



'Wet' care homes for older people with refractory alcohol problems: A qualitative study

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Opinions and recommendations expressed in this report are those of the authors.

¹ Drink Wise, Age Well is a Big Lottery funded UK-wide programme to reduce alcohol-related harm in people aged 50 and over. More information can be found at drinkwiseagewell.org.uk

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EXECUTIVE SUMMARY

This study describes a registered care home in England and a registered nursing home in Norway which provide permanent care for alcohol-dependent older people who are unable or unwilling to stop drinking and cannot maintain an adequate standard of self-care and/or live independently. Prior to admission, most residents have been living unsafely in their own home or were homeless. They have high levels of contact with health, social and criminal justice services and complex needs as a result of mental illness, poor physical health and physical disabilities. Most have lost contact with their families.

The homes strive to stabilise drinking, physical and mental health and improve quality of life. They are based on a harm reduction philosophy, that is, they focus on strategies to reduce harm from high-risk alcohol use, rather than insisting on abstinence. Residents can drink as much alcohol as they want on the premises but staff encourage them to drink less and in a less harmful way (e.g. spreading drinking throughout the day and having 'dry' days). Following admission, drinking usually becomes more controlled and some residents become abstinent whilst others become stable enough to move on to detox and community alcohol treatment.

Primary health care is available on-site either in the form of medical staff based in the home (the nursing home in Norway) or by regular visits from professionals e.g. a GP, district nurse, community psychiatric nurse, dentist, chiropodist, optician, dietician and physiotherapist (the care home in England). This, combined with less harmful alcohol consumption, regular health checks, better medication management and increased compliance with secondary health care usually leads to stabilisation of physical and mental health conditions and better symptom control. The provision of nutritional meals often leads to weight gain and further health improvements. The homes provide 24-hour-a-day assistance with self-care such as bathing, dressing and continence and this can have a positive effect on self-esteem and sense of dignity. Quality of life is enhanced by constancy, daily routines and providing a safe environment where residents have the company of their peers and can engage in social activities. The homes offer palliative care and somewhere to have a peaceful, natural and dignified death.

In the English care home, some residents felt that the home provided a safe refuge and a lifesaving intervention for which they were grateful. However, other residents had been judged to lack capacity under the Mental Capacity Act and their residence was imposed to protect their welfare. The staff had been legally authorised to make decisions on their behalf in their best interests. One resident described the home as being "like a prison" and another resident expressed anger at being "forced" to have a shower once a week. Some residents described being bored and not having much to do whilst staff in both homes said that motivating residents to join and pursue activities was a constant challenge. There were frequent altercations between residents which meant that CCTV had been installed in the communal areas of the home and staff were frequently verbally, racially and physically abused.

Defining and measuring "success" in wet care homes can be difficult. However, suitable outcomes include improved hygiene and nutrition, increased self-esteem, better compliance with healthcare, healthier living which is not entirely alcohol focused and more hope for the future. In the homes we visited, processes were not in place to collect quantitative measures in a way that could provide clear evidence of impact. The care homes are trying to achieve many different types of outcomes and no single outcome instrument exists which will measure them. However, a combination of standard tools administered on admission and at regular intervals thereafter could give a rounded picture across multiple domains. Placement in the homes is expensive but costs may be offset by a reduction in the use of other health, social and criminal justice services.

BACKGROUND

There are 23 million people aged 50 and over in the UK, more than a quarter of a million of whom (265,650) are dependent on alcohol (Wadd et al, paper in preparation). Many alcohol-dependent older people have chronic alcohol problems and they are unable or unwilling to stop drinking. In this report, we use the term 'refractory' to describe this type of alcohol problem. Many older people with refractory alcohol problems reach a point where, as a result of deteriorating mental and physical health, limited social support and reduced mobility, they become unable to care for themselves and may require permanent residential care. They have a right to live their final years being cared for in a home which can provide them with a place of safety, comfort and dignity. However, older people with refractory alcohol problems are often difficult to place in mainstream care homes and are unable to live according to the expectations and demands of these homes. They tend to be younger than residents of mainstream care homes, have different social and physical needs, do not meet the social norms and can cause conflict within the home.

In England, there are approximately 13,130 residential care homes (Davies *et al.*, 2014). By the year 2034, more than double the number of existing care homes will be required to meet the needs of the rapidly growing population of older people (Macdonald & Cooper, 2007). As the population of older people grows, the number of older people with refractory alcohol problems is also likely to increase. Therefore, there is likely to be a growing demand for residential care homes which provide specialist care for older people with refractory alcohol problems. This study describes two specialist care homes, one a registered care home in England and the other, a registered nursing home² in Norway. Both provide care specifically for people with refractory alcohol problems including a full personal care service. Residents have usually been homeless or living in an unsafe way at home prior to admission. The care homes are 'wet' services because residents are allowed to drink as much as they want on the premises but residents are encouraged to reduce their drinking or drink in a less harmful way. Wet care homes are based on a harm reduction philosophy, that is, they focus on strategies to reduce harm from high-risk alcohol use, rather than insisting on abstinence.

To our knowledge, there are only a very small number of wet care homes around the world. However, a number of housing solutions based on a harm reduction model have been developed for homeless people with refractory alcohol problems who don't require a high level of care. For example, wet hostels are transitional housing for the chronically homeless, usually street drinkers, where residents can either bring alcohol into the hostel themselves and drink it inside or, in the case of managed alcohol programmes, staff provide a regulated amount of alcohol to stabilise drinking. An example of this is a managed alcohol programme in Ottawa where the doctor determines the level of dosing which usually ranges from 5 to 7 oz. of alcohol an hour (McIntyre, 2009). Whilst a level of personal care is provided, it is not as extensive as that in wet care homes. An evaluation of the programme in Ottawa

² Nursing homes are the same as residential care homes but they have registered nurses who can provide care for more complex health needs.

showed that emergency department visits and police encounters decreased, participants reported less alcohol consumption and participants and staff reported improved health, hygiene and compliance with medical care (Podymow *et al.*, 2006).

Another example is “Housing First” which offers permanent housing ‘first’ allowing a client’s problems with alcohol and/or drugs and complex needs to be worked on (if the client wishes) after securing a permanent residence. The type of housing varies but includes scattered site bedsits with an assertive community treatment team available, to a purpose built building with on-site services including a health clinic and mental health treatment (Kertesz *et al.*, 2009). One Housing First programme in San Francisco includes a licensed residential care facility with nursing service. A systematic review of 184 publications on Housing First (Raitakari & Juhila, 2015) concluded that Housing First generates cost savings, increases wellbeing and is an effective route out of homelessness. However, a three-year evaluation for Scotland’s Turning Point Housing First showed that whilst there was an overall reduction in dependence on illicit drugs, there was little observable change in alcohol dependency (Johnsen, 2013).

Interestingly, a review of treatment and care of older illicit drug users in Europe (EMCDDA, 2010), identified a number of care facilities for older people with refractory drug problems. The early projects were developed as pilot projects in the late 1990s in the Netherlands and Germany. The Dutch facility was part of an existing retirement home and catered for older drug users who were no longer able to look after themselves. Older drug users lived in 24-hour supervised accommodation, where the aims included helping them to learn and maintain living skills, manage their income, monitor medicine use, engage in activities and follow a daily routine. The main goal was to help drug users live out their final years in comfort and dignity. While residents were encouraged to reduce their drug use, consumption was not prohibited. The services provided within the German project comprised long-term residential care for older drug users and “ambulatory forms of assisted living”. Housed in living communities, older drug users could make use of outpatient drug treatment services and “elder care”. It was up to the project leader to decide on a case-by-case basis whether the services should be primarily geared to the need of the treatment of dependence or to aspects of nursing care. The review also identified a series of ‘alternative nursing homes’ which have been established throughout Denmark. The homes are intended for “persons who, due to considerable and permanent physical and mental impairment of functions, need extensive help in ordinary, daily functions or care, nursing or treatment and who cannot get these needs covered in any other manner”.

In this report, we describe the models developed by two wet care homes in England and Norway and the characteristics of their residents. The research questions were:

1. What are the harm reduction services offered by each care home?
2. What are residents’, families’ and staff members’ experiences of these services?
3. What are suitable outcomes for wet care homes?
4. How might these outcomes be measured?

METHOD

Identification and recruitment of homes

We used our knowledge of care services for older people with alcohol problems to identify two care homes in England, both of which agreed to participate in the study.

Our criteria for wet care homes were:

- Designed specifically for people with refractory alcohol problems.
- Aim to reduce harm associated with heavy drinking without necessarily requiring abstinence or greatly reduced drinking.
- Allow residents to drink as much alcohol as they want on the premises but may encourage a reduction in drinking or drinking in a less harmful way.
- Provide a full on-site personal care service.
- Homelessness is not an essential criterion for admission.

Just as we were about to start data collection, one of the wet care homes in England closed. As an alternative, we recruited a wet care home in Norway that fulfilled the criteria described above.

Approach

This study was based on Appreciative Inquiry (Reed, 2007). Appreciative Inquiry focuses on the root causes of what works, why it works and how it works rather than focusing on problems. We adopted this approach because we were conscious that care home staff may have feared that researchers were evaluating their professional performance.

We undertook observation in order to gain a more holistic understanding of the situation being studied. Another advantage of this approach is that it can reveal phenomena that participants may be unaware of or unwilling to discuss in interviews or focus groups (DeWalt & DeWalt, 2002).

The study design was based on best practice guidance on conducting research in care homes (Luff *et al.*, 2011; ENRICH, 2017).

The key recommendations from these sources include:

- Use a practitioner-researcher who has a working background in social or health care to collect the data.
- Avoid rigid data collection designs based on the researchers' needs. Instead allow for an 'emergent design' based on the requirements within each care home and in consultation with care staff.
- Take time to get to know staff and residents at a personal level to ensure that people feel comfortable to participate and are willing to share their time and energy.

- Ensure that seeking informed consent from residents is a continuous process of information provision and negotiation.
- View care homes as researcher-partners as opposed to the research 'object'.

The researcher who collected data in the home in England came from a counselling background and the researcher who collected data in the Norway home was previously a social worker.

The researcher responsible for collecting data in the care home in England spent two weeks in the home familiarising herself with the home and residents prior to any data collection. She consulted with the manager, staff and residents to identify the most acceptable way to collect the data, taking into account the rhythms and norms of the home. The researcher who collected data in the Norway care home was only able to visit the home for one day.

Consent

Hall et al. (2009) have highlighted the complexities and time needed to seek consent from care home residents for reasons that include communication problems, physical and cognitive frailty and/or emotional vulnerability and health impairments. A further challenge in this study was that there were periods of time when some residents were intoxicated. We adopted the five stage consent model described by Dewing (2002, 2007):

Stage 1: Background and preparation

Stage 2: Establishing the basis for capacity to consent

Stage 3: Initial consent

Stage 4: Ongoing consent monitoring

Stage 5: Feedback and support

Residents were only invited to take part in the study if the staff felt this was appropriate and that the individual had decisional capacity.

Residents and staff were offered different levels of consent; for example they could consent to be observed within public areas but opt out of a formal involvement in interviews or focus groups.

Privacy

Issues of privacy and space are important in care homes (Brown-Wilson, 2007). Researchers respected the privacy of research participants by ensuring that observations were limited to communal living areas and public spaces.

Anonymity

We assured participants and staff that it would not be possible to identify individual participants (residents or staff) or the care homes from the outputs of this study.

Data collection

Data collection in the wet care home in England comprised:

- 11 one-to-one, semi-structured interviews, with two female and nine male residents ranging in age from 50-86.
- One-to-one interviews with the team manager and doctor attached to the care home.
- Two focus groups with staff.
- Observations of verbal exchanges, experiences and routines in communal areas.
- Field notes taken during staff rounds.
- Document analysis e.g. selection and allocation policy, care plans for individual residents.

We were unable to secure any interviews with family members.

Data were collected over a period of three weeks. At the end of the data collection period, we held an afternoon tea to thank residents and staff.

All interviews were audio-recorded (with permission) and transcribed verbatim before being coded.

Data collection in the Norway home comprised a day visit where the researcher shadowed the doctor on rounds and met with the staff team to discuss the care provided.

Data analysis

Analysis followed the National Centre for Social Research 'Framework' approach, involving a structured process of sifting, charting and sorting material according to key issues (Ritchie & Spencer, 1994). Recurring themes and concepts were identified to make up a thematic framework or index which was then systematically applied to the transcripts. From these commonalities, themes emerged. Data were analysed by two researchers separately for theme identification, and then compared for accuracy. When researchers reached the same conclusions, greater validity was ascribed to these findings. Few discrepancies emerged and where they did, consensus was negotiated.

Ethical approval

Ethical approval was obtained from University of Bedfordshire and the Institute of Applied Social Research ethics committee.

RESULTS

Care Home in England

Overview

The primary goals of the home are to achieve stability, increase the residents' self-esteem and improve overall quality of life.

The home provides care for up to 26 men and women who have refractory alcohol problems together with complex mental and physical health needs and who are unable to maintain an adequate standard of self-care and/or live independently. At the time we carried out the research, the home did not provide nursing care but they were introducing on-site nurses from August 2017. There is no maximum length of stay and many residents stay in the home until the end of their lives. Whilst the majority of residents had a history of sleeping rough this is not an essential criterion for admission. Individuals are not accepted if they are currently using illicit drugs.

The home is located in a residential area and the local community opposed it when it was first established (McIntyre, 2009). This resistance was overcome by staff explaining the nature of the home and its services to those concerned, and by focusing on the fact that, since residents would be allowed to drink alcohol indoors, they would not be drinking outside the home. Since the home was established 15 years ago there have been very few complaints.

Residents are free to come and go and have 24-hours access via an intercom. Visitors are permitted between the hours of 9am to 7pm. Overnight stay of visitors can be arranged by prior agreement with staff.

Facilities, amenities and diversionary activities

Residents have their own single room with a wash basin but they share toilet and bathroom facilities. Amenities include two lounges, a games room, one large kitchen for residents' use, a garden and allotment.

There is an activities timetable that includes a discussion group, shiatsu massage, cinema trips and IT computer class. Day trips are organised.

Staffing

Three members of care staff work each shift, all of whom are registered to provide personal care therefore care is available 24 hours a day. A personal recovery assistant works 9am-5pm each day. The service manager works Monday to Friday 9am to 5pm but there is a senior management on-call system for crisis, incidents and coaching. There is a full time domestic staff member and a chef who works between 8am-3pm. Additional domestic and chef cover is provided at the weekends.

Support and services provided

Staff can provide assistance with activities of daily living such as bathing, dressing, walking and continence. They also help residents with instrumental activities of daily living such as managing finances, shopping and managing medication. Full board is provided. Lunch and dinner are prepared, breakfast is self-catering.

A keyworker is a member of staff who is responsible for planning that resident's care and liaising with family members. Each keyworker provides support to two to three residents and monitors their progress and wellbeing. A GP, district nurse and community psychiatric nurse visit the home on a regular basis. The GP visits for half a day once a week but if a resident's health deteriorates between the GP's visits, she can easily be contacted for advice. A dentist, chiropodist, optician, dietician, physiotherapist and massage therapist also pay regular visits.

Staff observe residents four times throughout the night by entering their rooms. Some residents do not want staff to enter their rooms and have an agreement in place for staff not to disturb them during the night. However, this is overridden if there are concerns about a resident, for example after an incident or seizure.

Residents have a locked medicine box in their bedroom. Staff have keys to unlock the medicine boxes at medication times and administer medication to residents or observe residents who self-administer medication.

Staff monitor and record each resident's food intake during meal times. This is to highlight concerns with nutrition. If staff are concerned about a resident's nutritional needs, they present the food record to the GP for further advice. The GP is then able to refer to a nutritionist if required.

Alcohol policy

Residents can purchase alcohol independently, or staff can purchase it for them if they are unable to purchase it themselves. When we were collecting data, staff managed residents' money as a means of controlling drinking. Useable funds were agreed between the residents and their care coordinators once the cost of their care had been deducted. For most residents, this meant that they only had approximately £30 a week to spend on themselves. Staff gave out a daily allowance rather than giving the residents the full weekly amount to reduce the likelihood of binge drinking. This generally meant that residents could afford one beer each morning, one at lunchtime and one in the evening. However, residents would sometimes beg for money in the nearby park and sell possessions which provide them with extra money to purchase alcohol.

Alcohol use is an accepted part of residents' lifestyle but there is a consistent emphasis on harm reduction, albeit at the individual's pace. Staff try to stabilise residents' drinking, encouraging them to reduce alcohol use or strength of alcohol and change to healthier drinking patterns, for example spreading drinking throughout the day, or having dry days.

Staff attempt to monitor the level of alcohol consumption among residents.

Residents are free to consume alcohol in designated areas of the home, including their own rooms and one of the two lounges which is known as the 'drinking lounge'. They can also gather in each other's rooms to drink. Areas where they are not permitted to consume alcohol include the kitchen, dining room and 'dry' lounge.

Organisational change

Staff reported that they were in a "transitional phase" of organisational change. During the 6 months before we started our data collection, 50% of staff left. The service is changing the focus of care to make it more "recovery focused" around stabilisation and healthy living. Changes are to be introduced to enable residents to have more control over their money and their medication. The home was increasing staffing levels by an additional worker on each shift and a nurse.

Nursing Home in Norway

Overview

This is a separate addiction facility in a 'regular' nursing home. It opened in 2007 and is the only one of its kind in Norway. It has 17 beds for men and women. Admission criteria are the need for permanent care and a history of previous or ongoing alcohol or drug misuse. Individuals for whom a psychiatric diagnosis is the main health problem are not admitted. Residents are usually admitted because they have become unable to live safely in their own home. A review of the home (Vossius *et al.*, 2013) found that "all of them [residents] had a history of longstanding alcohol or drug abuse for several decades. Most of them had started to have a problematic use of alcohol in their late teens or early twenties."

The aims of the facility are to:

- Provide a safe place to live
- Maintain the residents' autonomy as far as possible
- Stabilise the residents' physical and mental state
- Provide a good quality of life

The location of the facility within a regular nursing home raised some concerns at first (Vossius *et al.*, 2011). However, the residents have not been a source of concern for other residents or their families. There haven't been any reports of disorderly conduct, theft or drug dealing. The staff have worked hard to prevent the establishment of a drug culture in the neighbourhood in close dialogue with the local police.

Facilities, amenities and diversionary activities

All rooms are single rooms with adjoining bathrooms. To encourage the residents to socialise instead of isolating themselves in their bedrooms, various activities are initiated by staff and the residents themselves. There is a big TV-screen in the

common room. The facility has its own minibus which is used for weekly shopping trips and other excursions. Individual activities are provided for each resident, based on their interest and need such as visiting friends or family. Some residents also carry out jobs, for example repairing wheelchairs, taking care of poultry in the nursing home garden and walking the dog.

Staffing

Staffing comprises a head nurse and two other nurses, 8.5 assistants and 0.2 FTE doctors. Each resident is assigned a nurse or primary contact.

Support and services provided

Residents' ability to meet their basic personal needs is very low. Support with nutrition, personal hygiene and other activities of daily living is provided. Assistance is also provided with everyday chores such as washing clothes and cleaning their room. Most residents chose to have a legal guardian to help them with their finances. Full board is provided.

Alcohol and drugs policy

Alcohol and drug use is an accepted part of residents' lifestyles although staff encourage residents to reduce their alcohol consumption and drink in a less harmful way (e.g. by spreading drinking throughout the day and reducing the strength of alcohol consumed). Residents can purchase alcohol independently, or staff can provide help where necessary and give out an agreed quota. Alcohol can be consumed in the residents' rooms and in the common room.

Illegal drugs are not allowed in the facility. However, the staff do not search the residents or their rooms and sharps bins and clean needles are provided.

Characteristics of residents

In the care home in England, at the time of data collection there were 20 male and 3 female residents ranging in age from 43-86. A review of the Norway nursing home in 2011 found that between 2006-2009, 31 clients were admitted to the addiction facility, five women and 26 men (Vossius *et al.*, 2013). Mean age at admission was 62 years (range 46-77 years).

The majority of residents in both homes had poor physical and mental health often combined with a history of homelessness. The review of the Norway home found that "the residents' social backgrounds vary widely, from well-functioning families to those who were raised in orphanages. Some residents are wealthy, while others have lived on welfare. Some have been homeless while others come from independent residency."

In the care home in England:

- Many residents had been living rough or moving between hostels prior to admission. Some residents arrive from hospital following injuries from falls or accidents.
- Prior to placement, most had been frequent users of health, social and criminal justice services such as A&E, emergency ambulances, homeless shelters, police callouts, and social care services.
- Many have mobility difficulties, requiring a wheelchair or walking frame. Falls and accidents are common.
- Mental health issues experienced by residents include schizophrenia, suicidal ideation, self-harm, depression, bipolar disorder and panic attacks. Two residents were on hourly checks because of suicidal ideation when we were collecting data.
- Resident's mental capacity often fluctuated due to their alcohol consumption
- Many residents had been through alcohol treatment and detox many times. Some were the subject of Community Treatment Orders.³
- Some residents present with antisocial behaviour and a history of Antisocial Behaviour Orders.

Most residents from the homes have lost contact with family members although some maintain minimal contact. Physical health problems such as stroke, cancer, liver disease/failure and epilepsy are common. Some residents are doubly incontinent. Many have cognitive impairment or Korsakoff syndrome.

Residents of the Norway home were described as a “fringe group that are beyond the scope of rehabilitation and re-integration into a normal social life combined with a relatively short life expectancy” (Vossius et al., 2013).

Interviews with residents and staff

Safety and security

Prior to moving into the care home, participants often lived chaotic and risky lives. In particular, they described their lifestyle on the streets, in hostels or emergency shelters as being hostile, high risk environments that posed a danger to personal safety.

“I was drinking a lot; I couldn't be bothered cooking or eating.... I lost my flat, I got a panic attack crossing over the road and I was knocked down by a car.” (Anne)

“Up in the hostel, they were drinking heavily and taking drugs... they were robbing each other,didn't have a key to the living room and anybody could come into your room cos you didn't have no locks on the doors...so I lost everything because of that.” (George)

³ Community Treatment Orders means that individuals have to keep certain conditions for example not calling emergency services repeatedly.

Interview narratives revealed how the wet care home provided a safe refuge from violence, threats and assaults.

"I was living in [a residence]... full of crack heads, druggies, and they used to come to my room and keep me awake, knocking on the door, one o'clock, two o'clock, three o'clock, four o'clock in the morning, and banging on my door. Give me a cigarette you [expletive]. I want it for crack. And there's none of that in here...."
(Jamie)

"Yeah I don't want to go back there again, I'm too old for the streets, it's dangerous."
(George)

Staff in the home in England said that there were frequent altercations between residents, and staff were often abused verbally, racially and sometimes physically. However, they tried not to evict residents because they were aware that for many residents, the only alternative would be a life on the streets. The home had recently installed CCTV in response to resident-on-resident assaults. This ensured that staff could monitor clients in communal areas and there was a sense that this promoted resident safety.

Health

Staff reported that residents' use of emergency health, social and criminal justice services usually reduced after placement and physical health usually improved. In the Norway care home, the doctor observed that the routine in the home, including cooked nutritious meals, meant that residents gained weight and their overall health stabilised.

The manager of the UK home said; "in terms of their physical health issues, if they were on the streets, half of the service users would have been dead a long time ago." A participant also expressed the view that if he hadn't moved to the care home, he may have died:

"I was in a bad way...mostly down to the drink...health wise, I had cancer of the mouth, of my tongue and they took a bit of my tongue away and that what started off the epilepsy which isn't very nice either and... only for them [the care home] I'd have been gone." (Mike)

As well as helping with medication, medical staff were in a position to shift from reacting to mental and physical health crises to proactive health care. Residents had regular "check-ups" and staff would accompany residents to hospital appointments. Doctors from both the homes reported stabilisation of liver function in residents who had liver disease.

Providing primary care services on-site was considered to be very valuable. The GP observed:

"If they were living independently, I would anticipate that 80-90%, possibly more of the primary care contact would not happen.... I think as they get to know the staff

here and get to know me, they feel more able to access healthcare if they need it, I think it's particularly helpful that I get to know them because even if it's something quite minor, they know that they've got an easy opportunity to ask about things or to bring up issues they might not otherwise have mentioned."

Having professionals who developed expertise in working with this client group was also beneficial. The physiotherapist told us that residents were unable to undertake the strength and balance programme to help reduce risk of falls which she would normally use with clients in the community. This was because residents in the home tended to have "ataxic gait" due to their history of heavy drinking⁴. She was able to develop a way of working that took account of their ataxia.

Palliative care was provided in both homes. The doctor from the Norway home remarked that they were in a position to give residents some dignity in how they died and described how they had recently been able to ensure that "a resident had the death he wanted." The GP from the English home said:

"We have certainly had very good outcomes with palliative care patients here recently, some patients who've had advanced cancer, have been able to be well supported by the palliative care team in conjunction with [staff from care home] and had excellent end of life care as well."

Alcohol use

Residents' alcohol use generally became less risky when they moved into the care home. They often drank less, spread their drinking throughout the day, had dry days and changed to drinking alcohol with a lower concentration. One resident told us.

"I've had a lot of change in my drinking. I used to drink every day from morning to evening... I've changed a hell of a lot from drinking...the staff they keep my drink in their office...because if I keep it upstairs [in bedroom] I can't stop". (Daniel)

The home's doctor described the impact that the care home could have on residents' drinking.

"I think just in terms of their general wellbeing, they seem to benefit from the stable daily routine here, from consistent encouragement to cut down on the drinking, if possible and also smoking actually, we've had a good success, somebody's managed to convert to electronic cigarettes from standard cigarettes and also a couple of patients here, who now consistently drink either nothing or only a very small amount and I think this environment really facilitates that, I think if they were in a less supportive environment, they probably would be drinking more."

Some residents become abstinent and others become stable enough to move on to detox and community alcohol treatment.

⁴ Symptoms of ataxic gait are lack of proper coordination, unsteady gait with a potential to stumble and fall, frequent falling episodes and lack of muscle coordination in the legs. Ataxia is common in people with chronic alcohol problems.

Choice, control and autonomy

In England, the Mental Capacity Act (Department of Health, 2005) provides a legal framework to making particular decisions on behalf of people who may lack the mental capacity to do so themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

A small number of residents in the care home in England had Deprivation of Liberty Orders. Some of these individuals resented being in the care home because they wanted to live independently. One participant said; "I was sent here...against my will" and another described the home as being "like a prison". These residents felt that they had little personal autonomy – one resident expressed anger at being "forced to have a shower" once a week.

The homes often have to strike a difficult balance between ensuring rights to autonomy and at the same time ensuring residents' safety and welfare. A physiotherapist from the home in England described one resident whose alcohol consumption had declined when he was unable to leave the home but now that he had a mobility scooter he had started buying himself an extra bottle of Southern Comfort. This made the physiotherapist uncomfortable but she acknowledged that she had to respect his life choices.

For some residents, a source of conflict was the management of money by staff as a means to regulate drinking.

"I feel like a boy scout queuing up" [for his daily allowance of money for alcohol and tobacco.] (Jamie)

"They never told me about the rules when I come here, I just come here, they never told me they'd give me £10 a day pocket money, I feel like a kid, insulted by £10 a day pocket money." (George)

Others saw the benefits of this approach.

"I used to have my money but now they hold onto it and they get my lagers for me...or they come with me and I think I like it better, they don't make a big thing of it", (Anne)

"The thing which annoys me is the money situation but I think the parties withholding it from me would know I'd probably get wiffly woo if I had a lot of money...If I had it outside I would have drunk it. Not on and on and on forever and a day but I would have probably had another because it was there." (Daniel)

The home was about to trial a new system for managing residents' money allowing those with capacity to have full control of their own money. It is not clear what the impact of this change will be on levels of alcohol consumption (particularly binge drinking) but the management envisaged that increased staffing levels and activities would help to reduce any negative impact.

Social and diversionary activities

Providing social and diversionary activities is important because they can provide a diversion from drinking and promote social interaction and integration. Activities may have a positive impact on mental functioning, concentration and physical coordination.

Staff in the care home in England told us that there were regular activities organised. However, residents felt that there was a lack of activities. Participants variously said "I'm not unhappy, just dreadfully bored"; "there's nothing much to do"; "I'm stuck here in my room...[they] don't do that anymore (holidays), and they used to have karaoke and things. They've cut those out as well."

However, staff from both homes said that motivating the residents to join and pursue these activities was a constant challenge. Staff in the home in England had recently made changes to the service to ensure that activities were identified that motivated the individual.

Outcomes

Staff from both homes agreed that how "success" is defined is individualised and unique to each resident. The doctor from the Norway home described a goal as "absence of problems" for example a decrease in A&E attendances and crisis driven hospitalisation. She felt that small steps constituted success.

A member of the staff from the home in England said:

"For me it would be around the health of the service user. I mean if we take someone like [name of resident], we wouldn't really expect her, for example, to move and acquire new skills to go on and lead a more active life, and or get involved in new employment [the resident was approaching pensionable age]. No. So that's really about health. So for us it's for her to stay in a safe environment and then for us to ensure that we support her to eat and nutrition and things are taken care of, if she gets ill, for us to support her to go for treatment. So those are the sort of outcomes we'll be looking for."

The GP from the home in England described "success" as:

"I think a sense of wellbeing and contentment on the part of the client, a reduction in hospital admission and overall, a stability in health conditions, particularly chronic conditions such as minimisation of liver disease, optimisation of COPD [chronic obstructive pulmonary disease] and support in all aspects of their care including the

ability to access healthcare if they want it, support with taking medication, support with symptom control”.

Staff from both homes observed that it was difficult to measure “success” in the care homes. They felt that standard tools don’t necessarily measure what these homes want to measure, this includes ‘non-events’ such as fewer A&E attendances and arrests.

At present neither home has a process in place to collect quantitative measures in a way that could provide clear evidence of impact and which is sufficient for full economic analysis. For example, neither home administers standard tools on admission and again after a period of time in the home to see whether outcomes have improved, nor do they collect data on use of health, social and criminal justice services prior to and after admission.

DISCUSSION

This study describes two residential care homes, a registered care home in England and a registered nursing home in Norway. These care homes are for people with refractory alcohol problems who require assistance with self-care and/or are unable to live independently. Residents are difficult to place and their needs cannot be met adequately in mainstream care homes. They have complex physical and mental health needs, many have cognitive impairment and Korsakoff's syndrome, issues with continence and limited mobility. Some residents' behaviour can be challenging, particularly if they become intoxicated. If the residents weren't in the homes, they would most likely be trying to 'survive' in a risky way at home, on the streets or in temporary accommodation for the homeless and they would be heavy consumers of emergency health, social and criminal justice services.

The care homes in this study offer a level and type of care that is not available elsewhere, that is, a home for life where abstinence or greatly reduced drinking is not required (but is encouraged) and assistance with activities of daily living (e.g. bathing, dressing and continence) and instrumental activities of daily living (e.g. shopping, managing finances and medications) can be provided. Primary physical and mental health care is available on-site either in the form of regular visits by practitioners (e.g. a GP who visits the English care home for half a day a week) or by staff based in the home (nursing staff in the Norway nursing home).

Residents are allowed to drink as much as they want to on the premises, in other words, these homes are a 'wet' service. Critics of wet services voice concerns that they enable ongoing alcohol dependence and that premises become akin to some sort of 'doss house' (McIntyre S, 2009). One critic wrote that "if [they] do not have the capacity to stabilise their tenants and offer them genuine recovery and rehabilitation opportunities, then these programmes become entrapping ghettos, in effect entrenching the person in enclaves where all manner of behaviour is permissible (and soon learned), no hope or expectations are in place, and no genuine opportunities for change are offered" (Triage, 2007). The image that this description conjures up is very far from the care homes that we visited. These care homes are not a 'free-for-all' environment. Whilst they might not insist on a reduction in alcohol use, the homes do encourage residents to reduce their drinking or to drink in a less harmful way. Residents' alcohol use often stabilises in the homes, some residents become abstinent and others move on to detox and then treatment in the community.

Not only is alcohol use stabilised, but staff report that mental and physical health often becomes more stable too. Providing on-site primary health care, ensuring that medicines are taken as directed and assisting attendance at secondary care appointments can result in a shift from physical and mental health crises to proactive management of health issues. Providing assistance with self-care can improve self-esteem and sense of dignity. Prior to entering the home many residents have poor diets, partly because they spent most of their money on alcohol rather than food, and partly because people with chronic alcohol problems are prone to health problems which affect their appetite and digestion. A thiamine deficiency in people with chronic alcohol problems is one factor underlying alcohol-related brain

damage. Therefore, when residents enter the home and begin eating regular, nutritious meals this can also contribute to health improvements. Quality of life and wellbeing is enhanced by constancy, daily routines and providing a relatively safe environment where residents have the company of their peers and can engage in social activities. For residents approaching the end of life, the homes offer palliative care and somewhere to have a peaceful and dignified death.

However, it would be wrong to paint an entirely rosy picture of these homes. In the care home in England, there were frequent altercations between residents which meant that CCTV had been installed in communal areas for the residents' safety and staff were frequently verbally, racially and physically abused. Some residents described being "bored" and not having much to do whilst staff in both homes described motivating residents to join and pursue activities as a constant challenge. Whilst some residents in the English care home were happy to be there, others had been judged to lack capacity under the Mental Capacity Act and their residence in the care home was imposed to protect their welfare. They were not free to leave and one resident described the home as being "like a prison". Another resident expressed anger at being "forced" to have a shower once a week. Staff managed residents' money as a means to regulate drinking and this often caused conflict between residents and staff.

A significant difficulty for wet care homes is that it can be difficult to define and measure 'success' for their residents. At the individual level, 'success' is unique to each resident, depending on their goals and aspirations. The care home in England used the Alcohol Outcome Star (Burns *et al.*, 2008) to measure the degree of progress or goal attainment that has occurred. The star has ten outcome areas: alcohol use, drug use, physical health, meaningful use of time, community engagement, emotional health, accommodation, money, offending and family/relationships.

We suggest that suitable outcomes for residents of wet care homes at the individual level could include:

- Increased safety – physical, social and psychological
- Improved hygiene and nutrition
- Compliance with healthcare, stabilisation of physical and mental health conditions and symptom control
- A transition from reactive to proactive health care e.g. regular health appointments
- Feeling/being 'settled' – a sense of belonging
- Increased self-esteem and respect for others
- Small steps to better manage addiction, own personal care, medication and money
- Experience of and engagement in fuller, healthier living which is not entirely alcohol-focused – leading a more "normal" life
- Having aspirations, hope for the future, being empowered and less stigmatised
- Increased involvement in society
- Improved relationships with family and friends

Measuring outcomes is not only important to evidence individual client change but also because outcomes can help determine whether the service is working well and whether it could be improved. Local authority budget holders are more likely to fund places if there is clear evidence that the homes have positive impact, not only on the resident, but also on their use of health, social and criminal justice services. However, neither home currently collects quantitative measuring in a way that that could provide clear evidence of impact or which allows full economic analysis to demonstrate to what extent the cost of the homes is offset by reduced use of other services. A combination of standard tools administered on admission and at regular intervals thereafter will give a rounded picture across multiple domains. We suggest that the following may be appropriate and realistic measures of impact for wet care homes:

Alcohol

Number of days consumed alcohol in last week
Average number of units consumed on a typical day
Strength of alcohol consumed on a typical day
Severity of Alcohol Dependence Questionnaire (SADQ) (Stockwell *et al.*, 1994)

Mental and Physical Health

Patient health questionnaire (PHQ-9) for depression (Kroenke *et al.*, 2001)
Generalised Anxiety Disorder 7 (GAD-7) scale (Spitzer *et al.*, 2006)
Short Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) (Tennant *et al.*, 2007)
SF-12 health survey (Ware *et al.*, 1996)

Life Skills

Questions from The Life Skills Profile (Rosen *et al.*, 1989)

Health and social care

Times visited accident and emergency department in past six months
Nights spent in hospital as an inpatient in past six months
Nights spent in a hostel for the homeless or emergency housing in past six months
How many times taken to hospital in an emergency ambulance in past six months

Criminal Justice Outcomes

Police callouts in past six months
Detentions and custody stays in past six months

To conclude, wet care homes provide a vital role in providing people with refractory alcohol problems and complex needs with a relatively safe home for life which promotes controlled and less risky drinking and healthier and more stable lifestyles. Whilst placement in a wet care home is expensive, the needs of this group are not being satisfied in other ways and admission may reduce the use of other health, social and criminal justice services. As the population ages, there is likely to be

increased demand for this type of care. Wet care homes should consider using a combination of standard tools to provide evidence of impact. In view of the costs of the service, the benefit to individuals' wellbeing and potential savings to other services, future research and service monitoring should include economic analysis. Since writing this report, the English care home has noted our recommendations and intends to adopt the impact measures suggested.

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