

# Alcohol in long-term care homes: A qualitative investigation with residents, relatives, care workers and managers

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## Abstract

**Introduction:** Western societies are aging rapidly, and habitual use of alcohol is changing among older adults. Hence, care facilities are facing novel challenges regarding alcohol use. This pioneering qualitative study seeks to investigate the role of alcohol in care homes, as seen from the perspectives of residents, care workers, relatives, and institution management simultaneously.

**Method:** Five residents, four care workers, three relatives, and two care home managers

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participated in semi-structured interviews lasting 60 minutes maximum. An interpretative phenomenological analysis framework were utilised for the analysis. **Results:** It seems that there is a positive attitude towards the use of alcohol in care homes across the four groups of participants. They find that the use of alcohol is presently low among the residents. Importantly there appears to be an important symbolic value in the rituals surrounding alcohol which is upheld by all four groups. **Conclusion:** While experiences between the four groups seem to converge regarding the use of alcohol, there are still some important differences. Importantly, we suggest that these unique views be utilised in developing methods for handling alcohol use in care homes in the future.

## Keywords

alcohol, alcohol use, care, care facilities, older adults

Western societies are aging rapidly (United Nations, 2010). The number of older adults over 60 years of age is growing numerically and proportionally to the number of people under 60. This means that “the population of older adults in long-term care [...] is expected to increase considerably in the near future” (Seitz et al., 2010, p. 1025). At the same time, older adults of today drink more alcohol than previous generations of older adults (Bjork et al., 2006). This change is expected to influence care homes and home care, as residents may carry a certain type of life-long alcohol use with them into care facilities (Klein & Jess, 2002). Additionally, a wide range of research documents adverse psychological and physiological effects of alcohol use for older adults (see Bagnardi et al., 2001; Boden & Fergusson, 2011; Boé et al., 2009; Brady, 2006; Diaz et al., 2002; Kanis et al., 2005; Waern, 2003).

Nursing staff are already aware of alcohol misuse in long-term care facilities (Castle et al., 2012; FOA Kampagne og Analyse, 2012). However, there are different estimates of how prevalent alcohol problems are in care homes. Seitz et al. (2010) found that the prevalence of alcohol use disorders varies from 1.03% to 29%, depending on care home specialisation. Furthermore, it is unclear what effect alcohol use and alcohol use disorders have on older adults in care homes. Brennan (2005) found that, when comparing older adults living

in nursing homes, diagnosed with an alcohol use disorder (AUD), with a similar group not diagnosed with an AUD, the residents with AUD functioned somewhat better than the comparison group regarding activities of daily living (ADL). There was no age difference between the groups at admission and no difference in repeated admissions. “However, residents with AUD were significantly more likely to have lived alone before admission” (Brennan, 2005, p. 480) and these residents used more mental health and social services. Further, there may be a relation between lifetime use of alcohol and long-term care placement. Kaplan et al. (2014) found that lifetime abstainers, former drinkers, and infrequent drinkers were more likely to have long-term placement than moderate drinkers. Burruss, Sacco, and Smith (2014) found that care home residents reported alcohol use as a part of their routines of socialisation and relaxation and that increases in drinking were associated with socialisation and drinking with peers. This can provide a sense of continuity from earlier in life, and congregate care settings may act as a normaliser regarding alcohol use, as they serve alcohol or have alcohol available. Similarly, Sacco et al. (2015) found that alcohol use in continuing care retirement community settings is “largely motivated by the desire for socialization” (p. 287). However, the residents also reported drinking alcohol for coping (Sacco et al., 2015).

In Denmark, citizens are recommended to follow the guidelines of the Danish Health Authority (low risk: seven standard drinks a week for women and 14 for men, high risk: 14/21) (Nordens Väldfärdscenter, 2019). However, one-third of 816 care workers, in an investigation conducted by FOA (a Danish labour union), stated that they needed clear guidelines for working with residents in long-term care who had alcohol problems (FOA Kampagne og Analyse, 2012). According to Klein and Jess (2002), only 57.7% of long-term care facilities indicate collecting any alcohol information about the resident during the admission process. Hence, guidelines and information gathering seem to be poor regarding residents' alcohol use, and there is a need for an in-depth understanding of care-needing older adults' use of alcohol to help develop guidelines and policies in care homes.

The present study seeks to investigate the role of alcohol in care homes,<sup>1</sup> as seen from the perspective of residents, care workers, relatives, and institution management. It asks what experiences these four groups have in relation to alcohol and the use of alcohol in care homes and seeks to compare these experiences to illuminate differences.

## Methods

This study is part of the project *Elderly Welfare and Alcohol – A tricky cocktail*. The aim of the project was to investigate the welfare and well-being of older adults in care homes and older adults receiving home care. Even though alcohol figures in the title and was a focus of the study neither the overall project nor the data collection was especially focused on alcohol problems or alcohol misuse. The project was performed in a Danish municipality in five different care facilities between February 2018 and February 2021. The collection of data was conducted in the first year of this project. The present study is based on interview data collected in care homes.

**Table 1.** Participants.

Alias	Group	Age (years)	Sex
Res1AA	Resident	94	F
Res2HB	Resident	83	F
Res3JC	Resident	77	M
Res4ND	Resident	95	M
Res5VE	Resident	77	M
Car1AF	Care worker	34	F
Car2HG	Care worker	27	F
Car3MH	Care worker	46	F
Car4RI	Care worker	41	F
Rel1BJ	Relative	70	F
Rel2MK	Relative	64	M
Rel3GL	Relative	47	F
Man1EM	Manager	57	F
Man2HN	Manager	64	F

## Participants

Five residents, four care workers, three relatives, and two care home managers were interviewed for this study. All managers and care workers were women. Among the relatives, there were two women, and in the group of residents, there were two men (see Table 1).

## Interview guides

Four different interview guides were constructed to fit the different groups of participants. While the questions focused on the same aspects of the basic research questions across the guides, the specific questions were formulated in a way that fit the group, specifically. (Please see Table 2 for the overall research questions in each guide. An English translation of each guide is available upon request from the corresponding author.) The interview guides were developed based on a period of observations (25 days in total) carried out in the care homes and home care, before the interviews. This procedure ensured that the questions for the participants were close to their everyday lives. The interview guide had both the main research questions and different specific questions and prompts for the interviewer to use freely.

**Table 2.** Research questions.**Residents**

How is the idea of wellbeing/life quality understood and how is it experienced?

What value conflicts arise and how can they be managed?

How is alcohol a part of the understanding of wellbeing/life quality and how is it experienced?

How do the care workers pay attention to (are sensitive towards) the wellbeing/life quality of the resident?

**Care workers**

Life quality (what are your definitions?)

Attention to the wellbeing of the resident: empathy, intimacy and the relation to the resident

Attention to the wellbeing of the resident: emotions and the role of mood/atmosphere

Alcohol (asking for examples of how it is involved in the work and dilemmas that may arise)

Perspective, reflection and self-understanding (asking for examples of reflections about the work)

**Relatives**

How is the idea of wellbeing understood and how is it experienced?

What value conflicts arise and how can they be managed?

How is alcohol a part of wellbeing/life quality and how is it experienced?

How are the care workers attentive (sensitive) to the resident's wellbeing/life quality/welfare?

**Managers**

How is the idea of wellbeing/life quality understood and how is it experienced?

How is alcohol related to the understanding of welfare/life quality and how is it experienced?

How are the care workers attentive (sensitive) to the residents' wellbeing/life quality/welfare?

**Inclusion**

Residents, relatives, and care workers were included by managerial selection as a convenience sample. Managers were asked to select two from each group. The managers were also selected by a convenience criterion as the group of managers was too small to attempt randomisation meaningfully. Participants were included for interviews between September 2018 and January 2019. While the method of inclusion should ensure an equal number of participants

in each group, it proved difficult to include relatives, and hence, there are only three in this group. As there is only one manager for each care unit, only two are included in the present study.

**Consent, anonymity, and ethical approval**

All participants gave written consent to participate after having received both verbal and written information about the study. Names given in the present article are all aliases to ensure anonymity. The study was processed on 22 February 2018 by the Danish National Research Ethics Committee.

**Interviews**

The interviews varied in length, with a maximum of approximately 60 minutes. All the participants were interviewed in the care facilities where they worked, lived, or where their relative lived. Interviews were conducted by the authors (JE, SE, RC, and SHK) and four student assistants. Generally, the interviewers adhered to the interview guides but followed up with additional questions if they deemed it necessary and they were encouraged to explore themes and points further.

**Transcription and translation**

In most cases, transcriptions were carried out by the person who did the interview. This was to ensure the best possible consistency between the interviews and transcripts. A student assistant transcribed the remaining cases. Transcriptions focused on content as recommended by Smith, Flowers, and Larkin (2009). Transcriptions were in Danish. All the transcripts amounted to a total of 206 pages (residents = 80 pages, care workers = 70 pages, relatives = 43 pages, managers = 13 pages).

The excerpts of data presented here were translated by the authors and reviewed by a proof-reader and translator. Translations focused on meaning and content rather than a

direct word-for-word translation in line with the phenomenological approach.

### Data analysis

Data were analysed based on a slightly modified version of the interpretative phenomenological analysis (IPA) described by Smith et al. (2009). As stated by Smith et al. (2009) “the essence of IPA lies in its analytical *focus* [...] that focus directs our analytic attention towards our participants’ attempts to make sense of their experiences” (p. 79, original emphasis), which is different from discourse analysis, as understood by Potter and Wetherell (1987), which focuses more on language.

During and after the collection of data, the research group held meetings where the data and the findings were discussed from different perspectives. For the present study, each interview transcription was copied into a worksheet to make exploratory comments focused on descriptive, linguistic, and conceptual comments. Exploratory comments were then used to create themes (emergent themes). These emergent themes were then sorted into superordinate themes (clusters of related themes formed by the researchers) in Word documents, including related transcription excerpts and comments. Cross-interview comparison was conducted on a group level, and superordinate themes were created for each discrete group of participants. In the present study, we investigate solely the superordinate theme “Alcohol”, which appeared in all groups. All themes for each group were compiled discretely to form the themes presented below.

### Findings

The findings are presented in four separate paragraphs based on the groups of respondents: residents, care workers, relatives, and managers. Comparisons between the results from the different groups are found in the discussion section.

### Residents

*Alcohol use before the care home.* The residents had used alcohol in different ways before they came to stay at the care home. This is important as it adds to our understanding of their current use of alcohol. It seemed that the residents themselves were aware of the changes:

Res2HB: No, we didn’t have that back then. It wasn’t that modern when we were young. It was only, when we were at a party and things like that. The late years, before he entered a nursing home, we had a glass of red wine with our food every day. It wasn’t like we were sitting... it wasn’t like that. We’d seen enough of that, so... (Res2HB, 83y, F, p. 13)

Res2HB is talking about the differences in her alcohol use between when she was young and when she was an adult. To her, it seems that there are two different uses – the occasional use at parties and social gatherings (in her youth) and the everyday use (as an adult). She even underlines how it was mostly in later years before her husband had to go into a care home, that she used to drink alcohol daily.

Residents would state how they used alcohol on certain occasions such as weddings, birthdays, and informal gatherings. They would also underline how alcohol was usually only reserved for these situations and how daily use of alcohol was never at the scale of being a problem. Lastly, one also mentioned a difference between what men and women drank, when she was younger:

Res1AA: [...] Back then it wasn’t modern to [I: No]. The men, you know, they had a beer [I: yes] you know, and we had mineral water [...] that we girls also like [I: Yes], no you [didn’t] have: spirits and stuff like that, you did[n’t]. But, at least not at my home [I: Mm] no. So. (Res1AA, 94y, F, p. 21)

*The care home serves alcohol.* Alcohol is available in care homes in Denmark. The residents can buy, keep, and drink alcohol for themselves.

Their rooms in the care homes are legally considered their own residence, so they have the right to do as they want. Care homes also serve alcohol as a part of meals and on special occasions:

Res5VE: No, not on weekdays, but once a month we all gather at our place to eat together, and we have beer. And sometimes schnapps.

[ . . . ]

Res5VE: Yes, we all get that up in our rooms, we get beer and schnapps. But it's like, only on special occasions, you know. (Res5VE, 77y, M, p. 15)

The occasional use of alcohol presented here is underlining the exclusivity of alcohol and portraying it as a luxury. It illustrates an understanding of alcohol as something that adds value to a situation. Since the care home provides the drinks on these special occasions, there seems to be a broader understanding of the value of alcohol. While it does not seem that Res5VE is feeling pressured or obligated to drink, the "special occasions" on the other hand, call for alcohol to a certain extent. However, if for some reason the serving of alcohol should stop, it seems that it would not bother the residents:

Int: How would you feel, if they stopped serving wine and beer at your communal meals?

Res2HB: Then you'd have to learn to live with that. When you don't need it, you should be able to. It's got to be harder for others . . . because there are those, who can't get enough, but that's their business [ . . . ]. (Res2HB, 83y, F, p. 14)

The statement "You'd have to learn to live with that" is an expression indicating that a change or a state has occurred that you are not necessarily satisfied with. Learning to live with something is different from being satisfied or feeling good about something. Hence, the change from being able to get alcohol, to not being able to get it, is put in terms of settling rather than satisfaction.

*Low use of alcohol.* Generally, the residents described a low current use of alcohol:

Int: What role, should we say, do you think alcohol plays?

Res5VE: No role.

Int: No role, okay. (Res5VE, 77y, M, p. 11)

It is obvious that alcohol plays little role in the life of Res5VE. However, elsewhere he describes how he gets a beer when his son comes to visit. We see a similar tendency when Res2HB explains how little alcohol she uses presently:

I: So, it's not something you miss?

Res2HB: I have some, if my daughter-in-law buys one of the small bottles, then I sometimes have a glass. But, it can be a fortnight in between. It's not like I need to have it in the house. (Res2HB, 83y, F, p. 13)

Here, we find a preconception about alcohol. She has a (small) bottle which her daughter buys for her, but she only drinks from it once every fortnight. It is interesting, how a low and unproblematic intake of alcohol rather consistently is described by *contrasting* it to a dependent use or problematic use: I am *not* dependent; the alcohol *is not* needed: "it's not like I need to have it in the house" Res2HB says. Res4ND, states plainly: "I haven't been a drunkard", when talking about his use of alcohol. It could be argued that this contrast could be a reaction to the way in which the questions about alcohol were presented. However, the three questions regarding alcohol included in the interview guide were: "How have you used alcohol in your life? What role does alcohol play presently? (Why?) How do you think you would feel if your possibilities for using alcohol were limited?". While these questions may lead the participant to think that we were searching for problematic alcohol use, we argue that the face value of the questions is relatively neutral. Exchanging the operative word (alcohol) with something else underlines the neutrality of the

question: “How have you used cars in your life?”. However, the participant may also have had the impression that we – the researchers – were naturally more interested in something problematic and have answered with that assumption in mind. Whatever the reason for the answers that participants have given it seems that alcohol is hardly a neutral topic neither in the research context nor merely asking about it. We speculate whether being asked about alcohol can ever be truly neutral?

*Use of alcohol at special occasions.* The residents described their alcohol intake as something that was suitable for special occasions or certain situations, particularly celebrations. These situations could be very varied and included Christmas, birthdays, Sunday dinners, etc.

Res1AA: So, if I'm out or [...], I mean, if I have guests; well, now I don't have guests over as much anymore, but if my daughter and the others visit [...], and it's my, my birthday, then [...] I buy some, we get wine and such and I pay for it [Int: yes] you know because, I can't have that many guests here [Int: No no] no. But [...] having wine, it's just like, you have two or three glasses. It's not like you-uhm... [...] [Int: No no no] sit and drink [alcohol the rest of the night] [Int: No] we don't do that at all, not at all [Int: No]. (Res1AA, 94y, F, p. 22)

Res1AA says that “I buy”, underlining that she buys the alcohol. This signifies her role as a host and buying alcohol for her guests allows her the opportunity to take on the role as host. Alcohol serves as a gift (or luxury) that you give your guests and, hence, as an expression of your appreciation of them. However, note how Res1AA explicitly underlines the moderation regarding the intake.

Another resident, who had previously experienced a significant health event, describes how he only drank a glass of watered-down red wine: “I usually have some for Christmas”. By mentioning Christmas, he underlines how it is not just a random act of drinking; it is a

purposeful, celebratory consumption of alcohol. This suggests that certain traditions can make people do things that are bad for them.

Another example of how alcohol use is viewed as having cultural or traditional significance is underlined as one of the care homes has attempted to introduce a Friday café, which Res5VE mentioned. However, the initiative quickly faded into nothing. It seems to suggest that this was not a way in which these older adults enjoyed drinking. Further, Res5VE stated that no one drank alcohol in the department where he lives. Even so, he underlined that they met socially for or with alcohol. Hence, it seems that alcohol use, which is purely recreational and not associated with an occasion, is uninteresting to residents.

*Abstinence.* There also appears to be a group of residents who, partly or totally, abstain from drinking. Some would cite health issues while others would talk about previous (borderline) problematic behaviour when drinking alcohol, as reasons for abstinence. In the following, Res3JC is talking briefly about his reluctance to drink alcohol:

Int: That's it... but you don't want to?

Res3JC: No, I don't want to go there again.

Int: No, you are too worried that you can't tolerate it.

Res3JC: Yes, there is alcohol-free beer down there, but I don't dare!

(Res3JC, 77y, M, p. 11)

In other situations, alcohol abstinence can be brought about because of changes in physical health:

Res4ND: I don't drink it.

Int: Not at all? No? Why is that?

Res4ND: I don't like it.

Int: Oh?



Res4ND: It's strange. It's like with the food. I don't like the food.

Int: Okay.

Res4ND: Well, yes . . . yes . . . of course I like the food, but I don't eat very much of it.

(Res4ND, 95y, M, p. 31)

Earlier in the interview, Res4ND talks about how food lumps together in his mouth and how uncomfortable it is. He compares this to what he thinks about alcohol and states that "it is strange", repeating this statement before he goes on to make the comparison. The strangeness is likely related to the fact that Res4ND previously had no problem with liking alcohol and food. This change may feel strange to Res4ND because it is unclear to him why the change has happened.

*Problematic alcohol use.* Generally, the residents only talk sparsely about their alcohol problems. One spoke to some extent about his use of alcohol which had become excessive around the time he was trying to get an electric wheelchair to get around with:

Res5VE: I remember once, where I'd gotten drunk. It was . . . yeah, when the hell was it. There was something I wanted, but I wasn't allowed to. Oh, it was because I'd applied for a wheelchair, a real wheelchair. I only had one of those where I could kick my way around using one leg [. . .] and then they wrote back, that when I could move around by kicking my way around the hallways, I didn't need a wheelchair. So . . . and if I had to go to town, I could just take a taxi. I don't know what they were thinking, when I was dropped off, thinking that I'd be able to manage. Well, it made me so sad that I drank an entire bottle of rum. (Res5VE, 77y, M, p. 11)

While Res5VE has previously stated that alcohol does not play a role in his life, it seems that it did play a role in this situation. The "so sad I drank" statement seems to indicate a certain comforting value in the alcohol. In a similar

situation, other people might have said, "I was so sad that I cried" or "It made me so sad that I went to bed", etc.

*Family and alcohol use.* Part of the residents' alcohol use seems to be relatively closely related to the behaviour of their families. This does not necessarily entail enabling as such but does mean that their alcohol use can be mediated by visits etc. from family. While this specific example may border on enabling, it is an example of how family and the family's use of alcohol influences the resident's use.

Int: No, okay. Do you still drink alcohol?

Res5VE: No . . . yes, I do because my son comes over every Saturday and says: "Res5VE, now we'll go to the pub". Oh well, then. Then I've got to go down and have a few brewskies. But other than that, it's not. It just doesn't matter, you know. Yes. (Res5VE, 77y, M, p. 9)

The son is apparently trying to recreate a situation that Res5VE has been fond of earlier in his life. This means that the son is helping Res5VE to maintain a lifestyle that he was fond of earlier despite his new life circumstances (being in a care home).

## Care workers

*Describing the resident's alcohol use.* Despite the care workers stating that alcohol was not a problem in the care homes, the choice of words, nevertheless, places some focus on problems:

Int: So, alcohol doesn't play a big role?

Car2HG: No, we don't have any problems with that up here. It's not like we get into an argument with them [the residents] or find empty bottles in their rooms. (Car2HG, 27y, F, p. 9)

This illustrates preconceptions that may exist among care workers: when people talk about alcohol, it is because there is a problem. Another care worker described how she did not



experience any dilemmas concerning the residents' use of alcohol. Meanwhile, she also pointed out several situations where she had to handle alcohol and different expectations about alcohol. One care worker underlined that there are no residents who use alcohol every day. It seems that in the eyes of the care workers, the residents' alcohol use is relatively low, and they do not experience too many dilemmas or difficulties with it.

*Controlling the use of alcohol.* Despite the perceived low use of alcohol, the care workers gave examples of situations where alcohol and the use of alcohol had been problematic:

Car2HG: There was one who couldn't accept being allowed only two beers a day, so he found out where we kept the beers. When we locked the storage, he got very angry with us, externalising and couldn't understand it. Then we sent a case of alcohol-free beer to his room, which he could administer himself, and that went fine, actually. He didn't realise that it was alcohol-free beer. (Car2HG, 27y, F, p. 8)

Legally speaking, the resident is living in his private home and can do as he pleases, but the care home policies state that he can have no more than two beers. The care workers estimated that drinking too much alcohol would be unhealthy for him. This is a poignant example of the value conflicts that can arise in care work. The resident must rely on others (care workers) to have his will carried out. If the others decide something is bad for him, then he is limited in arguing against it and may not realise that he is not getting what he wants. In another example, the care workers are serving alcohol-free wine while not being entirely sure whether the residents know that it is alcohol free.

When talking control versus cheating, the interviewer got the following comment:

Int: So, it wasn't like you "cheated" him directly, he just didn't realise it in the long run?

Car2HG: Yeah, it was a man with dementia so... (Car2HG, 27y, F, p. 8)

It seems that when the resident stops addressing the problem, the care worker no longer addresses the problem either. Ending the sentence with "so..." seems to underline the fact that the issue has been handled by not addressing it further.

According to one care worker, some relatives may try to interfere with the alcohol use of the resident:

Car2HG: [...] and there were relatives, who got involved and thought it was annoying. We had to explain that, this was simply the diet plan: a max of two beers per person per day. To which the [relatives] said, that if he hadn't been drinking beer for three days, couldn't he just have six beers the next day. No, he can't, he can only have the two beers allowed. (Car2HG, 27y, F, p. 8)

Care workers will often refer to the resident's autonomy as the gold standard for what is to be done in care work. They will illustrate how they try to negotiate another solution with the resident if they think something is better than what the resident wants. However, it seems there are limits. Here, the care worker is talking about trying to stop a resident from drinking:

Int: Yes. Do you think, you'd experience that as a violation?

Car4RI: Yeh, yes, I actually would.

Int: Why is that?

Car4RI: Hmmm... well, then I'm taking away his self-determination.

Int: Yes.

Car4RI: I can't do that. (Car4RI, 41y, F, pp. 45–46)

Self-determination seems central enough for the care worker to allow an alcohol overuse despite the negative consequences. The focus on self-determination is so prevalent that,

despite the resident's self-determination potentially being influenced by both craving and inebriation, the resident is still left to decide for herself. Self-determination seems to go above both health and social life. This also underlines the role of the care worker as someone who negotiates rather than decides.

*Serving alcohol at the care home.* There are overt ways in which the care home and care workers control the alcohol use of the residents. There seem to be rules at care homes specifying how much a resident is allowed to drink. However, this only goes for the common areas and with shared meals. The resident is still in control of their own room/residence and can drink what and when they want in there. Here we have an example of how alcohol is served in the care home:

Car1AF: and then sometimes during the weekend, we are sitting out here and have a glass of schnapps in the evening and a glass of red wine.

[...]

Car1AF: they should be allowed to do that.

Int: Yes.

Car1AF: I believe so. (Car1AF, 34y, F, p. 16)

This underlines the close relation between relaxation and alcohol but also highlights the individual perceptions that play a role in handling alcohol. When the care worker adds the "I believe so", she also draws our attention to the fact that deciding whether drinking should be allowed is – at least partly – something that is up to the individual care worker.

One situation that is mentioned by care workers in relation to serving alcohol is meal-times. Particularly, if the meal is regarding some special occasion:

Car2HG: We have communal dinners, and we have had a summer party where we served beer. Here at the department we also have alcohol-free red wine, white wine and beer, because some

would like one more glass, which is not good on account of their medication. Then it is nice to have the alcohol-free, that they can have a glass of. [...] It's more often during the evening shifts, on Sundays, where they'll have big Sunday lunches, or on Saturdays, where they have wine [...]. (Car2HG, 27y, F, p. 7)

It seems that this care worker is attempting to find a balance between the wants of the residents and the limitations of their health.

A rarer example of the care workers serving alcohol is the following situation described by Car3MH:

Car3MH: Well, at the communal dinners they may have two, if they want to, but we really don't have anyone in my department, who wishes for that. Also, during the weekends or the festive seasons they get a beer or a schnapps, if we think that's ok... sometimes we've been fixing something together in the kitchen, and if there's a bottle of sherry standing around, we'll have a glass. (Car3MH, 46y, F, p. 10)

As can be seen from the quotations above, in some situations, care workers will take a position against using alcohol, and in other situations, they will do the opposite and partake in a celebratory drink. In particular there seems to be a certain legitimacy to the use of alcohol in such situations, and it, thus, underlines how alcohol is much more than an ordinary food item.

*Alcohol problems.* One care worker, Car4RI, provided some examples of problems related to a resident's behaviour after having consumed alcohol and its influence on care workers and residents in the care home:

Car4RI: But, it is a little hard to avoid those conflicts [that there are], because he is also like... he becomes... when he's sitting out there and eating his dinner he also gets a little more rowdy and makes witty remarks and kind of lewd remarks to the old ladies and such... it's hard.

[...]

Car4RI: It is actually hard to act upon, I think.  
(Car4RI, 41y, F, p. 40)

The dilemma is between the resident's free will to drink alcohol and the social consequences it clearly has. The difficulty, implied by Car4RI, is navigating what to prioritise in this situation. Throughout the interviews, it was apparent that the care workers are often left to deal with such situations themselves. Hence, the care worker is not only trying to navigate the different wants and wishes of the residents but also the care worker's own personal insecurities regarding how to do the right thing. When she finds it hard to act, it is not just a systemic or organisational issue. It is also an expression of her experience of insecurity.

While some care workers said that the residents usually did not mind the others having a drink, there are examples of the opposite being true as well.

Car1AF: Yes, there's been, when we had a resident, that had beer every day with their lunch... and then there was another resident who said, oh you'll end up as an alcoholic when you need to have a beer every day.

Int: Yes.

Car1AF: and they got into like a row and stuff like that, and then we talked with them, that it was... well... it was natural for her to have a beer and that she didn't get drunk and such. So, we handled it, then there wasn't anything anymore [...] but she had to be confronted with that it's alright that she'll have that beer with her lunch. (Car1AF, 34y, F, p. 16)

According to the care worker it is the resident who called the other one an alcoholic who should be brought to understand that people are free to choose their use of alcohol. Whatever the intention of the remark from the one who called out the drinking, it seems that apparently there is a preconceived idea or cultural understanding at play: you do not call out other people's use of alcohol.

*The positive aspects of alcohol.* In some cases, alcohol was also talked about in terms of medicine or something that could aid a situation:

Car4RI: Yes, because we've also had someone... She got to be 103 years old, a lady... [Int: yes?]... that needed her medicine. She didn't actually take any medicine, other than a glass of red wine every evening, and that was... so much life quality for her, it was

[...]

Int: So, how did you experience that – that it was a lot of life quality to her?

Car4RI: Yes, because, then she would just sit there in her easy chair and enjoy that in the evening, when she had her medicine, as she called it. (Car4RI, 41y, F, p. 47)

While it is the interviewer who introduces the notion of life quality, the care worker seems to agree that having alcohol this way can be considered a type of life quality. The situation brings enjoyment to the resident, according to the care worker. However, using the word medicine also seems to put the situation in another light.

There are other positive aspects of alcohol:

Car4RI: Yes. We actually had a man with severe dementia once, he hit us and kicked us and spat and bit and what else he could come... he was in a wheelchair, so he couldn't chase us... but he had a good effect from getting a beer...

Int: Okay?

Car4RI: became really happy and... sang and... he was so easy to help

[...]

Int: So you actually used it actively...

Car4RI: Yes

Int: ... offered him a beer, and the it all went down much easier?

Car4RI: Yes. (Car4RI, 41y, F, p. 46)

The care worker talks about how the resident had “a good effect of having a beer”, which seems to mean that alcohol is seen as a positive intervention in this situation. She even confirms that they used alcohol actively because care went much easier if he had a beer.

A Danish term “hygge” is also coupled with alcohol and the use of alcohol by the care workers. The most direct translation is the English word “cosy”. In the following quotation, Car4RI is talking about hygge, and in her experience alcohol is related:

[...]

Car4RI: Well, they take [inaudible]. But other than that we've always used Sunday. That's when we had roast... in the evening and a glass of red wine with dinner and such... it's been cosy, they have been sitting there and toasted with each other [...]. (Car4RI, 41y, F, p. 48)

It seems that there is a certain level of drinking that can have a conducive effect on a pleasant atmosphere (“hygge”). She mentions toasting as an activity that is “hyggelig”. Toasting and the sense of community seem to be important – even more so that the alcohol in itself:

Int: So, there they are together with alcohol. Are there any issues with anyone, who doesn't want to drink? Do they feel left out, so, or?

Car4RI: No, we haven't... they've just gotten lemonade or water or whatever in their wine glasses.

Int: Do they toast with the others then, or?

Car4RI: yes-yes

Int: Okay. So, the alcohol is actually secondary, I hear. It's more important to make the toast?

Car4RI: Yes. (Car4RI, 41y, F, p. 49)

Apparently, toasting can be done with lemonade (the non-alcoholic Danish “saftevand”). It seems that the ritual can be maintained even without one of the ingredients. The non-

alcohol variation of the ritual apparently carries the same weight.

## Relatives

*Relatives describe a resident's alcohol use.* Relatives talked about the residents' use of alcohol historically and presently. One described the residents' use in the following way:

Rel1BJ: Absolutely not [I: No] and she has never been drinking beer in that regard [Int: no no] you know, she hasn't [I: no] no. She hasn't... and it's not because there's, well, there are no missionaries or anything in our family but [Int: [sniggers] no] it's just. (Rel1BJ, 70y, F, pp. 20–21)

While describing a low use of alcohol, Rel1BJ also refers to “missionaries”. She means members of the evangelical Christian community which is called “Indre Mission” in Danish (directly translated as “Inner Mission”). They do not use alcohol. She is underlining that the use of alcohol has been low but not abnormally so. Elsewhere in the interview, she also talks about how the resident's low use of alcohol is related to allergies.

Another way in which the relatives describe the residents' use of alcohol is in terms of very limited occasional use:

Rel2MK: My mother's relationship [with alcohol] is, that she does not drink much. She actually drinks, she doesn't drink daily and not even weekly. She has a nice three-litre box in her room that I see to is there. When her red cross visitor stops by every Tuesday, they grab a glass. Uhm., Yes, that actually, probably the only thing she drinks. Well, sometimes when she is at. [The nursing home] had a party not that long ago, then she wanted a beer. (Rel2MK, 64y, M, pp. 11–12)

He calls it a “nice three-litre box...” (nice = fin). He goes on to describe in slang terms how she drinks this alcohol with the Red Cross visitor. He uses an informal word (to grab = nuppe) to describe the act of having a glass of wine.

This underlines the informal and unproblematic way in which he perceives her use of alcohol. However, the slang word used (*nuppe/grab*) is a distortion (*aflydsforhold*) of the words “*nippe*” and “*nappe*” which also means stealing, snatch, pinch, etc. or achieving something by cunning. The choice of words relays a certain furtive or covert sense connected to the use of alcohol.

Some residents will also drink alcohol because of the taste and not necessarily because it is alcohol. Rel1BJ is talking about her mother-in-law and how she enjoys sweet drinks:

Rel1BJ: If we have attended something where we had a glass of dessert wine [Int: Mm]. then she wants to taste it and thin[ks]... [Int: Yes] well, that tastes good [Int: Yes, yes, yes, yes] right, but, she doesn't know what it is she is having [Int: No]. Not at all [...]. (Rel1BJ, 70y, F, pp. 19–20)

The residents' use of alcohol also seems to be facilitated by the relatives to some extent:

Rel3GL: [...] and then... he gets a beer now, and if... we often come here on a Friday afternoon and have a beer with him, but sometimes he actually – in the last half year – preferred a soda. (Rel3GL, 47y, F, p. 14)

*Perceptions of alcohol problems.* While some relatives described how the resident might have had an alcohol problem before entering the care home, none of them described an ongoing alcohol problem. However, some of them presented a certain view of alcohol problems and their causes:

Int: Even if it was primarily the company, it must have been loneliness a little bit or the blow from that, which did it?

Rel3GL: I think so. A little loneliness and a little... what can you come up with, if you get a blow, right? And then alcohol is easy. (Rel3GL, 47y, F, p. 13)

“what can you come up with, if you get a blow, right?” – the Danish wording includes the phrase “*finde på*” which is an active phrasing for coming up with something to do (e.g., I'll come up with something to do = *finde på*). Hence, Rel3GL seems to add a certain sense of intentionality in her understanding of the resident's use of alcohol. The idea of soothing loneliness or using alcohol to soothe emotion, is something that other relatives talked about, too.

*Social life and alcohol.* In the relatives' experience, some of the residents' alcohol use may be because of a certain type of social obligation:

Rel3GL: [...] but I don't think he wanted it anymore, but sometimes where he, on Sundays has gotten a beer with his food, if we've arrived in the middle of his meal. “Yuck” he'll usually say, but he'll drink it of course, because it's been served, and he doesn't want it to look like he doesn't want... what they serve him. (Rel3GL, 47y, F, p. 15)

The resident may drink because of pressure not to be impolite or not seem out of place. While it could be an example of an ironic comment from the resident, Rel3GL believes that it is an expression of the resident's wants. Hence, in the mind of the relative, there seems to be a social or cultural pressure to drink alcohol in some situations. When a resident says no to alcohol, a relative talks about it in this way:

Int: So, it's in, like, social situations?

Rel2MK: Yes, she does that. She sometimes says, that she'd rather have some water. She can say that, that she doesn't want it. Then she'll get what she wants of course, but she doesn't have a skewed approach to drinking alcohol. (Rel2MK, 64y, M, p. 12)

In Rel2MK's mind, the resident's saying no underlines her non-skewed relationship with alcohol. Saying no presumably illustrates control, and being in control of your alcohol use is

one of the culturally defined prerequisites for not having alcohol problems (see Elmeland, 2015). Further, in contrast to Rel3GL's statement, it seems that the social pressure is different, or that the resident can resist it.

*Dementia and alcohol.* Among the relatives only one talked about alcohol in relation to dementia. The relative had made some observations regarding how alcohol was handled with his mother, who suffered from dementia:

Rel2MK: [...] But sometimes then, like "what would you like?" when you suffer from dementia. She doesn't know. Then we say, do you want a soda? I can actually, what you said before about self-determination I can say: "you'll get a soda, and then you want a beer". She wants a beer then, fine, she'll get a beer. (Rel2MK, 64y, M, p. 12)

For the mother to make a choice, it seems to Rel2MK that the care worker has an idea of what the mother may like. Others facilitate her choice. Rel2MK finds that this a way to give the resident a level of free choice in her use of alcohol, even though she has dementia.

## Managers

*The personal view.* When asked about the role of alcohol in relation to life quality, the managers took two different stances:

Man1EM: Personally, I believe – and I know that many have similar beliefs – that really good food tastes better, accompanied by a glass of wine. A lot of people feel that way. And, a lot of people here who enjoy a glass of wine. (Man1EM, 57y, F, p. 5)

Man2HN: Yes, to me, it doesn't play that big of a role, I mean, I can have just as much fun [laughs] with and without alcohol. I don't need to have alcohol. And I don't believe that we should give a lot of it to the elderly. (Man2HN, 64y, F, p. 3)

While both managers allowed and served alcohol in their institution, one erred on the side of caution. Elsewhere in the interview, Man3HN

referred to dementia and the way it is influenced by alcohol to underline why it should not be served excessively. Simultaneously, Man1EM talked about how many enjoyed alcohol and seemed to use a vocabulary that normalised alcohol use. This shows how managers use two different types of arguments to back their views of alcohol. One refers to a medical issue as an argument for trying to limit alcohol intake, and the other refers to a normative standard to argue for more liberal use of alcohol.

### *The resident's own choice and privacy.*

Man1EM: [...] But it is not us who decide if she drinks or doesn't drink schnapps, or if she takes the diuretic [medication], but we must help her, where she is really at. (Man1EM, 57y, F, p. 6)

The liberal attitude towards the residents' behaviour is underlined in this quotation from Man1EM. Even though the care workers and the managers may have personal ideas and professional concerns about drinking, it is ultimately left to the resident to decide what they do. However, Man1EM also talks about a resident who feels she must hide her drinking. Elsewhere in the interview Man1EM states that there is extraordinarily little privacy when you need help to a degree as you do in a care home. In this regard, Man1EM also says: "We are professionals who do not interfere with private life". The manager illustrates a very open and liberal attitude towards the use of alcohol. This suggests that the sentiment to hide alcohol could be something perceived by the resident.

The managers are also aware of the boundaries that must be observed regarding the use of alcohol. Legally, the resident is in her own private residence when she is in her room. Hence, she can do what she wants. These limits are different in the common areas of the care home:

Man2HN: [...] But, well, we don't have it like, it's not like they get alcohol every day. Not from us, we have some that have something themselves and who buy red wine themselves and have a



glass every day or two glasses. Some drink port and some drink beer, but then they buy it themselves. (Man2HN, 64y, F, p. 4)

The line between the use in the care home and in private is also demarcated by how it is acquired. When the resident wishes to use alcohol in their own room, they must purchase it themselves, though of course it can also be brought by relatives, or (as was hinted at in one case), by other residents.

#### *Excessive use.*

Man2HN: Well, you can say that we have, uhm, sometimes had some residents that have been drinking quite a lot of alcohol. And who aren't too nice verbally, when they are drunk. Who also approach my employees, and want to touch them and hug them and maybe even kiss them. And you are not obligated to do that, just because you work in this profession. So, in that way then, then, then it gives, it can very easily become problematic. It can also cause trouble regarding the other residents if they can't figure out where the toilet is for example and pee in the common areas. (Man2HN, 64y, F, p. 4)

Talking about excessive use of alcohol, Man2HN is focusing on the consequences for the care workers and the other residents. Her example above illustrates that her concern is for the welfare of more than just the one resident, which puts her experience in a certain light.

#### *Alcohol and life quality.*

Man2HN: And they got it in a mug, and there's half a beer in a mug like that, uhm, and they enjoyed that a lot, you could see that, that it gave life quality. Also, the fact that it was a particularly good beer, uhm, you could easily see that, that, that gave them something extra, like, the food did. Because it like, went together. Yes. (Man2HN, 64y, F, p. 3)

A special beer can be enjoyed (and enjoyed a lot) and gives "something extra". Even though

alcohol was put in terms of poison by Man2HN elsewhere in the interview, it seems that there are some redeeming factors when using it. While Man2HN may not think of alcohol as a good thing, she can clearly see that it provides the residents with some pleasure and life quality.

## **Discussion**

Alcohol in care homes is a complex issue that involves many stakeholders. In this study, we have investigated the views of four of the central groups of stakeholders – the residents, care workers, relatives and managers. While it seems that there is a positive attitude towards the use of alcohol across the four groups of participants, it also seems that the actual use of alcohol is relatively low among the residents. The residents' occasional use of alcohol in relation to special events seems to be the most prevalent in the minds of the four groups. Moreover, there also appears to be a symbolic value in the rituals surrounding alcohol, which is upheld by all four groups. Even though there is a convergence between the experiences of the four groups, there are still certain individual perspectives that must be kept in mind when considering the findings.

Residents experience alcohol in terms of life quality but also in terms of what it means for their health, physical sensations, and social relations inside and outside the care home. The residents have a particular role in this study. They are the users of alcohol. They have the right to use alcohol but only seem to exercise this right if there is an occasion that calls for it. The idea of purely recreational use of alcohol seems to be distant for the residents. Instead, they engage in culturally or traditionally founded rituals concerning alcohol. This includes rituals such as toasting, which seems to hold social value. It also includes the role of the resident as a host. Where the actual hosting is now limited because of physical capabilities, the role of the host is maintained by serving alcohol.



Through the behaviour that residents seem to describe, we get the impression that, to residents, alcohol is *for* something. It is a symbol of celebration, something exclusive, and a luxury not to take lightly. Alcohol is something only used on special occasions, and which has also been documented for alcohol users elsewhere (Haighton et al., 2016). This may be the result of a relatively sparse use of alcohol throughout their lives.

In some cases, alcohol is provided by the care home and relatives, which puts the idea of autonomy in a particular light. Where the care workers and managers hold that the resident can do as they want in their private residence, it is a fact that the resident will often need help to get alcohol. Hence, the residents' alcohol consumption is controlled to some extent. Residents also talked about the gender differences in drinking, something which has been found in other studies as well (Wilson et al., 2013). However, the residents described this in historical terms and gave the impression that they believed things had changed in that regard.

Care workers experience the residents' alcohol use in relation to accommodating different residents' needs and focus on care rather than treatment. While care workers describe low use of alcohol among residents, there is also the experience that a certain level of control is mandated. However, a certain measure of control is exerted somewhat covertly, or without the knowledge of the resident. Control comes in different forms, and sometimes the physical state of the resident ends up being a way to control her alcohol use. Apparently, there are different wishes from the care workers and the residents, to a degree, where the care workers believe that a measure of, more or less, underhanded control can be mandated. Hence, the care worker holds a very complex role concerning alcohol and control, which is only delineated by the fact that the care worker is often left to make decisions based on their own experiences regarding alcohol. Serving alcohol for the resident, or communicating with the

resident about alcohol, seem to be significantly influenced by the care workers' private experiences of alcohol use. They do not refer to any centralised guideline for handling alcohol in their work. In light of previous research (FOA Kampagne og Analyse, 2012), it seems likely that there are no official guidelines. Hence, the care worker is not only trying to navigate the different wants and wishes of the residents but also the care worker's personal obstacles in finding an appropriate solution. When she finds it difficult to act, it is not just a systemic or organisational issue, i.e., the missing guidelines. It is also an expression of her experience of insecurity. Meanwhile, the care worker is the guardian of social practices and needs to facilitate social interaction between residents and other parties. In this regard, the care worker also needs to navigate the residents' differing views on alcohol and the consequences of residents' drinking. The care worker needs to assist the resident who may be harassed by another resident's drinking, while maintaining the individual resident's right to free choice.

Lastly, the care workers seem to view alcohol as something that adds to the life quality of the residents and which has a rightful place in the everyday lives of residents. If used in the right amount and context, alcohol can be conducive to "hygge", and certain rituals, such as toasting, seem to be encouraged by the care workers. However, they are also aware that alcohol may not be centrally important when performing cultural rituals. As one pointed out, toasting can be accomplished using lemonade.

Relatives view the residents' alcohol use in terms of life quality and seem to treat residents as part of the family, the way they have always done. To relatives, there is a permissible use of alcohol that the resident may have. This is partly facilitated by the relatives, as they will both bring alcohol and engage in certain drinking activities. However, it seems that the relatives have noticed changes in the residents' behaviour regarding alcohol. Where the residents may previously have been drinking on certain occasions (family gatherings etc.), they

are now less inclined to do so. The relatives seem to balance the wish to maintain a relatively normal alcohol culture with the residents, and the changes in the residents' behaviour. Relatives also talk about the residents' alcohol use in terms of partaking in social interaction at the care home. They have seen situations where the resident felt obliged to drink alcohol and witnessed incidents in which the resident unproblematically refused alcohol. It seems that relatives are aware of the autonomy of the residents. Hence, relatives are both the facilitators of a normal/cultural use of alcohol and keepers of resident autonomy.

Managers view residents' alcohol use from the perspective of policy and implementation of care and life quality. They focus on care for all the residents, while still wanting to accommodate the individual. Even though the managers seem to hold different basic ideas on how to utilise alcohol in the care homes, there still appears to be a general sentiment that alcohol adds something to life quality, that the residents should be allowed to drink and are free to choose their own use. Like care workers, managers seem to uphold the residents' right to autonomy within their own legal residence. However, they are also aware that excessive alcohol use may influence other residents and they probably seek to minimise distress for most residents.

Residents, care workers, relatives and managers hold different perspectives on alcohol in care homes. While care workers talked about control and limiting use, residents did not seem to mention feeling restricted. While residents often seemed to have decreased their use of alcohol (which was already minimal), care workers, relatives and managers still focused on resident autonomy, and facilitated some use of alcohol. By serving alcohol, care homes are conveying a certain set of values which may be copied from an even wider common or cultural understanding of the value-adding nature of alcohol. Simultaneously, they are offering a certain way of drinking for the residents in the care home. The general sentiment seems to be that alcohol holds

cultural and traditional value and adds to the sense of life quality.

Care workers, relatives and managers seem to focus on resident autonomy in relation to alcohol but may do so for different purposes. Where relatives view residents' autonomous use of alcohol as something to be facilitated, the care workers and managers seem to use autonomy as a safeguard against overuse.

### *Implications for research*

One motivation for this study is that changes in the older population's drinking culture (Elmeland, 2015) are predicted to have an impact on care work and create dilemmas for the staff. The present study does not offer a solution to these dilemmas. However, it does shed light on some of the central issues that must be addressed. While some alcohol overuse persists in the current generation of care home residents, the use of alcohol seems to be relatively moderate. How to handle new and different ways of drinking should be addressed further. While alcohol is considered part of the culture which adds to quality of life in care homes, the present way of dealing with alcohol seems to have several indirect and covert possibilities for care workers. We suggest that further research on handling these issues in a more open fashion may be productive.

As Seitz et al. (2010) pointed out, there are a multitude of estimates of the prevalence of drinking and alcohol problems in care homes. The present study cannot add to this beyond the impression that the use of alcohol in care homes is limited. While there are residents who suffer from alcohol problems, though only a few, they still may require a lot of care worker attention. Likewise, Brennan (2005) concluded that residents suffering from AUD do better regarding activities of daily living. We have not been able to clarify this in the present study.

Findings on the likeliness of long-term care home placement for abstainers, infrequent users and former drinkers (Kaplan et al., 2014) may have been nuanced by the present study. As all

the resident participants described low to moderate use of alcohol throughout their lifetime, we speculate that this leads to a longer life and, hence, to more extended placement in care.

Sacco et al. (2015) found that alcohol use among care home residents is mainly motivated by socialisation. Socialisation has also been found to be a motivation for drinking among older adults outside care homes (Wilson et al., 2013). To some extent, the findings in the present study seem to support this. Our findings suggest that rituals are important and connected to socialisation; however, recreational drinking with no celebratory/traditional/cultural purpose seems to be uninteresting to the residents. Moreover, it seems that care workers, relatives and managers place explicit value on the social and cultural dimension of alcohol use.

### *Implications for practice*

Our findings seem to back the notion that guidelines are needed for handling alcohol and alcohol use in care homes. It seems that decisions on drinking and drinking behaviour from the care worker perspective rest as much on personal values and experiences as on professional judgements. However, we must recognise that residents in care homes are not a homogenous group, and overarching guidelines may prove hard to implement. Even so, there may be some merit in attempting a change from the personal values guiding alcohol utilisation among care workers to a more standardised approach. Both to ensure stringent care and lift responsibility from the individual care workers.

As found by Klein and Jess (2002), little alcohol information is collected during admission. In relation to our findings, it seems that the focus on autonomy and the residents' ability to decide for themselves may be a hindrance in asking for details on alcohol consumption. For care workers and managers, it was clear that the important part of care work in relation to alcohol, is that the resident maintains her autonomy.

### *Limitations and strengths*

While a randomised selection of participants is rarely the goal of qualitative investigation, there were certain biases in participant selection in the present study. Managers were asked to select participants from each group which may have introduced selection bias. Further, it proved difficult to get relatives to participate as well. Hence, it seems that the convenience sample that we sought has additional selection biases. While participants in all groups talked about alcohol problems to some extent, there were no participants with a current misuse of alcohol. One resident participant seemed to have had some level of difficulty with alcohol previously, but other than that, there were no apparent alcohol problems. Hence, we have not been able to illuminate alcohol problems in care homes from a resident perspective. Additionally, as there were relatively few participants in each group, there are findings that rely heavily on one participant. However, we have not sought a representative sample or statistical generalisation and find that this is a minor issue.

Moreover, the present study was conducted in municipal care homes. Hence, the conflicts regarding alcohol that may arise in, for example, specialised care homes for those older adults with the poorest health/abilities, have not been considered in the present study. It is very likely that such individuals in such institutions would discuss and handle alcohol and alcohol-related issues differently. Hence, the present findings cannot be generalised beyond the municipal context.

An important strength of the present study is arguably the inter-group focus of the data. To our knowledge, no previous studies have attempted a simultaneous comparison between residents, care workers, relatives, and management in care homes. Moreover, the observations that provided information for the interview guide have suited the questions and interviewers very well in the research area.

## Conclusion

There is a convergence in the experiences of alcohol use in care homes between residents, care workers, relatives, and managers. Collectively, they find that alcohol use is relatively low at care homes and that it plays both a social and a cultural role. The differences in the experiences of alcohol use, and its consequences in care homes, seem to lie in the group's unique foci for its use. Importantly, we suggest that these unique views be utilised in developing methods for handling alcohol use in care homes.


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## Note

1. Care homes are the primary care institutions for older adults with various types of psychological and physical illnesses. An alternative to care homes is home care. Receiving home care is considered viable if the older adult can support themselves to some extent. Once their physical or mental difficulties are deemed to be too excessive, the older adult is offered admittance to a care home.

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