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Caring for elderly substance users: Challenges, dilemmas and recommendations

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Abstract

Aim: To investigate the challenges and barriers in Danish care professionals' work in relation to elderly citizens who use substances. **Method:** The study draws on data from a "going along" study of care professionals' encounters with citizens as well as interviews with professionals. This was conducted in two smaller, rural municipalities in Denmark. **Findings:** Providing adequate care for elderly citizens who use substances can be highly challenging. This is due to a multitude of factors, especially (1) the complexity of their health conditions, (2) contradictory logics of care (autonomy vs. healthy living), (3) citizens often unpredictable behaviours, (4) lack of cooperation between welfare systems and, not least, (5) lack of knowledge and education among healthcare professionals. **Conclusions:** There is a need for more specialised procedures locally, the appointment of local "experts", better cooperation between sectors and easier accessible training and information on the group on a national level.

Keywords

aging, dilemmas, healthcare, healthcare professionals, substance use

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Danish citizens who use large quantities of alcohol and drugs, hereafter referred to as substance users, in general have significantly worse health conditions than the majority of the population and die significantly earlier (Dansk sygeplejeråd, 2018; Sundhedsstyrelsen, 2021). Access to health services is often difficult due to a lack of health literacy (citizens' access to health information and their capacity to use it (Sørensen et al., 2013)), and it is often very difficult to establish and maintain contact with substance-using citizens in treatment and in care services. Many health professionals lack the knowledge and expertise on how to help this group, and the group is considered "difficult" to help, e.g., due to instability, intoxication, unwanted behaviour or lack of "willingness to cooperate" (Bach & Bjerge, 2021; Bach et al., in press; Bjerge et al., 2023; Jønsson, 2021; Kappel & Johansen, 2022; Sundhedsstyrelsen, 2021, 2022). However, the life expectancy of citizens who use substances has risen within the past two decades, e.g., due to harm reduction measures, prevention services, and street and social nurses. Yet, many become age-impaired much before the majority of the population, both physically and cognitively (Ahlmark et al., 2018; Bach et al., in press; Benjaminsen, 2019; Bjerge et al., 2023; Dansk sygeplejeråd, 2018; Pedersen, 2019; Sundhedsstyrelsen, 2020a, 2020b, 2021, 2022). Accordingly, the need for care, support and treatment in this group increases, and as the group is growing, the scope of this is larger than before. In addition, an increasing number of these citizens need services involving home care and nursing homes, which in Denmark are primarily municipal services. Thus, healthcare professionals have an increased number of interactions with older substance-using citizens, and this will rise in the future. Most of the larger Danish cities have specialised health services targeting marginalised citizens who use substances. Yet, there is limited knowledge of, or expertise in, dealing with age-impaired citizens who use substances in the elderly care sector in general and particularly in the smaller, rural municipalities (Bach et al., in press; Bjerge et al., 2023; Sundhedsstyrelsen, 2021). Further, guidelines, for example, regarding the consumption of alcohol by citizens in the care sector, are not clear and therefore depend on local interpretations by care professionals (cf. Klausen et al., 2023; www.sm.dk; Sundhedsstyrelsen, 2021). Compounding this, the sector is under constant political pressure, experiencing cutbacks and being reorganised regularly, and has difficulties recruiting and retaining qualified managers, nurses and healthcare professionals (www.sm.dk, www.aeldresagen.dk).

Despite this growing population of elderly substance users and a care sector that is under pressure and lacks specialised knowledge of the field, the topic has until recently drawn very little attention within research, in politics and in practice in Denmark (Bach et al., in press; Bjerge et al., 2023; Pedersen, 2019; Sundhedsstyrelsen, 2020a). However, there is a growing scholarly Danish and Nordic interest in the field, pointing to some of the challenges involved in caring for this population: a Finnish article based on interviews with care workers highlights the physical and psychological strain of the work and the need for qualifications and multiprofessional collaborations to best meet the needs of the target group (Koivula et al., 2016). In Denmark, the field study by Klausen et al. (2020) in a care centre identifies "subtle, widespread dilemmas" for the care staff, such as balancing health effects with experiences of coercion in relation to alcohol use. In a Swedish context, Karlsson and Gunnarsson (2018) have interviewed care staff and point out that individuals aged 65–80 years drink more than previous generations, and that women in this age group in particular have increased their consumption (Karlsson & Gunnarsson, 2018, p. 1624). Further, they identify four topics of particular importance: the squalor encountered in the homes of older people with alcohol problems; their failing bodies and body functions; their stresses and worries; and how care workers are involuntarily drawn into the lives of these people and them

feeling unqualified and very alone when faced with the problems of these older people (Karlsson & Gunnarsson, 2018, pp. 1631–1638). In addition, a pilot study from Norway (Flesland, 2014), based on interviews with nurses working in community healthcare, concludes that issues regarding substance use are challenging for the services, and that a lack of focus and competence limits the possibilities of identifying, preventing and treating substance use-related issues among elderly citizens. In Norway, there are national guidelines, including a particular target group (Helsedirektoratet, n.d.). In Sweden, there are no national guidelines, but there is ongoing work to develop guidelines. The report *Äldre hemtjenstmottagare med missbruksproblem: Förekomst, erfarenheter, svårigheter* (Jönson et al., 2019) gives an overview of current knowledge of the field and the authors point to the difficulty of establishing the extent of the problem as it is not always obvious which definition of abuse or overuse is used by various professionals and in surveys where old people self-report (Ibid: 8). In Denmark, there are general recommendations for alcohol intake, and generalised guidelines for staff regarding preventative measures for substance-using elderly people (Sundhedsstyrelsen, 2015, p. 133).

Taken together, the above studies and guidelines point to a growing interest in understanding and helping elderly substance users in the care sector in a Nordic context, yet they all underline that the topic is still not sufficiently mapped, researched or developed in research or in practice (Flesland, 2014; Karlsson & Gunnarsson, 2018; Klausen et al., 2020; Koivula et al., 2016). Adding to this, the majority of qualitative research articles have been based on interviews. Therefore, we set up an explorative anthropological pilot study of healthcare professionals' work in two municipalities in the Central Denmark Region, primarily in home care and secondarily at nursing homes, in relation to elderly citizens in need of care and living with problematic substance use. In our study, we refer to "aging substance users" as citizens who, according to the professionals providing care for them, use alcohol or other substances to a degree where it affects the mental and physical state of the citizens and/or the encounters with professionals and the possibilities of helping them.

The following research questions were posed: What characterises care services towards elderly substance-using people, specifically which dilemmas are present? How do care professionals experience and reflect upon barriers and dilemmas within this type of care? And finally, based on our preliminary findings, how can services be improved?

Dominating logics in Danish elderly care services

Key elements for understanding the dilemmas that healthcare professionals face when working with elderly substance users in practice is the sometimes-contradictory logic dominating the Danish care sector: patient autonomy and the provision of correct care according to medical guidelines. In line with international healthcare policies, respect for the patient's autonomy, rights, empowerment, patient-centeredness, providing assistance in achieving "the good life" and so on has long been on the healthcare political agenda and inform Danish healthcare guidelines both ethically and legally (Gomez-Virseda et al., 2019; Mol, 2008; Møller & Nørlyk, 2017; Pols et al., 2017; Rostgaard, 2006). It is also widely recognised in Danish elderly care that citizens should be allowed to enjoy life to the fullest when the end is approaching (Klausen et al., 2023). "Rather blood alcohol levels than pills" [DA: *hellere promiller end piller*] was the slogan of Thyra Frank, former Minister of the Elderly (and former manager of a privately run nursing home, which had a more relaxed approach to alcohol than public nursing homes), meaning that the life of the elderly should be joyful rather than marked by caution as well as a belief that moderate drinking could be gentler than medication (ibid.).

Substance use, particularly alcohol use, is often regarded as private and is accordingly tabooed as a non-intrusive area (Bach et al., in press; Sørensen, 2019; Sørensen et al., 2016).

Further, it is widely discussed at national elderly summits [DA: *ældretopmøder*] how the perspectives of elderly people can better be included in care services. In 2020, the government and the Local Government of Denmark [DA: Kommunernes Landsforening, the National Association of Municipalities] agreed that a yearly, national user satisfaction survey investigating the views of citizens who receive help with home care and at nursing homes will be conducted (www.sm.dk).

At the same time, core activities and values in the care sector are focused on helping citizens, e.g., alleviating pain, follow-up on rehabilitation, monitoring that citizens eat and drink properly as well as preventing negative side effects of "unhealthy living" or at least reducing them so that citizens live as "worthily" and healthily as possible (www.sm.dk, Dahl & Rasmussen, 2012, Hansen & Kamp, 2018). This is mirrored at the vocational schools of social and healthcare [DA: SOSU-skoler], where students take courses on a variety of topics, such as illnesses, symptoms and causes and learn basic treatment, such as giving eye-drops, ear drops, rehabilitation, how-to guides and motivating citizens to take care of themselves, and how to help citizens with physical weaknesses get out of bed in the mornings (SOSU Østjylland, 2023). This may require a person lifting and moving, helping citizens with compression stockings, showers, intimate care and housekeeping more broadly, along with meal preparation. In addition, the care sector is regulated by the Act on Social Services and the Act on Health legislation [DA: Serviceloven, Sundhedsloven] as well as §72 in the Danish constitution (Retsinformation, 2023). The latter addresses privacy rights – including that the home is inviolable, and all citizens have the right to decide how things are organised and managed in their homes unless there is a warrant. The care worker students learn about the legislation and how to act in private homes at the vocational schools. However, they keep encountering practical paradoxes, e.g., they are supposed to help citizens to rehabilitate themselves through practical engagement in as many daily activities as possible in order to make the citizens stay healthy, but at the same time they need to respect the freedom of privacy and the will of the citizens (cf. Bach et al., in press; Birkedal et al., 2021). Therefore, they cannot tell a citizen to stop smoking cannabis in their own home in order not to "pollute" the social and care worker while in the home (however, they can, in severe cases, refrain from entering and deny services because of the work environment). They cannot sanction unhealthy living or illegal conduct in the private home. Further, social health and care work in nursing homes is carried out between common rules in the common rooms (such as the living rooms and canteens) and the peace and privacy of the private apartments (Birkedal et al., 2021; Bjerge et al., 2023). In that sense, the Danish care sector – as many other types of welfare sectors – is marked by a duality between providing care treatment and nudging citizens towards more healthy living, and the value of respecting citizens' autonomy and freedom of choice, even when these choices are potentially bad for their health. Perhaps this is even more prominent in relation to citizens who use alcohol and drugs, as the potential health risks of falling, interference with medication and worsening of illnesses are magnified through substance use (see also Klausen et al., 2023).

Taken together, we see an increase in a group of elderly individuals, who stand out in relation to the "average" elderly person with their health conditions, who are considered extremely complex to handle by professionals in a system that lacks specific knowledge and expertise of the group and is under economic and staffing pressure. In addition to this, there is an embodied tension in the care sector between patient autonomy, respecting people's

privacy and how to provide "correct" care according to guidelines and training. All this serves as a structural, organisational and analytical backdrop for describing, analysing and understanding the concrete encounters and dilemmas related to caring for elderly substance users in our article.

Methods

Setting

The study was conducted in two municipalities in the Central Denmark Region. Both municipalities are predominantly rural. However, Municipality 1 has one central smaller city, which is the obvious centre of the municipality, and which services and houses more than half of the municipal population, totalling approximately 25,000 individuals. Geographically, the municipality covers approximately 225 km^2. Municipality 2 covers more than three times as much, and has approximately 45,000 inhabitants. It formerly consisted of four municipalities (before the municipal structural reform in 2007). There is not one central city in Municipality 2, and municipal services are placed in several larger towns.

Despite local differences in the organisation of the two municipalities, it is the common experiences that is the focus in this article. One geographical component the two municipalities share is the relative proximity to Aarhus, the second largest city in Denmark, with 350,000 inhabitants, and both municipalities are situated in the Central Denmark Region. Another is the rural districts and the relatively small populations, mirrored in relatively small municipal administrations. This means that there are fewer specialised services than in larger municipalities, such as Aarhus, but also that the chain of command is often shorter.

Ethnographic methods

Before conducting the study, we held initial meetings with the vocational school of healthcare in the Central Denmark Region [SOSU Østjylland] and employees at the two municipalities in which our project was presented and discussed. Discussions and themes from the meetings also informed our understanding of the challenges that caring for older people with substance use poses for professionals in the care sector. These understandings were brought into play in interviews and conversations during observations in the field. There were mostly consistencies between the perspectives presented at the meetings and encountered in the field, but sometimes this clashed with the experience of the individual care worker. In the meetings with the municipalities, a contact person was appointed who helped us get in contact with care workers locally.

The ethnographic approach of "going along" was applied (Kusenbach, 2003). Kusenbach describes the go-along method as "[A] hybrid between participant observation and interviewing" (Kusenbach, 2003, p. 463), as the researcher can be in dialogue with the research subjects, who can explain what they are doing and why they are doing it while they are going about their daily business, or, as in our case, while they were going about their work assignments. This was well suited to gain access to the practice, considerations and reflections of care professionals, and their interactions with citizens in need of care who had active substance use. Eight professionals were followed through their day or evening shifts with the researcher observing and asking clarifying questions when appropriate. In some cases, the fieldworker followed the professional on a full shift (7–8 h), and in some cases a half or two-thirds of a shift, depending on work assignments. In that sense, the performance of care services was observed, and observations were used to inform semi-structured interviews accordingly. Altogether approximately 50 h of fieldwork was conducted. In each municipality, it was ensured that citizens suited for the project (citizens with substance use) were on the list of the particular care worker who was followed by

a researcher. The citizens were not chosen because of the particular quantities of alcohol consumed or specific kinds of drug use (which is also not registered by care workers), but because they had a history of consuming alcohol and/or drug use to such a degree that it affected the care workers' encounters with them and/or their use of substances was of general concern in the teams of care workers. In that sense, the visits to elderly substance-using citizens were not based on diagnostic criteria (ICD-11), but rather based on the experiences and discretion of the professionals. There are also differences between heavy alcohol consumption (legal) and smoking cannabis (illegal). The types of challenges and dilemmas that substance use provide in care services were somewhat consistent, and it was often not clear to the professionals the specific content of substances, when citizens use more than one substance (e.g., a combination of alcohol, cannabis and medications). Other elderly citizens in need of care were also visited but encounters with them were not included in this article.

Seven semi-structured interviews (Kvale, 1994) were conducted with four healthcare workers (two nurses, two SOSU-helpers) who were all followed on a work shift, three team managers who also worked as healthcare workers (all SOSU-assistants), of whom two were followed on a work shift, and one area manager (trained nurse). Seven women and one man were interviewed. The interview schedule was developed according to a common set of themes identified by the research team, and the schedule was adjusted to the situation of the individual professional. The interviewing researcher would ask about situations encountered during the shifts as well as questions that were worked out beforehand.

Ethics

The project followed standard procedures for qualitative studies within the social sciences (Marshall & Rossman, 2006). The project was accepted by the Danish Data Protection Authority, Aarhus University, as a project with only scientific research purposes, and was carried out in accordance with the highest ethical standards of research. All informants were informed about the project and scope of it, and all quotes and examples were pseudonymised. Other details were blurred to ensure that no one was recognised in the communication of our results. If the citizen asked about the presence of the researcher, this was explained more in detail. At all visits, the researcher's participation was contingent on the care professional's careful evaluation of the citizen and in two cases their clearing of the researcher's presence with the citizen before entering at the discretion of the care professionals. As the analytical focus was on the practices of care and the role of the care professional and the researchers' role considered akin to a "foal" who is routinely part of rounds, written consent was limited to the care professionals. As this diverges from the traditional collection of informed, written consent, we decided to both pseudonymise and significantly blur all personal details and stories to avoid doing any harm to citizens or healthcare professionals. The pilot study would not have been possible to realise if informed written consent had needed to be collected beforehand on account of time limitations for the care staff and was considered more disrupting for the citizens visited.

Analysis

After completion of all interviews and observations, notes and transcripts were read and central patterns identified, which was the basis of thematic coding in Nvivo. Both notes and interview transcripts were coded thematically. We applied an inductive, open coding of the ethnographic data and the interviews (for a similar approach, see Braun & Clarke, 2006). To begin with, all data were coded very close to the text describing, for example, how "alcohol was talked about" in the individual interview or how "medication was given".

Next, themes and patterns, such as "lack of access to services" or "difficult to help", across the empirical data were identified and clustered. The processes resulted in a total of 10 thematic codes, and subsequently it was discussed which codes would best provide empirical data to describe, analyse and understand the daily dilemmas that health professionals faced when working with elderly substance users. This process resulted in five themes that were supplemented with analytical and more general insights about elderly substance users and the care sector. The themes are addressed in the "Findings" section below in the following order: (1) complex medical conditions; (2) ethics and autonomy; (3) citizens' behaviours; (4) citizens that do not fit into the boxes; and (5) lack of knowledge and expertise.

To provide insights into the various dilemmas, we selected empirical examples that individually and taken together demonstrate the findings of the material. On the one hand, the examples are unique in the sense that the content and composition of the citizen's problems are special for him/her, and that there is no "textbook" way of providing help. On the other hand, the examples are similar to the kinds of problems many other elderly substance users face as well as being exemplary of the kind of dilemmas that healthcare professionals face in their daily work (cf. Birkedal et al., 2021; Flesland, 2014; Karlsson & Gunnarsson, 2018; Klausen et al., 2020; Koivula et al., 2016).

Findings

Complex medical conditions

Diagnosing and hence providing adequate care and treatment to elderly citizens who use substances can be very difficult, as the example of Olga shows:

> Olga lives on her own in the countryside, in what used to be a well-kept house, but which is now falling apart. She is in her 70s and used to work as an accountant. On Olga's kitchen table is a 3-litre bag-in-box of red wine and an emptied wine glass when we enter. She is visited by healthcare professionals because she has begun to fall frequently and finds it difficult to get up on her own and seems to become more forgetful. The healthcare worker, Marianne, says that she has not been diagnosed with dementia because of her drinking, so no one is sure exactly what is wrong with Olga. Sometimes she will be wearing nothing but a bathrobe when the healthcare staff visit, and stacks of newspapers and letters are slowly piling up in her house. Little things that Olga used to take care of on her own, e.g., doing the dishes sometimes, seem overly demanding, so her son, the only relative Olga still has contact with, comes around a couple of times a week to help her.

Olga, before she retired, was able to maintain her job, her house and her car, but she cannot anymore. Her socioeconomic status has changed, and her style of living makes it difficult for the care professionals to help her. Even though her alcohol consumption is most likely to have a severe effect on her health condition (she is becoming increasingly forgetful and unable to manage her home), her condition has not been properly diagnosed, and Olga does not want to cooperate in a process of detoxification and rehabilitation.

Another example of the challenges of untangling ailments was Margaret, a woman in her 70s, living in a nursing home. The staff has suspected for some time that she might have Alzheimer's or dementia, and while Margret has agreed to be tested, the test could not be completed due to her alcohol use. The team coordinator assigned to Margaret in an interview aired her frustration: "(…) maybe she has dementia? Or has it been the alcohol that was creating the problems? We don't know. But she's bloody medicated for dementia. Right?"

The care workers are generally left with very few tools to manage this and provide proper

care according to guidelines and training (cf. Klausen et al., 2023). Despite Denmark's "loose" approach to alcohol policy, this has also been pointed out in other Nordic studies; for example, Koivula et al. (2016), in a Finish study of care professionals, point to how "[C]lients' alcohol use complicates the implementation of the tasks agreed upon in the care and service plan. For example, providing an intoxicated elderly client with medication becomes difficult and may become an obstacle to the adequate treatment and follow-up of diseases" (Koivula et al., 2016, pp. 542–543). Alcohol and drug use can have a strong negative impact on citizens' general health conditions and can potentially blur symptoms of more specific underlying illnesses in cases like Olga and Margaret. For example, it is not possible to test for dementia if the citizen is actively using substances, as this can blur the diagnosis (Klausen et al., 2023). This implies that citizens in care who use substances do not always receive the care they need, and when they do, they receive it when illnesses and problems arise at a rather advanced stage (Bach & Bjerge, 2021, Bach et al., in press; Bjerge et al., 2023). There has been a long tradition in Denmark that alcohol use belongs to the private sphere of the citizen – even in the healthcare system – which means that many older people can develop a severe use of substances that is only addressed and maybe even only detected when other health complications appear (cf. Bach et al., in press; Bjerge et al., 2023; Klausen et al., 2020).

Citizens' behaviours

Providing care for elderly substance-using citizens was often also presented as challenging due to their sometimes-unpredictable behaviours, moods, mental state or drinking habits.

> Henry is in his late 60s and lives in a public housing apartment targeted for marginalised citizens who cannot live in ordinary housing due to their mental illness and/or substance use. He has been living here for more than 20 years. It is known that Henry has been using alcohol and other drugs most of his adult life. At his kitchen table, various bottles of alcohol can be seen. The cigarette fog hangs in the air of the entire apartment. The healthcare professionals visit Henry several times a day. They help him go to the toilet, prepare his food and make sure he gets his medication. For periods, he can be psychotic, and he drinks a lot of alcohol. It is difficult for Henry to make it on time to the toilet, so he wears a diaper. He gets various forms of medication daily, which he needs help to manage. Usually, he is sociable, but in his bad periods, he can be difficult to talk to and can become angry at the care professionals and uncooperative. Inge, his care worker of that day, tells the accompanying researcher that in these periods, it is difficult for the professionals to come to his home. His condition also changes according to the kind of alcohol he consumes. Sometimes it is port wine, sometimes it is schnaps, sometimes a combination. Often, he refuses assistance to go to the toilet and stays seated in his chair (with an unclean diaper), and although the staff know that he most likely needs to go, they cannot force him to.

In contrast to Olga and Margaret, Henry has been diagnosed with various illnesses as he receives many kinds of medication. Yet, the picture of Henry's problems is blurred as they relate to both physical as well as mental illnesses (cf. Sundhedsstyrelsen, 2021, 2020b). How they interrelate is difficult to determine, and the consumption of hard liquor has a negative effect, not least on the latter. The professionals find it particularly difficult to help him in periods when he is psychologically unwell. While he relies on care and help daily, it is difficult to help him in the periods when he is at his worst, as he is equally reluctant to cooperate (cf. Bjerge et al., 2023, Sundhedsstyrelsen, 2021, 2020b).

Another example recounted by care worker Philippa was the case of Else and Hans, a couple who drank excessively and would scold and insult the care workers and attempt

to play the care workers against each other. While it was not strictly necessary to have two professionals to carry out the care tasks, there would still always be two care workers present when visiting the couple, as it was psychologically straining. Philippa described how the death of Hans unleashed a lot of resources for the care staff in the district. While all healthcare professionals pointed out that the necessary services were provided to citizens like Henry, Hans and Else, they also openly shared concerns about the effects of encounters like these on inexperienced and substitute staff. In that sense, such citizens were often described as contrasting with the "average" older citizens in care, who are often cast as grateful and cooperative. In the two municipalities, the teams of care workers tried to make sure that care professionals with an interest in and/or who had personal resources to manage "difficult" citizens who used substances would be staff members visiting these citizens. However, it was often not possible due to low levels of staffing (cf. Ældresagen, 2023). Even for experienced professionals, it can be challenging and frustrating to work with citizens who are psychotic, aggressive or intoxicated. As was also pointed out in other Nordic and Danish contexts, a risk of such "misbehaviours" of citizens is that care professionals may dissociate from such citizens, which can be a barrier for care workers to show the amount of commitment and compassion that citizens need in their care (see Karlsson & Gunnarsson, 2018; Klausen et al., 2023). In that sense, such examples demonstrate what might be called "catch-22 situations", where some problems that the citizens experience (mental illness, chaotic ways of living, aggressive behaviours, etc.) become an obstacle for receiving exactly the care they need (cf. Bjerge et al., 2019).

Ethics and autonomy

Nursing homes pose particularly challenging settings regarding substance use and healthcare, as the examples of Lizzy and Jack show:

> Lizzy, who is in her 80s, lives in a nursing home, drinks schnaps in bed and says "hello" with a smile. On the way out of Lizzy's apartment, the care worker, Sandra, points to a closet where Lizzy keeps her schnaps. Walking to the next citizen, Sandra talks about the challenges of caring for citizens at the nursing home who drink alcohol. Sandra says that some of the other care workers have resorted to taking away the bottles of alcohol of citizens whom they think are intoxicating themselves. There is a deep conflict around this because, according to law, the apartments of the nursing homes are in fact the homes of the citizens, and the care workers are not allowed to remove their belongings. According to Sandra, the practices of her colleagues also cause unnecessary conflicts with the citizens: "As long as Lizzy is not endangering herself or anyone else, I think she should be allowed to drink what she wants". Sandra says that she wishes there would be more knowledge and education available to staff in relation to elderly citizens who use substances. She also tells the researcher about Jack, who was a 65-year-old man living at the nursing home. He smoked a lot of cannabis, and people selling cannabis came to see him at the nursing home. He sometimes also acted aggressively towards the staff. The nursing home would not allow this, and finally Jack was told to move (sent out on "red papers") and ended to up in a hostel for homeless people, where he eventually died.

Nursing homes are often regarded as particularly challenging settings in which to provide care for elderly citizens who use substances, as nursing homes are in the grey zone of combining the private homes of citizens with the rules of the common areas, where drinking is often not allowed (cf. Birkedal et al., 2021; Bjerge et al., 2023; Klausen et al., 2023). However, Sandra described how even in the apartments of the elderly citizens, some professionals might choose to sanction drinking practices, and in particular practices of smoking

cannabis and visits from drug sellers. This is done to take care of the individual elderly citizen, e.g., in relation to negative side effects of drinking or to protect other citizens from unwanted visitors or behaviours, in the case of the latter. Yet, it challenges the autonomy of the inhabitants of the nursing home, which is also highly valued in Danish care practices (Bach et al., in press; Bjerge et al., 2023; Klausen et al., 2023; Møller & Nørlyk, 2017; Rostgaard, 2006). Further, this might also result in citizens like Jack not getting the kind of care and treatment that their health condition requires. A lot of good things can be said about hostels for homeless people [DA: *forsorgshjem*], but it is very rare that elderly citizens are able to receive expert care and treatment for ageing that a nursing home can provide. Adding to this, a place at a hostel for homeless people is much more expensive than at a nursing home, which also makes it an expensive solution within the limited budget of a small rural municipality. However, while Jack's behaviour could not be accommodated, the staff found a way to accommodate Lizzy and her occasional heavy drinking, despite the challenges.

Healthcare professionals tend to be caught up in what is legally possible to do, attempts to respect the autonomy of the citizen and still do the "right" things in relation to health, minimising negative side effects of substance use for the citizens and others, as well as the rules of, for example, a nursing home (Bach et al., in press; Birkedal et al., 2021; Bjerge et al., 2023; Klausen et al., 2023). In practice, this entails professionals having to balance between different vectors of concerns, as also pointed out by Koivula et al. (2016), where a care worker describes the need to be able to transform "from a plumber to a therapist" when dealing with alcohol-using older people (Ibid: 543). For example, can respecting a citizen's practices of drinking two bottles of wine a day be regarded as neglect in care, knowing that drinking might interfere with the medication the citizen is given? Or should it rather be regarded as caring for the citizen's wishes to let him/her "go out with a bang"? The examples of Lizzy and Jack in particular underline this, as staying at the nursing home enhances the dilemmas of respecting a citizen's autonomy and providing the best possible care for them and the other inhabitants. The care staff are often left with legal guidelines that rarely offer much in terms of reflection and contemplation on observations of self-destructive behaviour, rapid physical and mental decline, and volatile and conflictual interactions.

They do not fit the boxes

Having to provide care for elderly substance users is also challenging due to local, organisational setups in the care sector and other related welfare areas. In the interviews, it was repeated that collaboration with the psychiatric system was challenging. Home nurse Hannah pointed to the difference between elderly citizens discharged from somatic wards and elderly citizens discharged from psychiatric wards: in cases where an elderly citizen is transferred from treatment for somatic ailments in a hospital (regional responsibility) to their own home (municipal responsibility), extensive paperwork followed with descriptions of functional levels and what the citizen needed assistance for. When an elderly person was discharged from psychiatric treatment, there was limited or no paperwork available for the home nurses on functional levels and needs for assistance. This made it extremely difficult for the professionals in the care sector to provide proper care to these citizens, both in terms of what kind of services they required, but also the way in which healthcare professionals should approach them. The experience was also that when the healthcare professionals tried to approach the psychiatric system regarding citizens, they were also instructed to contact the citizens' GP as they were no longer enrolled in psychiatric treatment. However, Hannah continued, "It's a lottery with the GPs. Some of them take an interest, listen and are helpful,

but others just seem to have given up and not caring about these citizens." That is, the GP system is also not always regarded as particularly helpful in relation to providing proper care for elderly substance users, and this leaves the healthcare professionals to find ad hoc and pragmatic solutions in the daily encounters with citizens (cf. Bjerge et al., 2019).

Cooperation with (municipal) drug and alcohol treatment services seemed to be contingent on local tradition. While the healthcare staff in one municipality seemed to have stronger connections with these services, there seemed to be limited contact in the other municipality. A nurse from the latter pointed out that she had not seen examples of the individually tailored treatment processes, that she thought there was a need for: "I haven't heard of it being done here. I don't know if it has completely faded out or what is going on."

Returning to the example of Henry, who lives in a public housing targeted marginalised citizens, it becomes evident that, even here, he does not clearly fit in, according to healthcare professional Inge:

> During the visit, a neighbour comes by. It seems to bother Henry, but he is hesitant to ask the neighbour to leave again. When driving to visit the next citizen, Inge explains that there have been numerous cases before where neighbours have exploited Henry's hospitality, and it has been difficult for him to draw the line. Inge is concerned that the comings and goings of his neighbours in the public housing facility do not add to his well-being.

Despite Inge's concern, the idea of Henry moving to another kind of housing does not seem to be on the agenda as he does not have the economic, physical or mental resources to live on his own. It would be difficult for him to fit in at a regular nursing home because his behaviours are different than those expected of regular elderly citizens, as suggested by the examples of Jack from the previous theme. Taken together, we see a kind of challenge, which again seems almost generic in comparison to experiences in other Nordic countries where the care sectors too do not have the organisational setup to provide coherent treatment and care to this group of citizens (Flesland, 2014; Karlsson & Gunnarsson, 2018; Koivula et al., 2016).

Lack of experience and knowledge

A common thread through all the material and themes is that many healthcare professionals experience that they fall short on competences in dealing with the group of substance-using elderly (cf. Flesland, 2014; Karlsson & Gunnarsson, 2018; Koivula et al., 2016). Hence, there is a general wish for more specialised instructions, knowledge and training on how to handle elderly substance users. Keeping in mind that the training healthcare professionals have, for example at the vocational schools of social and healthcare, it is perhaps not so surprising that newcomers in the field experience many dilemmas and challenges in working with elderly substance-using citizens, but also the fact that elderly substance users have been given very little focus in the local organisation, until recently, underlines the (understandable) lack of knowledge and experience in the field among experienced healthcare professionals as well.

In this pilot study, all interviewed professionals thought there was a need for more education on the subject but also dissemination of knowledge through shorter lectures or easily accessible "experts" in the organisation (e.g., nurses with special training or psychologists or doctors with particular knowledge) who could help frontline staff better understand and handle citizens with substance use. As team manager Sandra put it, "We just don't have anyone we can call who has experience or are specialised on this (…) You would want that. When you're in the situation. A number you could call and say, could you come out here,

we're… we have someone we could need some assistance with." Tellingly, none of the professionals interviewed knew of useful information materials about the subject. Sandra pointed out that she often used Google to find information about alcohol and drug use.

Thomas, another of the team managers interviewed, also pointed out the lack of official specific procedures or guidelines for citizens with active substance use: "As far as I know, we have no specific procedures for – for citizens with – with substance use issues. As far as I know, it is the same procedures and guidelines that are set out in the Service Act. So, any… any specific preparedness in relation to them [citizens with substance use issues], we don't have that."

Conclusion

In our study, several dilemmas and challenges involved in caring for older citizens with problematic, active substance use surfaced. These challenges and dilemmas mirror those described in comparable contexts in Nordic research (Flesland, 2014; Karlsson & Gunnarsson, 2018; Koivula et al., 2016) about behaviour, lack of specialised knowledge, feelings of repulsion and disgust, and so on. Further, our go-along method and interviews also pointed to challenges connected to the organisation of healthcare assistance (lack of specialised procedures, lack of cooperation between sectors etc.). While the healthcare professionals were all highly motivated to provide good services for older people with active substance use, they encountered barriers to doing so. As demonstrated in the examples, there were examples of professionals who individually tried to overcome dilemmas and barriers (looking the other way, when a citizen's drinking was considered harmless or googling information about substance use to learn more). However, there seemed to be no systematic, organisational engagement with how to address barriers and dilemmas.

The present study has some limitations. We only conducted a smaller pilot project, out data are limited in size, and we did not conduct interviews with the elderly themselves. However, as dilemmas and themes were reported and observed across the municipalities, and many of these are also mirrored in other Nordic studies, we argue that there is still basis for some preliminary recommendations that might be beneficial to consider for municipalities:

1. Establishing some level of specialised procedures for the evaluation of elderly citizens with active, problematic substance use and how to provide healthcare services for them.
2. Appointing local "experts" with experience and preferably also specialised training or education on substance use who can be called upon for assistance.
3. Strengthening coordination and cooperation between sectors and professional boundaries (e.g., between regions and municipalities and between care, health and drug and alcohol treatment services).
4. On a national level, to develop easily accessible information and/or training material aimed at healthcare professionals who encounter substance use in their daily work (e.g., in the form of flyers, apps, VR tools).

Further research, possibly in connection with testing some of the above recommendations, would likely improve our insights into this field, and comparative research across municipalities and regions in Denmark, and possibly across the Nordic countries, might offer interesting perspectives and possible solutions in the future.

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