How does older people’s drinking appear in the daily work of home care professionals?

RIITTA KOIVULA & CHRISTOFFER TIGERSTEDT & ANNI VILKKO & KRISTIINA KUUSSAARI & SATU PAJALA

ABSTRACT
AIMS – In this article the authors ask how the alcohol use of elderly home care clients affects the daily work of home care professionals and how the professionals act to support the drinking client. METHODS – Semi-structured interviews with 10 home care professionals were conducted from December 2014 to February 2015 in the Helsinki metropolitan area of Finland. Everyday situations during home visits related to the clients’ alcohol use were analysed according to modalities of agency of the home care professionals. RESULTS – The results focus on three themes raised in the interviews: supporting life management of the client, the lack of qualifications in tackling clients’ drinking and the need for multi-professional collaboration. Intoxicated clients complicated the home care nurses’ work and obstructed the implementation of recommendations set out to guide the professionals’ operations. Care work with alcohol-using clients was particularly demanding, and the professionals were concerned about not having enough training in how to encounter elderly clients’ drinking. Multi-professional collaboration with substance abuse services and emergency department personnel was called for to remedy this problem. CONCLUSIONS – More extensive and detailed research is needed for a better picture of how clients’ drinking influences home care nurses’ working conditions and what kind of skills nurses need in different alcohol-related situations. Such research would have the potential to benefit clients and improve the well-being of the employees.

KEYWORDS – old people, home care, alcohol, Finland

Introduction
In Finland, as in many other countries, elderly people’s alcohol consumption has increased considerably in recent decades, like “a silent epidemic” (Wallace, Black, & Fothergill, 2010, p. 15). Contrary to the overall Finnish population, 65–84-year-old people’s alcohol consumption did not reduce during a severe economic recession in the early 1990s. Neither did five incremental increases in Finnish alcohol taxes between 2008 and 2014 change the upward trend in alcohol use among this age group. Hence, the ongoing 30-year trend of increasing use of alcohol among old people may be driven by a generational or cohort effect (Vilkko et al., 2010).

In Finland, weekly at-risk drinking for people aged 65 and over is defined to be more than 7 portions of alcohol (1 portion = 12 cl of wine). In 2001 approximately 18% of men aged 65–69 exceeded this level, while in 2013 the proportion had risen to 28%. The corresponding figures for women of that age were 7.5 and 15%. The increase was slower in older age groups. (Helldán & Helakorpi, 2014.)
Alongside the growing number of older people and the rising trend in their alcohol consumption, a continuous increase is registered in the number of deaths from alcohol-related diseases or accidental alcohol poisoning among those aged 65 and over. The number of such cases rose gradually from 345 in 2005 to 583 in 2014 (+69%). At the same time, the proportion of alcohol-related deaths in that age group has grown in the last ten years from 17 to 32%. (Statistics Finland, 2015.) These figures clearly indicate that also in this age group a long-term growth in alcohol use causes increased negative health consequences.

Current national population projections suggest that every fourth Finnish citizen will be 65 years or older in 2030. If the current drinking trends continue or even if the present consumption level stabilises, this population group will – in terms of its size, purchasing power and need of treatment – be a crucial group of alcohol consumers.

The combination of growing alcohol use in older age and the simultaneous increase in the number of elderly people is far from trouble-free. Moreover, the main goal of Finnish ageing policy is to provide care and services in elderly people’s private homes or in home-like residential environments (Act 980/2012, 3, 13 and 14 §§). This creates new demands and tasks for home care professionals. We will analyse how alcohol use of community-dwelling older people affects the daily work of home care professionals and how they manage situations and duties in elderly people’s homes. In doing this, we do not see a need to distinguish between, for example, “light” and “heavy drinking”. This is because our primary focus is on the personnel and its work, not on the alcohol-using clients. Thus, the ultimate criterion in this study is not whether the client is a “heavy drinker” or not, but rather whether the client’s alcohol use presents problems for the personnel.

Besides other professionals – such as police officers, ambulance personnel, waiters and waitresses – home care professionals represent an occupational group which on a daily basis is confronted with customers suffering from alcohol problems. While alcohol research has typically concentrated on studying the consequences of alcohol use for the drinker, we decided to choose a different perspective by asking what kind of meanings the alcohol use of elderly home care clients bring to the work of home care professionals.

There is a wide array of research on older people’s alcohol consumption, including analysis of relevant questions concerning home care. These studies have focused on such issues as the relationship between alcohol consumption and mental health (St. John, Montgomery, & Tyas, 2009; Rakshi et al., 2011), chronic diseases (McEvoy et al., 2013; Ryan et al., 2013), pain (Brennan & SooHoo, 2013), falls (Tait et al. 2012; Kurzthaler et al. 2005; Cawthon et al. 2006; Sorock et al., 2006) and suicides (Morin et al., 2013). The alcohol–drug interactions have typically been studied separately (Ilomäki et al., 2013; Immonen, Valvanne, & Pitkälä, 2013; Johannessen, Engedal, & Helvik, 2015; Cousins et al., 2014). Furthermore, there are studies on the utilisation of emergency department care (Levy Merrick et al., 2011; Woodruff et al., 2009) and on the effects of referral to treatment, screening practices and various kinds of
early interventions (Schonfeld et al., 2014; Ettner et al., 2014; Benza, Calvert, & McQuown, 2010; Kuerbis et al., 2015; Google & Owens, 2015; Wallace, Black, & Fothergill, 2010; Bakhshi & While, 2014). There are also studies that have examined the effect of gender (Epstein, Fischer-Elber, & Al-Otaiba, 2007), retirement (Wang, Steier, & Gallo, 2014; Zantinge et al., 2013) and social involvement (Dare et al., 2014) on old people’s alcohol consumption.

However, few studies have strived to disentangle how clients’ use of alcohol affect home care professionals’ daily routines and how the professionals should act to support clients whose drinking causes problems (however, see Herring & Thom, 1997 and 1998; Gunnarsson, 2013; Gunnarsson & Karlsson, 2013). Examining these questions is topical because, due to the ongoing reform of the structure of the Finnish social services and health care system, there is a great need to intensify and improve the quality of care which more and more is taking place in people’s homes. Further, Finnish substance abuse services are currently in the middle of major changes both because of reorganisations within these services and because of a national reform of the Finnish social services and health care system as a whole. Taken together these reforms will have an effect on the execution of home care. To aid understanding these issues, we will next characterise present changes in the Finnish service systems.

New trends in the service structure

With an ageing population costs are expected to shoot up. One way of controlling expenditures is to curtail the inpatient services and increase outpatient services for elderly people. The Act Supporting the Functional Capacity of the Ageing Population and on Social and Health Care Service for Elderly People (Act 980/2012), together with the Quality Recommendation (Quality, 2013) supporting the implementation of the Act, constitute the foundation of the work carried out by home care professionals. Finnish home care covers both home services and supporting services. Home services comprise individual care, while supporting services include meals, cleaning and transport services. Health services, in turn, consist of treatment and rehabilitation prescribed by a medical doctor. Under the Act, the local authorities are liable to carry out an assessment of a person’s need for services. This assessment is done together with the client and, if needed, the client’s family or other close people, and it serves as a basis for an individual care and service plan.

According to the service plan, elderly persons can be offered regular or short-term home care. Regular care typically continues without interruption, whereas short-term home care comprises care episodes of various scope and length. It has been estimated that only one third of the new clients end up in regular, uninterrupted home care lasting more than two months (Noro et al., 2016). In most cases clients who receive home care and have alcohol-related problems do not deviate from home care clients in general by their demanding spectrum of diseases. However, compared to other home care clients, their need for assistance emerges at an earlier age and covers a wider variety of support to help them manage their daily routines (Vilkko & al., 2013).
Importantly, also the Finnish substance abuse service system has become more outpatient-oriented than before. The decrease in traditional inpatient substance abuse services has created a growing demand for outpatient services such as home care, especially among older people with alcohol abuse.

Data and method

This study is a part of the project Harms to Others from Drinking: Effects on Health, Wellbeing and the Burden to Society, funded by the Academy of Finland (no. 259289) and carried out by the National Institute for Health and Welfare (THL). Our main object is to study the agency of home care professionals who are confronted with community-dwelling elderly people using alcohol in their homes. We interviewed 10 professionals individually (registered nurses, public health nurses and practical nurses; below numbered from 1 to 10) from December 2014 to February 2015. The interviews were conducted in one home care district in the Helsinki metropolitan area in Finland. The professionals gave their consent in writing to participate in the study. The interviews were conducted at the home care workers’ office. Active interviewing was applied: both the interviewee and the researcher created information of the issue studied (Holstein & Gubrium, 1995).

The interviews were semi-structured, focusing on themes drawn from previous research and practical knowledge within the research team. In the initial phase of the interview the researcher posed the question: “During your home visits, have you come across old people’s alcohol use, and if yes, in what way and to what extent?” “Old age” was not specified by the interviewer, but the cases described by the professionals covered people from slightly below 60 to 101 years of age. Neither was “use of alcohol” – or abuse of alcohol – defined in any way, because it was not relevant to the study. Instead, the essential thing was to observe whether the clients’ drinking had become an issue in the professionals’ work.

The home care professionals were asked to describe everyday situations in old clients’ homes and how they tackled these situations, as well as how they were instructed to act if their client had problems related to drinking. These broadly defined themes encouraged the professionals to reflect, talk freely and express their own meanings about the themes. The bulk of the data consists of descriptions of ordinary situations, such as bathing, shopping, assisting functional mobility, etc. Moreover, we got stories about practices the workers had collectively agreed on and about guidance they had been offered (or were in need of) when handling old people’s alcohol use. The interviews were recorded and transcribed.

Typically, the data contain descriptions of harmfully drinking old people who were aware of their excessive drinking. Some of them were at the younger end of old age. There were also stories about clients who denied or underrated their alcohol use, while the professionals had found that the clients’ drinking caused problems during home visits. It should also be mentioned that any form of alcohol use was by no means perceived as problematic by the home care workers.

The data were analysed using agency as a guiding framework (see Jyrkämä, 2008;
Jyrkämä & Haapamäki, 2008; Giele & Elder, 1998; Giddens, 1984). Hence, the focus is on the individual as an intentional actor in various everyday situations. Local social practices involve a set of goals, values, norms, rules, knowledge, skills, resources, power and time schedules, which guide workers and contribute to maintain the moral order in the daily work (Heritage, 1984). Other actors involved in the social practices – such as old people using alcohol – are more or less aware of these rules, use their resources in different ways and give their own meanings to the action. Everyday situations are regarded as a result of joint social action.

When analysing the data we applied various modalities of agency of the home care professionals as a heuristic tool (see Kiovula, 2013). We took note of the fact that when describing concrete situations, the workers expressed, for example, knowledge, skills, motives, feelings, bodily capacities as well as desires, restrictions and opportunities. This helped us to interpret how the workers related their knowledge, skills, motives, feelings, etc., to the daily situations they described. However, the modalities are not explicitly mentioned in the results.

We approached our subject from a home care professional’s point of view and concentrated on how elderly clients’ use of alcohol appears in their work. Our research questions were: 1) What kind of alcohol-related situations do the workers run into? 2) How do the workers act in these situations? 3) How do they feel they manage these situations?

Home care and older people’s alcohol consumption

The impact of elderly clients’ alcohol use on home care professionals’ work varies depending on the branches of the service system. This is due to temporal and local consequences of the stages of drinking and the differences of the duties the home care workers have in their work environments. Home care professionals visiting old people in their homes during the week are confronted with problem users in any stage of drinking. A client might be sober on Monday, excessively drunk on Tuesday and suffering from a hangover on Sunday. The basic task of the professionals is to assist the clients’ functional ability and help them manage their everyday activities according to each person’s individual care and service plan.

In the following we will first describe the challenges connected to supporting the clients’ life management. We then turn to the issue of the workers’ professional qualifications. Finally, we give space to the workers’ thoughts about the need for multi-professional cooperation.

Supporting a client’s life management

In Finland an older person becomes a client of home care either through their own initiative or on request of a close person or through authorities within social services and health care. In this process, the need for service will be assessed, and the issue of alcohol use is also brought up.

Home care professional: We make an assessment visit with a regular content. During the visit we bring up almost everything: alcohol use, smoking, physical exercise, medication. (2)
Based on the assessment, an individual care and service plan is drawn up in writing for each client. However, the professionals who write down the document do not always want to set the goal of supporting abstinence in the plan, because it might contribute to creating a stigma.

Interviewer: Is there any written goal about alcohol in the care and service plan of this lady?
Home care professional: Well, you know, usually we don’t write it into the plan, because it’s stigmatising. We have no right to stigmatisate anybody. For the moment we have one person who hasn’t used alcohol for many, many years. And still when this client visits the hospital, doctors write, every time, “heavy user of alcohol”, just because it’s mentioned in some document. And so it keeps going. I myself am really cautious, I don’t want to stigmatisate anybody. It’s a nasty question. (2)

Heavily drinking clients often have problems with managing their everyday activities both because of age-related changes in their ability to function and because of their use of alcohol. Due to this, the level of service need varies a lot.

Interviewer: What was the original reason for you to start visiting this home?
Home care professional: Alcoholism, I mean the client really drinks a lot and is without company and doesn’t take care of the apartment at all and invoices remain unpaid, there is no food in the pantry, [the client is] unable to take care of his hygiene, and so on, I would say things are in a very bad way. (5)

In accordance with the common values of home care, the primary intention of the professionals is to accept and respect the autonomy of heavy-drinking clients. Yet, an elderly client is not always able to adhere to mutual agreements, such as not being drunk at the time of the home care visit. Therefore, the home care professionals met intoxicated clients “daily”, “twice a week” or “weekly”. The client may have started drinking after waking up in the morning. The home care worker would find a heavily intoxicated client lying on the sofa soiled by his/her secretions and unable to communicate. In addition, home care professionals often had to work through their own emotional dilemmas when solving these problematic situations.

Home care professional: The client may be drunk [when I arrive], he starts drinking at five am, wakes up and starts drinking. So when we arrive at eight o’clock he’s already found time to be drunk and take a nap. (1)

Interviewer: Could you describe a typical situation when you arrive in a client’s home?
Home care professional: He is lying on the sofa, sleeping. The last two weeks he has not been drinking. Sometimes I’m really uneasy about it. When he’s been drinking, it’s impossible to talk to him, he’s just staring into space, I get no answer to my questions and I have to repeat over and over again that, please, answer me. (5)

Clients’ 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.

Interviewer: What about this client of yours, you said he’s suffering from diabetes and you’re not able to give him medication. Is it likely to complicate the treatment of his diabetes?

Home care professional: Yes indeed, the level of treatment. And you know, although he takes only one beer let’s say on Monday his blood sugar count fluctuates a lot and can suddenly fall dramatically, and so you find yourself thinking, what to do next. But he doesn’t understand it himself, he doesn’t understand that alcohol is a real threat [taking care of diabetes].

The length of the home care professionals’ visits is generally short. However, many times visits to clients with alcohol problems were longer than planned, for example because there was a need to give a client an extra shower. Sometimes duties were too demanding for a single worker to manage, and the workers had to call for help from a colleague. Because of occupational safety reasons it was agreed that if an intoxicated client had fallen, the home worker was not allowed to lift the client on her/his own.

Older people using alcohol were regarded as a client group whose need for care is complex. On this account, the home care professionals felt that their job description (responsibilities, rights, restrictions, etc.) was inadequate. As one interviewee put it: being a home care nurse in different kinds of everyday situations calls for transforming “from a plumber to a therapist”.

Due to clients’ alcohol use, home workers spent extra working hours on supporting the life management of these clients. In addition to basic care and health care, they ran such errands for the client as buying new sheets, a new mattress, etc. Sometimes the client’s apartment was such a mess that even the delivery of medications could be a complicated task because of the lack of a clear table top. By conducting such tasks the workers eased both the life of the clients and the work of their colleagues. Nevertheless, these tasks were often perceived as extra work.

If the clients’ functioning was weakened due to alcohol use, home care professionals also took care of their financial and other matters, for example taking bills to the social services. Alcohol consumption also proved to be an obstacle when the home care professional took up a trusteeship arrangement with the client. This was because the client considered it would have an effect on his/her own decisions to use money, reducing the pocket money needed to buy alcohol for example.

Interviewer: Is the client able to take care of his finances?

Home care professional: Sort of. You know, we’ve considered supervision, but he doesn’t accept it. So far a social worker pays his bills [in the office], but he’s not able to deliver the bills, because of bad legs, so the bills are taken [to the office] by us. We always have to go through his piles of post, looking for his bills. To him it’s all the same where the bills are, he may throw them straight in the rubbish bin. He just tries to hide his problems. And for the moment he rejects supervision,
because he knows what it means.
Interviewer: What do you mean?
Home care professional: That the supervisor will take care of the bills and the client gets pocket money. He knows that after that drinking will be brought to an end. Because he's a clever man he certainly understands what supervision would imply from that point of view. (5)

Financial matters were also linked to the clients’ own social relations. Many of the clients with excessive alcohol use were divorced or lived alone. They lacked support both from family members and from other potential supporters. Some of the clients had relatives who took care of, for example, their cleaning or financial matters. At the same time, home care workers were sometimes worried about the family relations of some severely diseased clients because of suspicions about possible financial manipulation.

Professional qualifications
Because of the issues described above, older people’s alcohol use put the home care nurses’ professional competence to the test. One of the nurses reflected during the interview that because she lacked professional knowledge and skills concerning this elderly client group, she had to encounter these people only relying on her previous life and work experience. A special challenge was the need to combine general nursing and caring of older adults with knowledge about how to treat alcohol problems in general. Clients using alcohol often suffered from several illnesses and problems. Thus, when making home visits the workers had to assess, for example, whether they could give an insulin injection to a client suffering from diabetes who apparently had used alcohol. Or the worker was concerned about whether the client remembered to eat the food that was ordered and delivered to him or her from the catering service. And how to decipher a tremble or a cramp – was it a symptom of a hangover, illness or ageing in general?

Home care professional: Considering education, our girls didn’t recognise cramps related to drinking. I mean, drinking is not simple drinking, it is a broad concept. (8)

In the region where the interviews were conducted, the training to update the home care workers’ knowledge about older clients’ alcohol use and consequent problems had been launched, but so far only a few of our interviewees had participated in it. The workers said that they also lacked tools, such as written guides for older people and their relatives about health and other harm related to drinking, although such aids are available on the Internet. According to the workers, the most workable way of approaching clients using alcohol was to exercise a certain amount of “energetic” and “assertive” control. At the beginning of a client contact they explored the situation, but when they got to know the client better they straightforwardly addressed alcohol use and encouraged reduced drinking. Still, even when clients were motivated to attend substance abuse treatment, the efforts of the workers did not always succeed, because the self-determination of the client had to be respected.

Age and gender of the client mattered when home care professionals tried to
motivate clients to change their drinking habits. According to the interviewees, clients below 65 years of age thought they were too young to participate in (alcohol treatment) services aimed at older people. They were neither willing to join activities in the adult day care centres nor in rehabilitating group sessions, although they were offered both. As one of the clients said: “Isn’t it for those oldsters?” (5).

Older women felt especially uncomfortable about the topics in male-dominated peer groups discussing alcohol use. Clients of both genders had expressed their preference for more action-centred groups focusing on the clients’ personal strengths, such as manual skills. The interviews also revealed that not all home care professionals were aware of services to older adults with alcohol abuse in the region they worked.

Multi-professional collaboration
Due to their shortcomings in handling older people’s alcohol problems, the workers felt they needed support from other professionals. However, our interviewees considered multi-professional collaboration difficult and were annoyed with it. The workers particularly criticised professionals in the social and mental health care services for being short-sighted.

Interviewer: Would you have needed more support from other professionals?
Home care professional: Yes, sure, would be really good to have a substance abuse expert who does a little more than “well, I’ll just make this home visit” and then forgets the client right away. (9; also 6)

To make things easier, some nurses had asked social counsellors for help. On one occasion the social counsellor was requested to help the client in filling in an application form for transport subsidy. However, things did not proceed as expected.

Interviewer: You mentioned that you applied for transport subsidy, but does this really belong to your tasks?
Home care professional: Listen, everything belongs to us. First I thought that what if the social counsellor took care of the application, because it’s actually part of their job. But she said that she’ll send the forms, assuming that the client is able to fill in them. I was thinking that, no, that’s not at all the case. Of course I couldn’t tell the social counsellor that we have an alcohol problem here, so I said that what we need is social assistance, that the client needs conversational therapy, that filling in forms is really no problem, I’ve done it many times. And then the social counsellor said only yes, just fill in the forms and send them to me. (2)

The workers also pointed out that in a case of an accidental fall, for example, the emergency department personnel did not intervene in the patient’s alcohol use, although the accident was clearly related to it. It could even happen that on the way home from hospital the patient would take a taxi and drop into a liquor store – and would start drinking immediately at home. “Revolving doors” between home care and hospital care, due to heavy drinking, was a well-known phenomenon among the home care professionals.
Home care professional: With one client we are in a bad spiral of drinking. First he’s rehabilitated, sobered up and fed in hospital, and then when he returns home he takes a taxi and heads for the liquor store. (...) After a week you find him lying on the floor (...) and once again he’s passed to hospital. But sometimes when he’s been lying on the floor three or even four days, the home care has had to bandage his wounds.

According to the interviewees the clients’ mental problems got worse during drinking bouts, particularly if they did not take their medications. Occasionally, drinking led to domestic violence, and home care workers were called in.

Thus, from the perspective of home care nurses, other professionals had a short-sighted and insufficient approach to home-dwelling clients with alcohol abuse. According to Gunnarsson and Karlsson (2013), differences between professionals are probably due to different professional tasks and goals when working with the aged and with problem drinkers.

Discussion
The home care professionals spoke bravely and openly about challenges in their daily work with elderly clients who use alcohol. In doing this, they highlighted different aspects of their professional agency. When talking about the role drinking played during their home visits, they also brought up experiences of fear, coercion and lack of qualifications, which increased their workload. This was regarded as a serious problem both for the conduct of their daily work and for the service system at large.

Thus, although our data included only ten home care professionals, it raised several important questions.

It turned out that the clients needed a lot of support to manage their everyday lives. An intoxicated client complicated the home care nurses’ work in numerous ways and obstructed the implementation of rules and recommendations which are set out to guide the professionals’ operations.

It also turned out that in terms of qualifications, residents using alcohol were a particularly demanding clientele for the home care workers. Although substance-related issues by no means belong only to home care professionals, they were clearly bothered by the fact that they had not received enough training in how to encounter problems caused by elderly clients’ drinking.

From this follows our third observation: the interviewees thought that it was necessary to cooperate on a multi-professional basis with substance abuse services and emergency department personnel. At the same time, however, they regarded the existing collaboration as insufficient and unsatisfactory. They also thought that the collaboration was short-sighted and did not result in a sufficiently trustful relationship between client and professional.

In recent years both substance abuse services and elderly care services in general have become more outpatient-oriented. Simultaneously, the number of elderly people living in their own homes has grown and their alcohol consumption has increased. This calls for a reassessment of how to organise home care so that it more effectively supports clients to cut their alcohol use. As mentioned in the beginning,
there are very few studies and developmental experiments on services offered to elderly people receiving home care and having alcohol-related problems. Our results suggest that there is a strong societal demand for such undertakings. More extensive and detailed research is needed if we are to get a better picture of how clients’ drinking influences home care nurses’ working conditions and what kind of skills nurses need in different alcohol-related situations. Such research would have the potential to benefit clients and improve the well-being of the employees.

Declaration of Interest None

REFERENCES

Act 980/2012. Laki 980/2012 ikääntyneen väestön toimintakyvyn tukemisesta sekä iäkkäiden sosiaali- ja terveyspalveluista [The Act Supporting the Functional Capacity of the Ageing Population and on Social and Health Care Service for Elderly People]. Retrieved from http://www.finlex.fi/fi/laki/alkup/2012/20120980

Bakhshi, S., & While, A. E. (2014). Older people and alcohol use. British Journal of Community Nursing, 19(8), 370–374.

Benza, A. T., Calvert, S., & McQuown, C. B. (2010). Prevention BINGO: Reducing medication and alcohol use risks for older adults. Aging & Mental Health, 14(8), 1008–1014.

Brennan, P. L., & SooHoo, S. (2013). Pain and use of alcohol in later life: Prospective evidence from the health and retirement study. Journal of Aging and Health, 25(4), 656–677.

Cawthon, P. M., Harrison, S. L., Barrett-Connor, E., Fink, H. A., Cauley, Jane A., Lewis, C. E., Orwoll, E. S., & Cummings, S. R. (2006). Alcohol intake and its relationship with bone mineral density, falls, and fracture risk in older men. Journal of the American Geriatrics Society, 54(11), 1649–1657.

Cousins, G., Galvin, R., Flood, M., Kennedy, M.-C., Motterlini, N., Henman, M.-C., Kenny, R.-A., & Fahey, T. (2014). Potential for alcohol and drug interactions in older adults: Evidence from the Irish longitudinal study on ageing. BMC Geriatrics, 14, 57.

Dare, J., Wilkinson, C., Allsop, S., Waters, S., & McHale S. (2014). Social engagement, setting and alcohol use among a sample of older Australians. Health and Social Care in the Community, 22(5), 524–532.

Epstein, E. E., Fischer-Elber, K., & Al-Otaiba, Z. (2007). Women, aging, and alcohol disorders. Journal of Women & Aging, 19, 31–48.

Ettner, Susan L., Xu, H., Duru, O., Kenrik, A.,...
Alfonso, Tseng, C.-H., Tallen, L., Barnes, A., Mirkin, M., Ransohoff, K., & Moore, A. A. (2014). The effect of an educational intervention on alcohol consumption, at-risk drinking, and health care utilization in older adults: The project SHARE study. Journal of Studies on Alcohol and Drugs, 75(3), 447–457.

Giddens, A. (1984). Constitution of society: Outline of the theory of structuration. Cambridge: Polity Press.

Giele, J. Z., & Elder, G. H. Jr. (1998). Life course research: Development of the field. In J. Giele & G. H. Elder Jr. (Eds.), Methods of life course research: qualitative and quantitative approaches (pp. 5–27). Thousand Oaks: Sage.

Google, C. L., & Owens, M. G. (2015). Screening and brief intervention for alcohol misuse in older adults: training outcomes among physicians and other healthcare practitioners in community-based settings. Community Mental Health Journal, 51(5), 546–553.

Gunnarsson, E. (2013). Alkoholmissbruk och självbestämmande – en kartläggning av den svenska hemtjänstens förutsättningar att arbeta med äldre personer med alkoholproblem [Alcohol abuse and self-determination: a mapping of the conditions for home care work with older persons with alcohol problems]. Nordic Studies on Alcohol and Drugs, 30, 227–242.

Gunnarsson, E., & Karlsson, L. B. (2013). “Man slutar inte dricka för att man får städat” – om bistånd, hemtjänst och alkohol [On assistance, home care and alcohol]. Arbetsrapport/Institutionen för socialt arbete 3. Stockholms universitet.

Heildän, A., & Helakorpi, S. (2014). Eläke-ikäisen väestön terveyskäytätyytymisen ja terveys kevällä 2013 ja niiden muutokset 1993–2013. Raportti 15 [Health behaviour and health among the Finnish elderly, Spring 2013, with trends 1993–2013]. National Institute for Health and Welfare (THL), Report 15/2014, Tampere.

Heritage, J. (1984). Garfinkel and ethnometodology. Cambridge: Polity.

Herring, R., & Thom, B. (1997). The right to take risks: Alcohol and older people. Social Policy & Administration, 31(3), 233–246.

Herring, R., & Thom, B. (1998). The role of home carers: Findings from a study of alcohol and older people. Health Care in Later Life, 3(3), 199–211.

Holstein, J. A., & Gubrium, J. F. (1995). The active interview. Thousand Oaks: Sage.

Ilomäki, J., Gnjidic, D., Hilmer, S. N., Le Couteur, D. G., Naganathan, V., Cumming, R. G., Waite, L. M., Seibel, M. J., Blyth, F. M., Handelsman, D. J., & Bell, J. S. (2013). Psychotropic drug use and alcohol drinking in community-dwelling older Australian men: The CHAMP study. Drug and Alcohol Review, 32(2), 218–222.

Immonen, S., Valvanne, J., & Pitkälä, K. H. (2013). The prevalence of potential alcohol–drug interactions in older adults. Scandinavian Journal of Primary Health Care, 31, 73–78.

Johannessen, A., Engedal, K., & Helvik, A.-S. (2015). Use and misuse of alcohol and psychotropic drugs among older people: Is that an issue when services are planned for and implemented? Scandinavian Journal of Caring Sciences, 29(2), 325–332.

Jyrkämä, J. (2008). Toimijuus, ikääntyminen ja arkielämä – hahmottelu teoreettis-metodologiseksi viitekehykseksi [Agency, ageing and everyday life – a theoretical and methodological frame of reference]. Gerontologia, 22, 190–203.

Jyrkämä, J., & Haapamäki, L. (2008). Äldre och alkohol. Nordisk forskning och diskussion [Old people and alcohol. Nordic studies and debates]. NAD-publikation 52/2008.

Koivula, R. (2013). Muistisairaan ihmisen omaisen terveyskeskuksen pitkäaikais-osastolla – tutkimus toimijuudesta [Being a family caregiver of a person with dementia on a long-term care ward. A study on agency]. Research 108/2013. Terveyden ja hyvinvoinnin laitos. Tampere: Juvenes Print.

Kuerbis, A. N., Yuan, S. E., Borok, J., LeFevre, P. M., Kim, G. S., Lum, D., Ramirez, K. D., Liao, D. H., & Moore, A. A. (2015). Testing the initial efficacy of a mailed screening and brief feedback intervention to reduce at-risk drinking in middle-aged and older adults: The comorbidity alcohol risk...
evaluation study. *Journal of the American Geriatrics Society*, 63(2), 321–326.
Kurzthaler, I., Wambacher, M., Gosler, K., Sperner, G., Sperner-Unterweger, B., Haidekker, A., Pavlic, M., Kemmler, G., & Fleischhacker, W.W. (2005). Alcohol and benzodiazepines in falls: An epidemiological view. *Drug and Alcohol Dependence*, 79(2), 225–230.
Levy Merrick, E. S., Hodgkin, D., Garnick, D. W., Horgan, C. M., Panas, L., Ryan, M., Blow, F. C., & Saitz, R. (2011). Older adults’ inpatient and emergency department utilization for ambulatory-care-sensitive conditions: Relationship with alcohol consumption. *Journal of Aging and Health*, 23(1), 86–111.
McEvoy, L. K., Kritz-Silverstein, D., Barret-Connor, E., Bergstrom, J., & Laughlin, G. A. (2013). Changes in alcohol intake and their relationship with health status over a 24-year follow-up period in community-dwelling older adults. *Journal of the American Geriatrics Society*, 61(8), 1303–1308.
Morin, J., Wiktorsson, S., Marlow, T., Olesen, P. J., Skoog, I., & Waern, M. (2013). Alcohol use disorder in elderly suicide attempters: A comparison study. *The American Journal of Geriatric Psychiatry*, 21(2), 196–203.
Noro, A., Mäkelä, M., Vilkkö, A. & Väyrynen, R. (2016). *Ikäihmisten palvelut* [Services for old people]. In Kuntatalouden ja hallinnnon neuvottelukunta, Peruspalvelujen tila-raportti 2016, osa II. Valtiovarainministeriön julkaisuja 9/2016, p. 105–117.
Quality (2013). *Laatusuositus hyvän ikääntymisen turvaamiseksi ja palvelujen parantamiseksi* [Quality recommendation for services for older people]. Ministry of Social Affairs and Health, Publications 2013:11. Retrieved from http://urn.fi/URN:ISBN:978-952-00-3415-3
Rakshi, M., Wilson, I., Burrow, S., & Holland, M. (2011). How can older people’s mental health services in the UK respond to the escalating prevalence of alcohol misuse among older adults? *Advances in Dual Diagnosis*, 4(1), 17–27.
Ryan, M., Merrick, E. L., Hodgkin, D., Horgan, Co. M., Garnick, D. W., Panas, L., Ritter, G., Blow, F. C., & Saitz, R. (2013): Drinking patterns of older adults with chronic medical conditions. *Journal of General Internal Medicine*, 28(10), 1326–1332.
Schorndorf, L., Hazlett, R. W., Hedegock, D. K., Duchene, D. M., Burns, L. V., & Gum, A. M. (2014). Screening, brief intervention, and referral to treatment for older adults with substance misuse. *American Journal of Public Health*, 105(1) 205–211.
Sorock, G. S., Chen, I.-H., Gonzalez, S. R., & Baker, S. P. (2006). Alcohol-drinking history and fatal injury in older adults. *Alcohol*, 40(3), 193–199.
Statistics Finland (2015): Causes of death. Helsinki. http://www.stat.fi/til/ksyyt/2014/ksyyt_2014_2015-12-30_kat_004_en.html
St. John, P. D., Montgomery, P. R., & Tyas, S. L. (2009). Alcohol misuse, gender and depressive symptoms in community-dwelling seniors. *International Journal of Geriatric Psychiatry*, 24(4), 369–375.
Tait, R. J., French, D. J., Burns, R., & Anstey, K. J. (2012). Alcohol use and depression from middle age to the oldest old: Gender is more important than age. *International Psychogeriatrics*, 24(8), 1275–1283.
Vilkko, A., Finne-Soveri, H., Sohman, B., Noro, A., & Jokinen, S. (2013). Kotona asuvan ikäihmisen kohtuutta runsaampi alkoholinkäyttö ja omaisen hoivavastuu [At-risk alcohol use among older persons living at home and family members’ care responsibilities]. In K. Warpenius, M. Holmila, & C. Tigerstedt (Eds.), *Alkoholi- ja päihdehaitat läheisille, muille ihmisille ja yhteiskunnalle* (pp. 63–77). Tampere: Terveyden ja hyvinvoinnin laitos.
Vilkko, A., Sulander, T., Laitalainen, E., & Finne-Soveri, H. (2010). Miten iäkkäät suomalaiset juovat? [How do old Finns drink?] In P. Mäkelä, H. Mustonen, & C. Tigerstedt (Eds.), *Suomi juo. Suomalaisten alkoholinkäyttö ja sen muutokset 1968–2008* (pp. 142–153). Tampere: Terveyden ja hyvinvoinnin laitos.
Wallace, C., Black, D. J., & Fothergill, A. (2010). Integrated assessment of older adults who misuse alcohol. *Nursing Standard*, 24(33), 51–57.
Wang, X., Steier, J. B., & Gallo, W. T. (2014).
The effect of retirement on alcohol consumption: Results from the US health and retirement study. *European Journal of Public Health, 24*(3), 485–489.

Woodruff, S. I., Clapp, J. D., Sisneros, D., Clapp, E., McCabe, C., & DiCiccio, R. (2009). Alcohol use risk levels among older patients screened in emergency departments in southern California. *Journal of Applied Gerontology, 28*(5), 649–660.

Zantinge, E. M., Van Den Berg, M., Smit, H. A., & Picavet, S. J. (2013). Retirement and a healthy lifestyle: Opportunity or pitfall? A narrative review of the literature. *European Journal of Public Health, 24*(3), 433–439.