are on the table. God, how lovely, I don’t have to worry - I can lay down and sleep because when I wake up, my smokes are there (Vivian, Bayside)

The quote illustrates how the distribution response was presented as a way to reduce residents’ stress levels. Several narratives were built on stories of residents’ stressful past and a peaceful present and distribution of alcohol was portrayed as a way of increasing residents’ quality of life.

The use of alcohol was integrated into some daily activities at Bayside, in some dinners, in visits to the barber and in the existence of “a user-friendly pub” (Thiesen, 2007). The manager stated that hopes to steer residents away from alcohol for any longer time through the provision of alternative or competing activities, ignored the reality of a long-standing alcohol dependence: “I think that it is unrealistic [to think] that we could compete… we find it really hard to compete with alcohol – we can’t offer anything that is better [in the view of residents].”

When asked about drugs and drug dealing, the managers at Bayside said that only one resident smoked cannabis. In line with the strategy to control through distribution, the manager had made an agreement with the drug dealer that he was allowed to visit the room of his customer but then walk straight out of the facility. The arrangement provides yet another example of how approaches were merged. Staff looked away while a prohibited activity occurred, since the activity was framed as a type of controlled distribution that fulfilled the need of a resident.

## Discussion: a typology on strategies for the use of alcohol and drugs

To group together people with long-standing alcohol problems and allow them to drink is not in line with mainstream policies on alcohol and treatment. As has been shown in this article, the existence of such arrangements is justified with last resort logic (Emerson, 1981) that points to the character and history of residents – they have already tried all types of treatment – and on the alternative to their stay at the facility – they would be homeless or dead. What our study has shown is how this basic justification of *acceptance* is complemented by strategies that address the fact that residents continue with a destructive behavior in a context that has been created by the facility and where staff is present as witnesses. Three main strategies were identified for how to respond to the challenge of presence and visibility. Even though certain strategies were more prominent at certain facilities, several responses were invoked at each setting and by the same individuals. Each strategy had a different emphasis regarding the *degree of acceptance* and a second aspect was to what extent the facility applied different types and *degrees of control*, manifested in more or less active attempts to work on or with the consumption of alcohol and drugs.

The looking away response, meant that the staff chose not to focus on some destructive behavior and was associated with a high degree of acceptance, but a low degree of control (P1). The intervention and prohibition response meant that the staff used some kind of ban to keep the social order and was associated with a high degree of control, but a lower degree of acceptance (P2). The intervention and distribution response (P3) meant that the staff were actively involved in distributing alcohol in a regulated manner to residents. This response was associated both with a high degree of control and a high degree of acceptance. Figure 1 illustrates these different positions.

Figure 1: A typology on strategies applied to the use of alcohol and drugs

Cap of acceptance

Degree of acceptance

P1loo

P3

P2

Degree of Control

A topic for further studies is whether any particular strategy is associated with a higher quality of life for residents. The data that we have collected so far does not allow for an evaluation of the outcome of different strategies, but it is still possible to point to some general gains and risks.

*Intervention and prohibition responses* acknowledge residents’ alcohol abuse and are means to create social order and to protect individuals from harm. The obvious risk is that different kinds of prohibition raises the threshold to the extent that they are at odds with the cap of acceptance. Victoria Lodge was only a wet facility in the sense that residents were allowed to be drunk in their rooms, but they had to drink outside. The manager described a situation where he had offered an apartment to an older homeless man during a visit to a shelter. The man was in need of care but declined the offer to move to Victoria Lodge, since the alcohol ban inside the facility was not acceptable to him.

*Intervention and distribution responses* also acknowledge residents’ alcohol abuse and work to reduce harm, while having a long-term goal of reducing the consumption of alcohol and drugs. But distribution responses may be criticized for sending paradoxical messages by on the one hand distributing alcohol to residents and on the other hand asking them to drink less. At Bayside, all residents had alcohol related dementia and many had physical impairments. Staff members’ involvement in purchasing and distributing alcohol was a way of enabling alcohol consumption for people who may otherwise have had difficulties buying these goods. If a person died from drinking alcohol at Bayside, that person would have died by drinking alcohol that was provided by the facility.

*The looking away response* could be described as a bi-product of the choice to focus on the provision of shelter, safety and care. This would be similar to a case where a person with alcohol problems who refuses treatment still receives home care (Karlsson & Gunnarsson, 2017). Loss of control and chaos are obvious risks and looking away strategies may be challenged and relabeled as *denial* and *neglect*. While all three strategies have their pros and cons – and in reality they are combined in complex ways – looking away responses seem to be associated with an inherent vulnerability. They represent the absence of what *is* in focus – care or social activities for instance – and are difficult to develop into systematic strategies that can be *defended* in the way that prohibition or distribution strategies are. Although interviewees tended to justify their own actions, some of them, when referring to the looking away response, questioned if they in fact facilitated continued abuse and caused additional harm, rather than a dignified life.

As a practice, social work deals with complex and morally charged situations and social workers are frequently placed in a position where preferred (morally desired or beneficial) actions simply cannot be applied. This gives social work practice a muddy and morally doubtful character in the sense that many activities are difficult to defend if they are questioned. In this article we have provided basic outlines for a typology that could be developed into an elaborate framework for analysis and decision making in *non-preferred social work practices*. By identifying, in detail and through examples, different components of *acceptance* and *control*, social workers could be provided with tools that facilitate the development of balanced and justified strategies in complex and morally challenging practices where preferred solutions are not possible to apply.

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**Extended abstract – submitted for TC-conference**

Older people with complex needs and addiction are often described as a “hidden group” with unmet needs and several researchers have addressed the gap in service provision. There is also great frustration among regular home care staff, who experience difficulties in working with the shifting needs of this population within the limited timeframes that governs regular home care, and among municipal social workers who argue that reoccurring coercive treatment efforts for “chronic” addicts with complex needs is a waste of resources. In response to this, some municipalities in Sweden, and in other Nordic countries, arrange wet eldercare facilities for persons above 50 years of age. These facilities are a type of nursing homes or care homes where no treatment is provided, and residents are accepted as being active in their abuse. Wet eldercare facilities aim for safety, increased dignity and wellbeing. Usually, residents are allowed to consume alcohol (and some use drugs) in the privacy of their apartments.

Wet eldercare arrangements result in challenges; not only will harmful activities be witnessed by the staff, the grouping of people with similar problems makes it difficult for residents who wish to drink less to actually do so. Facilities have a for-life approach, meaning that residents can feel safe by knowing that they will not be evicted if they abuse alcohol or fail in treatment if they do not manage to qualify for the next step in a program. But his approach may also result in some living at the facilities for decades, and some being sober but unable, based on a previous history in the housing market, to move on to other housing alternatives.

The *aim* of this article is to explore approaches and strategies that address challenges associated with the lenient approach of wet eldercare facilities, in light of the for-life approach that is applied.

Data for the study consists of 12 interviews with managers and staff (a total of 17 respondents) at five eldercare facilities with different sizes, organizational styles, and approaches. Qualitative content analysis was used to identify strategies that were used to handle the presence of alcohol and drugs under a “cap of acceptance” deemed to be necessary for a low-threshold facility. A “*looking away” strategy* meant that staff focused on providing *care* and regarded the consumption of alcohol and drugs as a private matter of residents. An *intervention and prohibition strategy* was used to establish social order and reduce harm through regulations. An *intervention and distribution strategy* meant that staff negotiated with residents on how much alcohol (and tobacco) they could afford and these products were then bought and distributed by the facility in order to even out the consumption.

In the final analysis, findings are brought into a typology for strategies, based on the two variables of acceptance and control, and the use of different strategies is critically discussed in relation to the question: is this a promising practice or is it institutionalized ageism applied to persons accepted/labeled as “chronic addicts” and provided care instead of treatment?

1. Since residents at Swedish nursing homes have tenants’ rights, this arrangement would not hold up legally if challenged. [↑](#footnote-ref-1)