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‘It can be difficult to help them’: Colliding logics of care and choice in Danish elder care for older citizens with substance use

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Older marginalized citizens with severe substance use are presently a growing population in Denmark. They struggle with comprehensive and complex needs for care and treatment, which put high demands on health and care professionals working with them. Yet, the complexity of their needs for care and the care provided to them is highly understudied. We take our empirical point of departure in an anthropological pilot study of care work in private homes and retirement homes in two municipalities, where we followed care professionals on their shifts and interviewed them in order to identify challenging situations in daily care. Building on Mol’s concept of logic of care (Mol 2008), we examine how the care professionals in their everyday work with substance using older citizens faced dilemmas in the provision of care within the logics of on the one hand Danish standards for “correct” care and on the other respecting the autonomy of substance using citizens.

Keywords: Aging, Substance use, Elder care, Marginalization, Inequality in health, logic of care

Introduction

It can be difficult to help them sometimes. […] If they don’t want to accept help first of all, because they’re comfortable in their misuse, or that thing where you see a life falling apart in misuse […] That you can’t give them the help they need, because either they don’t want it, or because the right services aren’t there, and they don’t fit into what we can offer.

(Karoline, home nurse, interview, when asked about her experiences of working with older substance- using citizens)

Older marginalized citizens with substance use form a growing population in the Danish care sector (Poulsen, 2021; Bjerge et al., 2023; Bjerge et al. 2024; Sundhedsstyrelsen, 2020a, 2020b, 2021; Mammen, 2018; Ahlmark et al., 2017). They struggle with comprehensive and complex needs for care and treatment, and place high demands on health professionals working with them. Yet, the complexity of their needs for care and the care provided to them is highly understudied, especially regarding qualitative and observational studies (Bjerge et al., 2022; Bjerge et al. 2024; Klausen et al., 2023; Klausen et al., 2020; Pedersen, 2019). In this article, we take up this challenge and present findings from an exploratory qualitative study of care practices involving substance-using older citizens in private homes and one retirement home in two rural Danish municipalities. The aim of the project has been to compile observational and interview data in order to analyze and understand the encounters between care professionals and substance-using older people. In particular, we were interested in unfolding the dilemmas and challenges that are constitutive of how practices of care are carried out.

The opening quote by Karoline pinpoints some of the very core findings of our article: Providing care for older citizens with substance use is considered difficult to conduct in line with the training of health and care professionals due to the fact that 1) these citizens have other ideas of how to conduct their lives than do 'ordinary' older citizens, *and* notions of patient autonomy are deeply embedded in care practices, and 2) the organizational set-up in and between the health and care systems is not geared in such a way that health professionals can always provide the best possible care for these citizens. In the article, we call the first theme *citizens´ behaviors and respect for autonomy*. The second theme we call *falling through the cracks*. As a backdrop for understanding the dilemmas and challenges in providing care for older substance users, we draw on Annemarie Mol´s concept 'the logic of care' which approaches care practices as collectively constituted and ongoing processes without a separate moral sphere (Mol, 2008, p. 90). That is, we point to how the two themes and the dilemmas included in the practices of care are formative for the ways in which practices of care are carried out.

Background: Aging, substance use, and the care sector

Older citizens in need of care with substance use (mainly alcohol, but also prescription painkillers and cannabis, heroin, and other illegal drugs) form a growing subpopulation in Denmark (Poulsen, 2021; Bjerge et al., 2023, Sundhedsstyrelsen, 2020a, 2020; Mammen, 2018; Ahlmark et al., 2017) as well as in other European countries (Gustavsson & Karlsson, 2018; Rosen et al., 2019; EMCDDA, 2010; Han et al., 2018; INCB, 2020; Helsedirektoratet, 2019). We use the term 'older' as the average life expectancy in Denmark for socially marginalized citizens is 64 (contrasted with 81 for the general population, see Pedersen et al., 2023) and many people with substance use, often combined with other factors, suffer age impairment and poorer health conditions much earlier than others, meaning that in some of the cases we refer, the citizen being cared for may only be 50 years of age (Pedersen et al., 2023, p. 16, see also Sundhedsstyrelsen, 2020; Benjaminsen, 2019). While the difference in life expectancy is substantial, the gap has actually decreased since 2009, from 22 to 17 years (Pedersen et al., 2023, p. 34). This is, among other reasons, due to harm reduction measures and improved treatment of drug and alcohol-related illnesses. Adding to this, the percentage of older people in the population is increasing, comprised specifically of the post-Second World War 'baby boomer' generation, wherein alcohol and drug use has been more common than in previous generations. This generation is now entering old age and care services (Poulsen, 2021). The needs and requests for care, support, and treatment in this group are growing along with the size of the group.

The lives of older citizens who use substances are often more unstable than the lives of their peers, and it is often very difficult to establish and maintain contact with these citizens in treatment and in care services (Bjerge et al., 2019; Bach & Bjerge, 2021; Sundhedsstyrelsen, 2020; Pedersen et al., 2023). They are often considered challenging by health and care professionals and even sometimes 'difficult' to care for due to instability, intoxication, or unwanted behavior, and they tend not to seek medical attention until a condition is highly acute (Bach & Bjerge, 2021; Bjerge et al., 2021; Kappel & Johansen, 2022; see also Flesland, 2014; Koivula et al., 2016; Karlsson & Gunnarsson, 2018). In addition to substance use, these citizens often suffer from health conditions (e.g., poor balance) and illnesses (e.g., dementia). This can be worsened by, or difficult to diagnose due to, substance use (Klausen et al., 2023; Bjerge et al., 2023; Pedersen et

al., 2023). Further, substances may also interfere with (enhance or weaken the effects of) medication (Sundhedsstyrelsen, 2020).

At the same time, the municipal care systems and the health and care professionals are often inexperienced in, and unprepared for, handling and providing services to aging citizens who use substances (Bjerge et al., 2023; Klausen et al., 2023). The care sector´s core activities and values are centered around helping citizens 'correctly'. That is, by first alleviating pain, following up on rehabilitation, ensuring that citizens have meals in standardized rhythms, eat and drink (not alcohol) properly, and that negative side effects of 'unhealthy living' are reduced so that citizens can live their lives as 'worthily' and healthily as possible (Dahl & Rasmussen, 2012; Hansen & Kemp, 2016).

Further, respect for the patient´s autonomy, the patient´s choice, and patient centeredness are also key elements in the Danish health care guidelines both ethically and legally (Møller & Nørlyk, 2017; Rostgaard, 2016), and it is widely recognized in Danish elderly care that citizens should be allowed to enjoy life, also when the end is approaching (Klausen et al., 2023). This, to some extent, includes enjoying alcohol. In line with the broader liberal Danish alcohol 'culture' (Thomsen et al., 2023; Klausen et al., 2023), there are few general policies regarding alcohol and alcohol consumption in elderly care, and health care professionals are often left with equally few guidelines locally, leaving them with a large space for interpretations (Bjerge et al., 2023; Klausen et al., 2023). Therefore, they can be hesitant to talk to, or act upon, older citizens regarding the consequences of heavy alcohol consumption or acting unsystematically. Added to this, the care sector is regulated by both the social service legislation and the health legislation (The Danish Act on Social Services and The Danish Health Care Act, DA: *Serviceloven* and *Sundhedsloven*) but also §72 in the Danish constitution (retsinformation.dk), that addresses privacy rights. This entails that the home of the older citizen is regarded as inviolable, and that all citizens in principle have the right to decide how to manage and make choices in their homes unless there is a warrant (Birkedal et al., 2021). Substance use, in particular alcohol, is often regarded as belonging to the private sphere and accordingly tabooed as a non-intrusive area. Rosenthal (1994) contends that alcohol consumption is viewed as a highly private issue even among health professionals, including physicians in Sweden. This tendency has been confirmed in recent Danish studies and identified as a barrier for interventions in substance use problems (Sørensen

et al., 2016; Sørensen, 2019). In that sense, the elderly care sector is characterized by a duality between 1) providing 'correct' health care and treatment as well as nudging citizens towards more healthy living *and* 2) respecting citizens´ autonomy even in cases of a conduct that is potentially highly damaging to their health and quality of life.

Compounding this, the Danish health care sector is organized across different sectors and areas of responsibility: private general practitioners (GPs), specialized medical care in hospitals (somatic and psychiatric) run by the public regions, and finally the municipal health and care services executing daily health care tasks for local citizens. This cross-sectional organization of the health sector is repeatedly mentioned by health professionals as a challenge to the holistic health care of patients and citizens (Mejnertz, 2012). Cross-sectional collaboration is challenged by financial divides. Communication across the sectors is limited due to diverse IT systems with limited possibilities to transfer data across sectors including GDPR limitations that prevent citizen and patient data from circulating across the sectors (Mejnertz, 2012). However, the treatment of complex and challenging problems, such as dual-diagnoses patients, requires cross-sectional collaboration and tends to fall through the cracks (Bjerge et al., 2019; Schepelern-Johansen & Larsen, 2019).

We also know from other studies of substance-using citizens with complex problems that, despite years of debating and trying to generate 'holistic' and 'client or patient centred' approaches and services, it is often difficult to make such services work in practice (Bjerge et al., 2019; Bach & Bjerge, 2021; Nygaard-Christensen et al., 2018; Andersen & Bengtsson, 2019; Johansen & Larsen, 2019). In that sense, ordinary health care and welfare services and policies tend to focus on one problem at a time. This may be reasonable and effective if a citizen has one well-defined illness or problem. Nevertheless, there is a general tendency that older citizens often struggle with co–morbidity (Pedersen et al., 2023). This requires a different kind of holistic attention to symptoms and medication. Yet, our present organization of narrow time limits in general practice and narrow specialization in the regional hospitals compose a risk that a given problem is handled in isolation from other factors that can influence the situation of the citizen too (Bjerge et al., 2019; Bjerge et al., 2020; Møller & Merrild, 2019; Bach & Bjerge, 2019; Merrild et al., 2016). Such framing conditions can affect the way care is provided towards citizens in counterproductive ways.

Analytical framework

Older citizens with substance use are thus a complex subgroup and are often in need of specialized attention from various parts of the health care system. How then do we analyze how care for older marginalized substance users is constituted?

As have many other ethnographers studying health care before us, we draw on Annemarie Mol´s perspectives on care practices (Mol, 2008; see also Mol et al., 2010; Bjerge et al., 2014; Nielsen, 2014). Through an ethnographic study of care practices concerning diabetes patients, Mol describes how the patient/citizen is expected to engage actively in care, patiently, enduringly, and as a prominent member of the care team (Mol, 2008, p. 28). She contends that in Western societies a *logic of choice* supports autonomy and is considered to be valuable in health care. In contrast, the *logic of care* is thought of as a collective act, a form of collaboration between the citizen/patient and the health care professionals in an ongoing process (Mol, 2008, p. 66-84). The logic of care does not start from what people want, but from what they need; therefore, care professionals do not abandon their patients/citizens but keep trying to assist and help (Mol, 2008, p. 25). Accordingly, 'the logic of care is not preoccupied with our will, and with what we may opt for, but concentrates on what we do' (Mol, 2008, p. 8).

In a similar way, when unfolding how practices of care are constituted in care towards older substance users, we pay attention to both individuals and collectives (Mol, 2008, p. 58). Although there are many differences between the lives of patients with diabetes and the older substance users we write about here, a focus on the care interactions and the logic of care seems highly relevant.

Older substance users are interrelated through social networks, time cycles, substances, values, wishes, and material environments etc. Adding to this, providing care is tightly connected to framing rationalities of what it is possible to do, e.g., the authoritative medical treatment system, the legal framework concerning ways of intervening in citizens' privacy including their use of substances, professionals´ experiences or access to information from other welfare systems, and the variety (or lack of) of services available to older citizens. In other words, sometimes contradictory expert systems' rationalities produce dilemmas and challenges both at the organizational levels within the municipalities and to the individual care workers, who may be caught – even sometimes paralyzed – between these two rationalities.

When coding out empirical material, this perceived clash between professionals´ training in care and health support and dealing with substance-using older citizens, including accepting their autonomy, was a recurring theme. Such dilemmas concerning substance use privacy and professionalism mirrored patterns found in studies of other health professionals namely physicians (Sørensen et al., 2016; Sørensen, 2019). Having trained as both nurses and SOSU-assistants and SOSU-helpers, these professionals are trained to support healthy living – yet they may need to compromise this over and over again in order to respect privacy rights. We found these particular dilemmas mirrored in Mol's concepts regarding different logics in care and the logic of choice and thereby we found these concepts as useful analytical lenses.

Further, in the process of coding the empirical material, another reoccurring theme was found, namely that of the limitations within the services towards the group, lack of cross-sectional collaboration mirroring previous cross-sectional studies across hospitals, general practitioners and nursing homes (Mejnertz, 2012). This theme we term *falling through the cracks*. By following Mol´s approach of paying close attention to the many constituting factors that collectively compose processes of care, it enabled us to display the complexity of surrounding factors that also inform and constitute care practices. While there were several other interesting notions and dilemmas to pick up on in our data, the two mentioned themes were by far most pointed to by the care professionals and home care nurses and in our observations.

Methods

The article is based on a pilot study conducted in collaboration between the researcher group, and two municipalities (Referred to here as A and B) which gave the researchers access to follow care professionals (DA: *Ældreplejen*), mainly care assistants (DA: *social- og sundhedshjælpere*), but also some social and health care assistants (DA: *SOSU-assistenter*) and home nurses (DA: *Hjemmesygeplejen,* consisting of trained nurses and social and health care assistants) in their everyday practice, with a particular focus on older citizens with substance use. Both municipalities are situated in the Central Denmark Region and are predominantly rural. They vary in number of inhabitants and geographic spread (municipality A has 25,000 inhabitants and covers over 200 square kilometres, municipality B has 44,000 and covers more than 600 square kilometres). Despite local

differences in municipalities A and B, the dilemmas and challenges constituting care practices were predominantly similar, which is why it is the common experiences that are in focus in this article.

Applying the method of 'going along' (Kusenbach, 2003), eight care professionals were followed in their daily practice on shifts (seven of these were followed by author 1, one by author 3). This allowed us to focus on the role of the care professionals and their encounters with older citizens, and the sometimes implicit and unreflected practices and actions of the care professionals.

Access was secured through the planners in participating municipalities; they assigned routes for care workers, and the care workers' contact to the visited citizens. The ethnographer was assigned to one particular care professional for either half of or the entirety of a workday (shifts of usually eight hours), following them on work assignments, including preparations and breaks, and in particular visits to older citizens to provide care. The care work could include preparing food, taking out garbage, taking out and assuring that the older citizens took their medication, observing whether they were eating and drinking, talking with them about their well-being and needs, helping them get dressed, getting them out of or into bed etc. It could also include assisting the citizens to the bathroom or in taking a shower, in which case the ethnographer kept a distance to secure some privacy for the older citizen. For the home nurses, preparing and sorting medication, changing bandages, assessing health needs, and coordinating with doctors and care staff were primary work assignments. Between visits (lasting between one minute and 20 minutes), the ethnographer rode with the care worker or home nurse in their car, which allowed for informal conversations and questions about practice. In general, drives were short and within smaller towns, but some of the older citizens lived in the countryside, which meant longer drives of up to 30 minutes back and forth. While on the go, the care professionals would often coordinate with colleagues by phone to increase efficiency or if the presence of more than one care professional was necessary during a visit. The ethnographer´s participation in visits was contingent on the care professional's evaluation of the citizen and oral consent on the part of the citizen. If citizens asked for further details about the ethnographer´s presence, this was of course explained more in detail.

The majority of the care professionals and both home nurses were interviewed to gain insight into their work life and their reflections on it, particularly concerning citizens

with substance use that was to some extent considered excessive or problematic. As James Spradley famously put it, '[R]ather than *studying people*, ethnography means *learning from people'* (1979, p. 3). That is exactly what we wanted to do through the interviews. They were conducted one on one, except for one interview, where the care professional was joined by another care professional, who also doubled as a team planner. The interviews were conducted as semi-structured interviews (Kvale & Brinkmann, 2015) with a template with thematically grouped questions, and recorded and later transcribed. The interviewers asked follow-up questions prompted by situations from the shifts. This we deemed important in the project team, because of the exploratory nature of the project. Altogether, seven interviews (six conducted by author 1, one by author 3) were conducted with four health and care professionals (two nurses, two SOSU helpers), three team managers who also worked as care professionals (all SOSU assistants), and one area manager. One team manager and the area manager were not followed; however, the interviews were conducted after following the two SOSU helpers that were not interviewed.

Written consent was secured from all the care professionals interviewed and followed in the pilot study. The cases of older citizens presented here are amalgamations of cases referred to by interviewed care professionals and interactions observed in fieldwork. Both care professionals and older citizens have been pseudonymized and personal details blurred for anonymity.

While we strove to make as little negative impact as possible, we were aware that the presence of a researcher could prompt reactions from the older citizens. All situations of entering into homes were discussed carefully with staff beforehand, and the conduct of the following researcher aligned with that of observers who might otherwise follow the care professionals in their work. Observational work of this kind can potentially, no matter how many precautions are taken, cause unexpected outcomes and reactions from the people involved. However, none of the older citizens expressed unhappiness with the presence of the ethnographer, while several seemed to enjoy the presence of a 'new face'. We believe that, with respectful and careful conduct, studies like these are essential to understanding the interactions of care professionals and older citizens with substance use better, and while there are certainly potential ethical dilemmas, we have striven to deal with these carefully.

In the following section, we explore the actual practices of care and the views of professionals in terms of what is regarded as appropriate or even logical, focusing on how specific possibilities and constraints influence practices of care (cf. Moore & Frazer, 2006).

Citizens´ behaviors, and respect for autonomy

In the following section, we turn to the presentation and analysis of the data in two clusters. Firstly, we introduce and discuss examples of situations where the logic of choice collides with the logic of care. The logic of choice is prevalent in citizens' autonomous lifestyle choices as illustrated below in the case of Bente.

> Bente is lying in her bed – or to be more precise, the hospital bed installed in her living room, because her bedroom is too small. Next to the bed is a small table where a glass of red wine stands, a few smears of drops of red wine dotting the table. The TV is on. The care worker, Nana, says hello. Bente seems to lighten up, perhaps because of the presence of a new face. She has trouble getting around on her own but can do so with the help of a walker, which is discarded near the bed, with a half-empty bottle of red wine in the basket. Bente needs assistance to get out of bed and to the bathroom and relies on a wheelchair if she has to go longer distances. She does not move from the bed while we visit. Stacks of celebrity magazines line the bed and are piled next to the glass of red wine. Nana brings Bente some medicine and a glass of water and asks her how things are going. She is fine, but bored, she says. As Nana rummages in the kitchen, I chat idly with Bente and get the impression of a lively lady who likes to talk. When we leave, I ask Nana about the red wine. 'Someone must be buying it for her and bringing it. She can't shop on her own, and we're not buying alcohol for her,' Nana says. I mention that she seemed very lively and sociable and Nana nods. 'I think it actually took quite some time before we realized that she has a drinking problem, because when we started coming she was more mobile and had been managing a job until a short time before, so she could hide the bottles and the traces for us, and she seemed coherent,' she says, and adds: 'She can't do that anymore, and she can get quite drunk and abusive when she drinks too much. Sometimes she stumbles because she is trying

> to move around, and it can be difficult to help her back up. She was in a good mood today, and then it is much easier for us.' (Fieldnote excerpt)

Bente's autonomous lifestyle choice illustrates the challenges within the logic of choice and how it collides with the logic of care. On the one hand, we see Nana practicing care along the lines of what is expected of care professionals: She brings Bente her pills, gives her water, and asks her how she is. Nana notes how Bente appears today; in a good mood, more cheerful than usual, friendly, 'easy'. This contrasts with days when she is abusive, stumbles, and has increasingly become less mobile and coherent. Nana notes that 'someone' buys alcohol for Bente, which care the professionals are not allowed to. This exemplifies a moment of unity across the legal and health rationalities that meet in the care practices. On the other hand, we see Bente, who recently managed a job, now immobile, bored, chatty, lacking company, and appearing disinterested in quitting her red wine. In that sense, the logic of choice overrules the health rationality and Bente resists the advice of care professionals to not drink, or drink less. In short, Nana insists on providing correct care following her training and her guidelines, while Bente insists on her autonomy to make her own choices regardless of health rationality and care logics.

What at first glance might seem to be a dichotomy (care provider vs. citizen), is in fact more complex than that, because patient autonomy is also a cornerstone in the Danish care sector. This is experienced as very limiting for the kinds of care that can be provided, but it also evokes experiences of powerlessness when watching another human being 'waste away' and deteriorate while the care professionals are unable to intervene due to rules about privacy and personal choice. This contrasts what care professionals have learned about prevention and supporting healthy living, which potentially raises feelings of inadequacy and frustrations even more. A care professional, Pia, and a coordinator, Marianne, discussed the dilemma in an interview.

> *I:* What could that typically be [challenges of providing care to substance users]?
> M: Well, how we go about doing our jobs, then the [citizens] might have a different idea about how we should do it […] Also, the way they behave towards us sometimes, right? Their language and actions towards us. It's not always nice being in that [situation].

> P: And then there is that, that they can quite often reject our assistance because they don't want us to help them […] That can also be very difficult to handle, when you can see that they very clearly need help.

In practice, this entails that standards for care have to be compromised to a much larger extent than is experienced when assisting with more 'ordinary' older citizens. The care provided for substance-using older citizens also had a more shifty and unpredictable character than other types of care. Home nurse Maria phrased it like this in an interview:

> (…) You also have to handle what you enter and meet. And especially if there is only 10 minutes marked out, because that's not really anything you can fix in 10 minutes if – if it's someone lying almost unconscious. Then it's a new situation you have to adjust to.

Maria further explained:

> Some of them are verbally abusive, when they are drunk [...]. Sometimes they are sexually aggressive [...]. But mostly, the substance use is a problem, because we cannot physically help them. We cannot change their diaper. Or wash them. Or get them to eat something. Or give them medication for that matter. (Interview excerpt)

The health rationality, including extensive documentation of the negative effects of alcohol in relation to health and illnesses (www.sm.dk), and the logic of care are both challenged by the logic of choice i.e., citizens' autonomy in cases of substance use disorders supported by §72 in the Danish constitution addressing privacy rights in the home. There are often no clear alcohol policies and guidelines implemented locally in the care sector (Klausen et al., 2023; Bjerge et al., 2023), and while the Danish Board of Health recommends "systematic early detection conversations about alcohol" and that "action plans should be developed for staff with citizen contact with the purpose of handling citizens' alcohol issues" in their +200 page handbook for the municipalities on prevention in elderly care (Sundhedsstyrelsen, 2015, p. 138-142), these guidelines were not mentioned by any of the professionals during fieldwork or interviews and did not

seem implemented fully in practice. This entails that providing care for older citizens who use substances is very much left to the discretion of the individual care professionals (Klausen et al., 2023; Bjerge et al., 2023), which may cause clashes between approaches represented by the individual care professionals (what we might refer to as hardlining vs softlining on substance use). This was illustrated when following a care worker in a nursing home into the home of Miriam.

> Miriam sometimes drinks strong liquor excessively in her small apartment in the nursing home. The care professional, Laura, referred how some of her colleagues had on occasion confiscated Miriam's hard liquor, which had led to conflicts with Miriam, who then refused to let these care professionals enter her apartment and provide care services for her. Laura explained: 'We [care workers] are geared to tell them [older people with substance use] what is wrong. But what is wrong? The way I see it, it might be it's wrong for us, because it's not part of our everyday lives. But it's not wrong for her. But we're trained to, we have training that says that it is wrong; it's not okay to get drunk. But it's not their [the colleagues] everyday life. And that is what we have to learn to understand, but no one really does. Because we don't have the tools.' Laura and one of her colleagues had good relations with Miriam, so they were the ones caring for her. However, Miriam's family was also concerned about her drinking, and while Laura understood their concern, she also remarked that the staff had no legal right to confiscate the liquor from Miriam or otherwise intervene in her personal choices as long as they presented no immediate risk to herself or the staff. (Fieldnotes and interview excerpt)

The logic of choice combined with the view of alcohol consumption as a deeply private issue seems to overrule the logic of care in the collectively negotiated process in which the health professionals supported health and well-being. When some of the care professionals tried to protect Miriam against long-term alcoholic self-destruction by taking her liquor, she simply refused their care and services. The care professionals feel inadequate in dealing with the citizen's substance use in particular care situations and many, like Laura, requested more knowledge and tools.

To further illustrate how bridging between care, autonomy, and substance use puts

strain on the professionals, Laura referred to another previous resident at the nursing home.

> Manfred used cannabis frequently and called his dealer who would make deliveries at the nursing home. He also smoked inside his apartment and could become aggressive towards staff when they told him it was not allowed. Laura explains: 'It was a really hard piece of work because I was completely out of my comfort zone. Everyone was. He would shout a lot and throw things around, because we tried to control him. He said, 'You fucking control everything.' In the end, Manfred was transferred to a shelter [DA: *forsorgshjem*] outside the municipality, because he could not be accommodated at the nursing home. (Fieldnotes and interview excerpt)

The care professionals could not provide care for Manfred because of his substance use and unpredictable behavior. Here, one could argue, the distance between care and the autonomy of the citizen was too wide. Miriam, on the other hand, was allowed to stay in the nursing home, though Laura had to make an effort to make the team accommodate her and accept her occasional excessive drinking. Practices of care were constituted collectively by the rules (or lack of rules), the approaches of the professionals towards substances, the citizens' different types of behaviors, their bodily want for substances, the set-up of the nursing home, what is regarded as medically correct, as well as notions of the importance of autonomy, and the logic of choice. The difference between these two cases, in Laura's rationalization, came down to 1) the illegality of the substance used by Manfred and the presence of dealers on the premises, and 2) his transgressive, violent behavior towards the staff. These factors combined meant that he could not be accommodated in the facility, whereas Miriam's use of alcohol could be, even though it posed dilemmas for the staff.

While most of the older substance users in the two municipalities would admit openly to their use and insist on their right to consume e.g., wine or other substances, it was also reported that some citizens would try to hide their use. Team coordinator Robert explained that sometimes citizens would call in to cancel planned visits, because they felt that their drinking or drug habit was disapproved of by the care staff, or they were ashamed of being inebriated.

> R: These citizens know that home nurses basically most likely disapprove of them doing these things [drinking excessively or taking drugs]
> I: So, they hide it a little?
> R: Of course! Very much so, not just a little. And often, then – we have a lot of citizens who call in to cancel the evening visits. […] We know them well in here in the office, those who try to do it to be able to sit and drink [in peace]. And we try to like to hold them tight, isn't it all right that we will just come by and check that you're all right and … of course, we can't force them. If they really don't want to, we don't come. Then there's nothing we can really do. (Interview excerpt)

Trusting relations are often pointed to as fundamental for providing accurate care (Rasiah et al., 2020), but the logic of choice i.e., citizens refusing visits or to talk about substance use, sometimes made the possibilities for care professionals to provide what they considered adequate care a lot more difficult. At the same time, the care professionals could not – and did not want to – force the older citizens to comply. They had to respect the decisions and choices of the older citizen (Klausen et al., 2023; Møller & Nørlyk, 2017; Rostgaard, 2016).

To bridge between the logic of choice and the logic of care when providing care for the citizens, Robert elaborated that the obvious, pragmatic solution was to be more accepting of the drinking or drug habits of the citizens. This would make it easier to build a relationship and provide services benefitting the citizens in the long run, rather than what the citizens needed from a health rationality perspective.

> We all agree that it [drinking excessively or taking drugs] is not healthy. But we have to compromise [the health rationality], we have to work with what is possible. How can we reach these citizens? How can we get our foot in the door to start with? And if you start out entering and saying, now you have to stop drinking, then you're straight out the door again. And then these citizens call Citizen Processes [DA: *Borgerforløb*], if they know how to, or they call us down here, and then they say, 'I don't need care services anymore, I don't want you to come to my house anymore.' And then they're left to their own devices.

In that sense, providing care for the group entailed that ideals of correct care needed to be adapted to the practices of the citizens (cf. Mol, 2008). In addition, finding ways to provide care for older citizens with substance use also required strategic planning, as the nurse Hanne explained:

> H: It is something about identifying the right time to visit the citizens.
> I: The right time of the day?
> H: Yes, to avoid visiting them when they are too intoxicated. […] that could be in the morning. Also, when I visit citizens with abuse in their own homes, and they have wounds, it is important that it is the same nurses that visit them. It is very much about building trust and then sometimes, people can change.

Again, it becomes evident that the effects of care practices are a collective influenced by many factors (cf. Mol, 2008). To bridge between dilemmas of the logic of care and the logic of choice, care required a sensitivity not only to the cycles of day of the citizen in relation to substance consumption, but it also required a trusting relationship and knowledge of the citizen, which could take a lot of time and continuity to build.

Falling through the cracks

A second theme in the data is that of older citizens 'falling through the cracks' within the organizational set-up of services. Elderly care is run by municipalities whereas hospitals (both psychiatric and somatic) are run by regions. When the care professionals tried to provide what they considered holistic and good services, it was not only the citizens insisting on autonomy that constituted and limited the space of maneuvering for care, but rather the lack of coordination and communication between different sectors. Home nurse Maria expressed it this way:

> I have encountered over time, that if it's something with alcohol use disorders, that they can fall through the cracks. They're not really psychiatric patients. And then it's really difficult to get qualified help. Mostly, Disulfiram treatment is offered, but it's not followed up by psychological treatment […] It can't stand alone, it needs to

> be followed up by conversations […] they need to be helped out of their social environment and into something else for them to […] break out of the substance use.

Again, it is pointed out that proper care and help for older citizens' substance use should be constituted by a collective of factors (cf. Mol ,2008); in this case, medical treatment, psychological help, and social networks. As long as the current health and welfare systems do not take this into account, it is difficult to provide the care that is needed according to the interviewed care professionals.

Helene, another home nurse, pointed to a cross-sectional challenge in the transfer of citizens from treatment in hospitals to care and treatment in their own homes. The somatic hospital wards provided extensive paperwork with descriptions of functional levels and what the citizen needed assistance for. However, if the citizen was discharged from psychiatric treatment, there was limited or no paperwork available for the home nurses. Trying to provide care along the lines of standard medical guidelines was made difficult because the systems were not aligned. That made the home nurses' job much harder and meant that they often had to generate their own assessments, which were based on prior expertise and intuition rather than psychiatric expertise.

Part of the reason for such challenges is the different legal and administrative frameworks they operate under: The Social Services Act and the Health Care Act mentioned previously. While the health care professionals followed and interviewed here were municipal employees, they often communicated with regional employees in specialized health services at hospitals. Danish GPs are self-employed, working under a collective agreement with the Regions and covered by The Danish Health Care Act. This adds another layer to communication. While efficient in many ways, Danish health care systems do not always communicate effortlessly and occasionally responsibility falls through the cracks (Mejnertz, 2012).

Several of the care professionals also pointed to issues in the communication between different groups of professionals. In an informal conversation, care professional Ellen noted that the care professionals' words carried little weight in relation to those of health professionals like nurses and doctors. References to coordination and communication problems in internal hierarchies and in cross-sectoral relations were more

numerous in fieldnotes than in interviews. This may be due to the more formalized frame of the interview situation, where words might have been weighed carefully, whereas the informal conversations were more direct. One example of this was during a shift following Ellen.

> One of her visits was to a woman in her 50s with a stoma who also had mental health issues. Living with her was her son, a young man in his 20s who had an anxiety diagnosis, which Ellen also felt compelled to attempt to handle.
>
> In the car after the visit, the ethnographer asked about the range of issues Ellen was handling on her visits. The previous visits had included a heavy drinking couple around 50 years of age and an ex-criminal cannabis user who was beginning to lose his memory. 'It comes with the job,' Ellen said. 'No one else does it if I don't.' She had tried contacting psychiatric services to get some help for the young man with anxiety several times. She had been told that there had been previous attempts at contact and the citizen's case was 'closed', or that it was only the GP could make a referral. "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 care about these citizens,' Ellen said. (Fieldnote excerpt)

The care professionals had to communicate upwards through organizational hierarchies, to nurses and GPs, who would then report onwards in the system. A few of the care professionals pointed to a lack of natural contact with the home nurses as problematic. Also, communication between the different sectors was often slow and had to filter through the barriers of different IT systems and the professional hierarchies.

In that sense, practices of care towards older substance users are highly affected by factors outside the physical encounters between citizens and care professionals too. Hence, it is evident that it is not only substances, certain behaviors, time cycles, care professional´s education and experiences, medical procedures et cetera that constitute the possibilities (or lack of) for care in practice. This is situated in relation to specific organizational, legal, sectorial, and hierarchical frameworks, which all affect the outcomes of care (cf. Mol, 2008).

Conclusion

In this article, we have demonstrated how care for older substance using citizens is constituted by a multiplicity of factors, including the composition, training, and attitudes of the health and care professionals, the coordination between groups of professionals and sectors, the structuring of work assignments and time slots, and the actions of the individual older citizens themselves. We have also demonstrated how many of these dilemmas are closely related to the logics of care and choice (Mol, 2008), which are present in the care sector. Sometimes, it is fairly clear cut that one logic overrules the other; e.g., in the case of Manfred. But in most cases, it is a blurred picture as both logics are at play at the same time; e.g., the example of Miriam. In that sense, caring for older substance-using citizens is constituted in a messy middle ground that, according to the professionals, makes their job demanding and straining, but also interesting and challenging.

While our data material is limited, consisting of relatively few interviews and a limited number of hours of fieldwork, our findings are in line with findings from similar settings (Flesland, 2014; Karlsson & Gunnarsson, 2018; Klausen et al., 2023) and with overall public discussions on health care for older citizens in pointing to challenges both structural and practical. The data from our sample are consistent in pointing out the challenges mentioned above. However, further data collection, e.g., including larger municipalities and more specialized facilities, will likely offer more nuances and new perspectives, as practices differ and are adjusted locally.

Our findings clearly indicate that substance use among older citizens in need of care is a subject that merits more attention across regions and municipalities but also at a more structural societal level. Substance using citizens and their relatives are at risk of not receiving the specialized types of services they need and of lacking access to help and information. They sometimes hide their substance use to avoid intervention or to avoid stigmatization. In addition, the professionals providing services for them voice concerns of being underqualified, and lacking experiences and professional training in managing substance using citizens. Care professionals express that they sometimes lack support within their organizations and colleagues with specialized knowledge to draw on. In order to counter this, we suggest: More available time during visits to build relationships, more specialized training on how to approach the group, less divides between sectors and

professions, and better local and national guidelines to improve the conditions for the care professionals and, in turn, the citizens themselves.

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