Managed Alcohol:

10 Years of Learning

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Overview

- History of the program
- What we knew when we started, the myths and expectations
- The evolution of the program
- The research and the reality of day to day life
- The present and the future-more to learn

And in the Beginning. .

- 1998 presence of street alcoholics significant "public nuisance" issue
- EMS and justice costs
- Impact on business and neighbors
- Human suffering and death

- Community planning initiative
- The “Eugene” story
- Seaton House experience
- Planning committee which included all concerned (ie BIA, police, health and social services)

What We Thought We Knew!

We Understood. .. .

Compulsive nature of alcohol addiction

Entrenchment in street culture

Lack of social skills and loss of connection to family

Risks associated with lifestyle

Loss of hope or expectation for a better life

We Did Not Understand

- Value placed on alcohol
- Prevalence of SMI
- Lack of basic life skills including literacy
- Cognitive impairments, dementia etc
- Potential for change and learning
- Process of recovery from homelessness

How Did We Start?

- 10 of the most difficult street alcoholics + 2 staff
- One room where everyone lived, ate and argued
- 5 oz of home made wine on the hour
- Low expectations in terms of behavior

- Slept in crowded room with people not in the program on the floor when the shelter was full (always)
- But they had their own bed, regular alcohol, health care and a sense of community so. . .

Expectations?

What We Expected?

- To be able to keep them safer
- To be able to reduce "public nuisance"
- To reduce use of EMS and police calls for service
- To provide care for physical health problems

What They Expected?

- Not much. … . It was hard to convince most of them to even try the program

Myths and Reality

Just tell them to stop. . .

Myths

- Lack of public support and understanding for this kind of addiction
- Prevailing belief that they are "just drunks"
- Prevailing belief that if they are not drinking then life is fixed

Reality

- Search for and consumption of alcohol takes over all aspects of life
- All copings skills are eventually lost in favour of alcohol
- Complex picture of physical and mental health combined with other impairments-many have not functioned well previously

Giving Alcohol to Alcoholics?

- Approach very similar to other maintenance programs except that

1) alcohol is very harmful
2) expectation that client will ever take over management is not realistic
3) requires communal living with staff 24 hours per day

And first of all do no harm…

- Generally benefits in terms of quality of life, reduced EMS and police interactions, increased social inclusion, etc BUT
- People still die much too young

The First Surprises!

They Were Sick. . .

- We expected poor health but. . .they were

1) Malnourished
2) Mentally ill
3) Diabetic etc
4) Wernicke-Korsakoff
5) Liver failure

- Alcohol was masking the real health issues as well as preventing them from getting care

Future? What Future?

- Our objective was to keep them as safe as possible and try to improve health and quality of life
- No expectation of change, new skills, plans for the future
- No appreciation for their capacity for change

- They wanted a normal life!!! Who knew?

What They Wanted

- A home which was safe, quiet and did not have any drunk people
- A chance to contribute to the day to day needs of themselves and the program
- To learn new things
- To be part of a community

Surprise.. . We Were not Actually in Charge of much..

- Rules
- Routine
- Chores
- Living skills
- Normal life celebrations
- Focus on building a happier life

The Implications?

- Need to staff with a very different skill set and approach to their work
- Lack of space for "living" a huge problem
- As people recover from homelessness being in a shelter is less and less appropriate

Rules?

- Clients rules are usually much tougher than what the staff would suggest
- Clients always like the rules until they are applied to them
- The rules and routine are essential for people to stay stable but… not when someone first enters the program

Living Skills

- Counseling had no impact in that setting
- Only coping skill was alcohol
- As they grew personally the clients recognized need to develop skills to live in community

Normal Life Celebrations

- Many clients had never experienced normal life celebrations and all had missed them during street drinking period
- Important part of recovery and becoming "normal"
- Important to "de-link" celebration from excessive drinking

What is Important?

- Alcohol
- Family and friends
- Belonging to a community
- Having a role or responsibility in the community
- Having a dog
- Having a garden
- Having things to look forward to
- Being able to weather the ups and downs of life without a "crash and burn"

How Did We Learn?

- **Experiential**-lots of trail and error
- **Evaluation**-close monitoring of specific outcomes and outputs
- **Research**-cost benefit study, mental health services

Experiential Learning

Experiential learning is learning through reflection on doing,

- Allows us to try “what if we. . . ?”
- Useful in creating highly individualized approaches to care
- Started with training from Seaton House staff and took off from there

- Needs to be supported by the reflection and in having what you learn codified in policy, training, practice
- Example: don't allow people to be inebriated in the common areas

Normal Cycle of Program Participation.. . . . . .

- Engagement
- Honeymoon
- Crash and Burn
- Re-engagement
- Goals
- Real living
- Accepting dependence
- Normal cycle of living with chronic disease
- Death

Some big lessons

- Real change (ie decreased compulsion) takes 3-5 years on average
- Cycle of problems mental illness and addiction are minimized by careful monitoring and early intervention

Limits of Experiential Learning

- Although essential to operations it is not "proof" as needed by public and funders
- May ignore the newest or best information
- Limits your responses to what you know

Program Evaluation

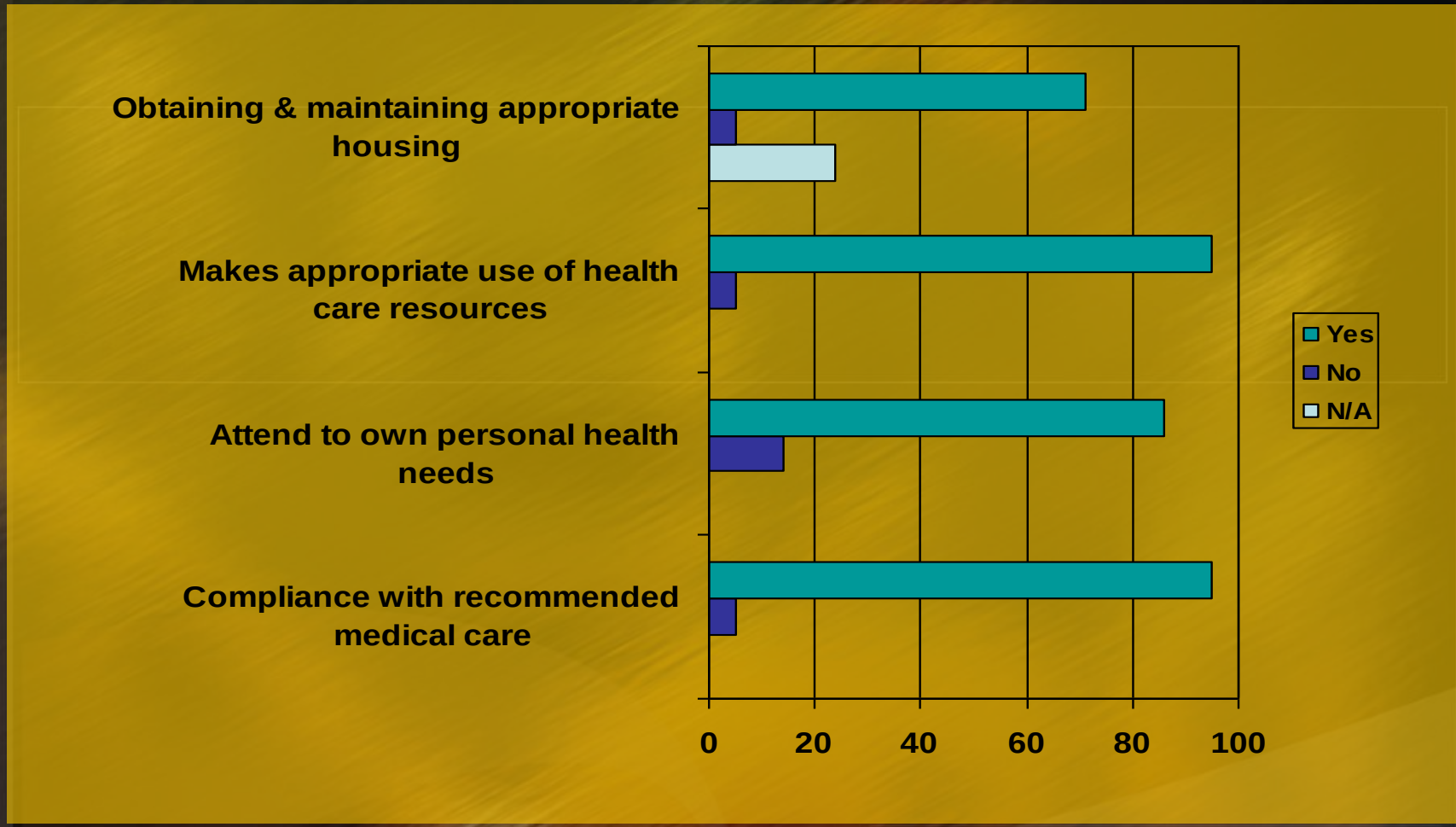
The pain of data collection!

Ongoing detailed data Collection

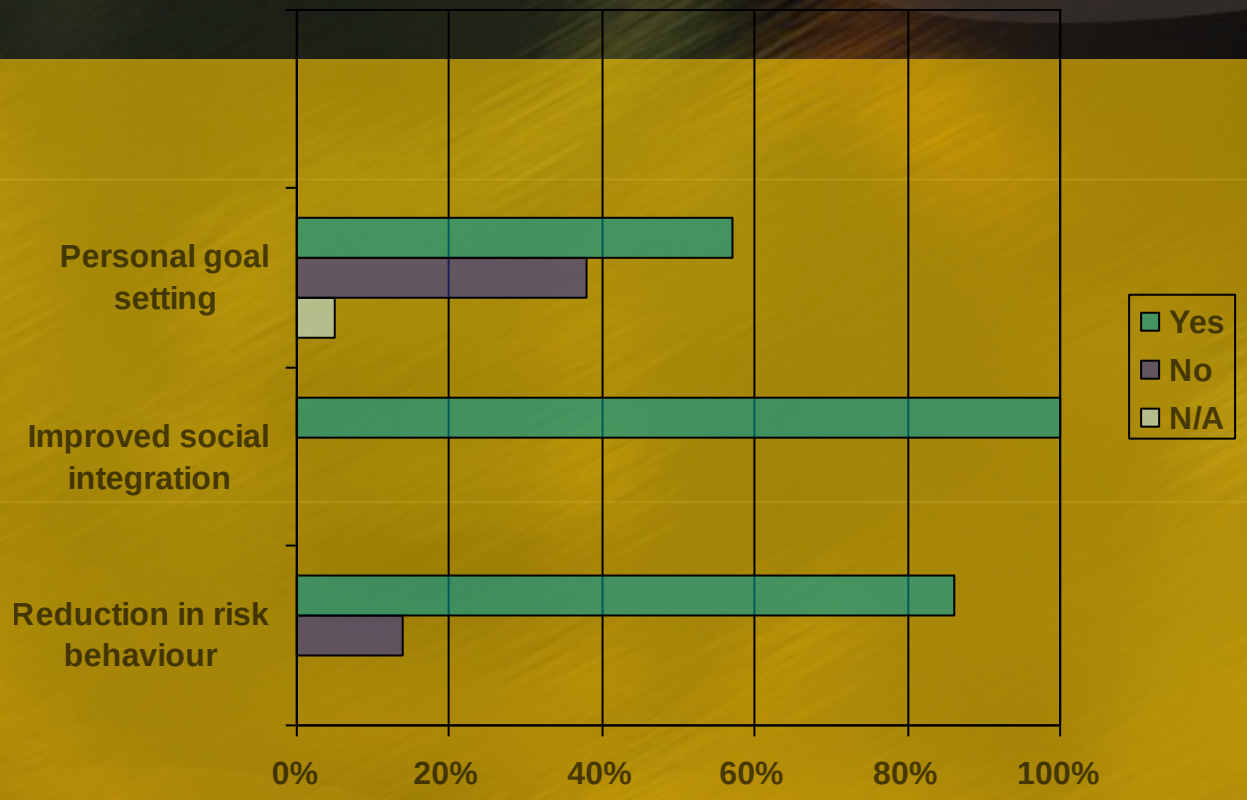
- Collect two kinds of data (monitoring + outcome data)
- Capacity to look at trends over time (ie alcohol consumption)
- Capacity to monitor outcomes against benchmarks

Outcomes Indicators 2003 Q1

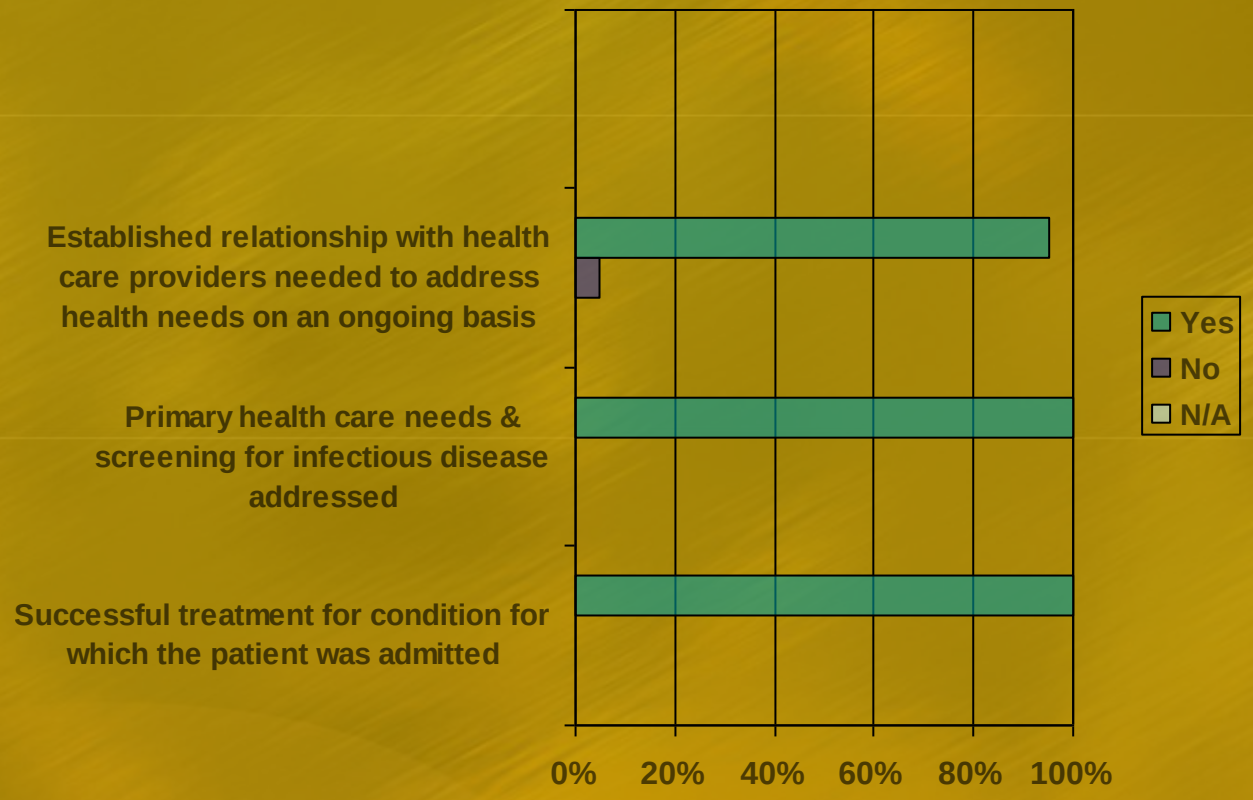
Program outcomes



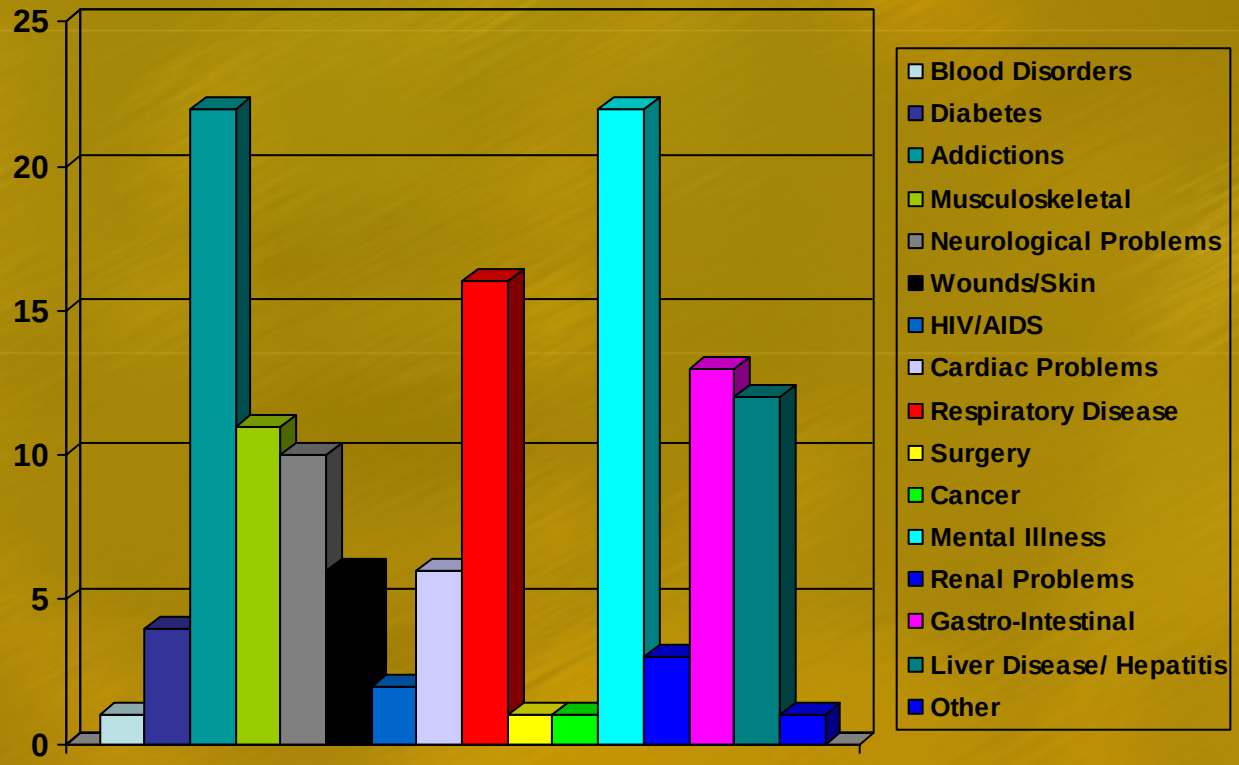
(Program outcomes continued)



Health outcomes



Diagnoses


25
20
15
10
5
0
Blood Disorders
Diabetes
Addictions
Musculoskeletal
Neurological Problems
Wounds/Skin
HIV/AIDS
Cardiac Problems
Respiratory Disease
Surgery
Cancer
Mental Illness
Renal Problems
Gastro-Intestinal
Liver Disease/ Hepatitis
Other

- Able to prove improvements in mental and physical health
- Average amount of alcohol consumed per person reduced by 2/3 over ten years
- Show medication adherence rates

The Research

Interesting Subjects

- The participants in MAP have been included in many research initiatives including a number of multi-site studies
- Three studies which have had an impact on the development of programs and services for them

The cost-benefit study

- Conducted by Dr Tiina Podymow and published in the Canadian Medical Association Journal
- Huge media response nationally and internationally
- On the face page for Yahoo and Google for two days

The residents response

- Took to media attention like ducks to water!
- Appointed media spokespersons themselves
- Did interview after interview after interview
- Whole program on Canada AM

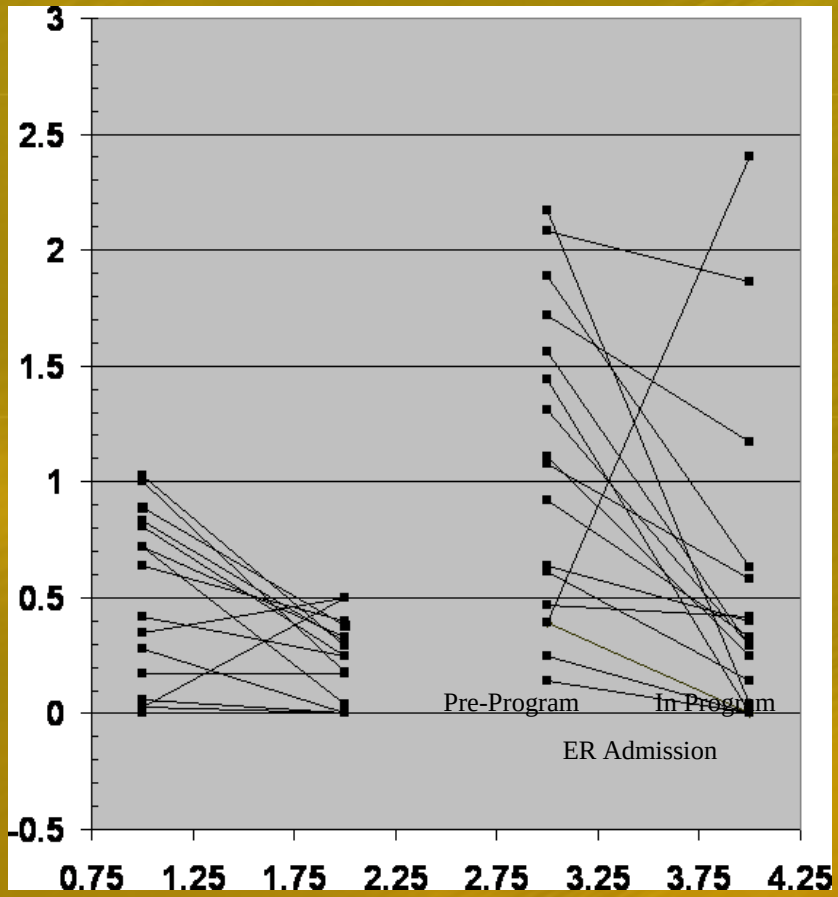
The Community Response

- Suddenly our program could no longer "fly under the radar"
- Backlash from conservative elements
- Support and defense from police, other health and social organizations, family members etc
- Generally beneficial for the program

Main findings from the study

- It cost less to intervene then not
- Cost savings of 3 dollars for every dollar spent plus+
- Participants were healthier, had more normal lives plus costs of care reduced.

Appropriate Care = Major Savings



Pre-program and In-program ER Visits & Police Reports per Month by Subject n=17

Pre-Program In Program

Police Reports

Client	Admission	Arrests	Arrests Pre-Admin	Arrests Post-Admin	Approx. cost per pre-Admin	Approx. cost per post-Admin
	18/06/2001	181	175	6	$19,775.00	$678.00
	23/04/2003	31	31	0	$3,503.00	$0.00
	22/07/2003	321	306	15	$34,578.00	$1,695.00
	04/10/2006	92	90	2	$10,170.00	$226.00
	08/10/2004	326	313	13	$35,369.00	$1,469.00
	13/04/2007	104	103	1	$11,639.00	$113.00
	01/04/2005	213	195	18	$22,035.00	$2,034.00
	11/07/2007	102	102	0	$11,526.00	$0.00
	29/04/2004	111	98	13	$11,074.00	$1,469.00
	16/06/2006	54	54	0	$6,102.00	$0.00
	19/12/2006	19	18	1	$2,034.00	$113.00
	08/06/2005	37	31	6	$3,503.00	$678.00
	28/11/2005	60	55	5	$6,215.00	$565.00
	23/09/2003	18	18	0	$2,034.00	$0.00
	18/11/2004	43	42	1	$4,746.00	$113.00
	02/06/2005	51	48	3	$5,424.00	$339.00
	11/08/2006	46	46	0	$5,198.00	$0.00
	20/10/2005	22	22	0	$2,486.00	$0.00
	18/07/2006	40	34	6	$3,842.00	$678.00
		1871	*1606*	*90*	*$201,253.00*	*$10,170.00*

Info until Nov 1/2007

Note: Cost only an approximation, calculated using $113.00 per officer dispatched

Executive Dysfunction in Persons with Chronic Alcohol Dependence

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Wendy Muckle, RN, MHA, Executive Director, Ottawa Inner City Health

Purpose of the Study

- To examine executive functioning (higher levels of cognitive thinking such as planning, inhibition, flexible thinking etc) between individuals who suffer from chronic alcohol dependency and are detoxified at the time of the study to those individuals who are not detoxified at the time of study.

Methodology

Sampling

- Individuals with chronic alcohol dependency who are currently drinking through the Harm Reduction Program.
- Individuals with chronic alcohol dependency who are currently abstinent. Alcoholic's Anonymous groups within the Ottawa region were approached.

Methodology - Measures

- The **CAGE Questionnaire** (Mayfield, McLeod, & Hall, 1974) is a commonly used screening tool to identify the presence of alcohol use disorders.
- The **Wechsler Test of Adult Reading,WTAR** (Wechsler, D. 2001) provides an estimation of an individual's premorbid level of functioning, based on a reading recognition paradigm.
- The **Wisconsin Card Sorting Task Computer Version 4 Research Edition, WCST**. (Heaton, 1993) examines an individual's ability to form abstract concepts and modify behavior according to feedback. It measures one's ability to plan, organize, initiate, and self-monitor.
- The **Delis Kaplan Executive Function System, D-KEFS (Delis, Kaplan & Framer, 2001) Color-Word Interference subtest** examines verbal inhibition and mental flexibility.
- The **Delis Kaplan Executive Function System, D-KEFS (Delis, Kaplan & Framer, 2001), Trails Making Test** is made up of 5 conditions: visual scanning, number sequencing, letter sequencing, number-letter sequencing and motor speed.

Possible Implications

- Executive dysfunction is directly related to treatment and future outcomes such as employment and everyday functioning!
- It is relevant to treatment because lack of planning, judgement difficulties, flexibility, problem solving, on the part of the individual could compromise treatment (Grant & Adams, 1996; Ihara et al, 2000 book) and result in higher rates of relapse (Zinn et al, 2004).

- Revealed shocking deficits in function
- 4 people scored below the fourth percentile in their ability to respond to visual stimuli
- Highly developed verbal skills masked serious deficits which were not remedial
- Helpful in managing expectations of the client

An Examination of the Delivery of Psychiatric Services within a Shelter-Based Management of Alcohol Program for Homeless Adults

Susan Farrell, Beth Wood, Heather King-Andrews, Donna Lougheed, Wendy Muckle, Lynn Burnett, Jeffrey Turnbull

Accepted in "Homelessness and Health in Canada"
M. Guirgus-Younger and R. McNeil (Eds)

Purpose & Objectives of Project

- Assess impact of delivering psychiatric services within residential HR program
- Examine changes in psychiatric symptoms, behavior, quality of life, mental status, global functioning and alcohol consumption patterns
- All MAP clients (without dementia, ABI or head injury) considered for project

Recruitment & Assignment

- Modified RCT design (between low and no treatment) – done using BPRS interviewer
- Compare persons with no service , low level (1-6 contacts/ yr) and high levels of psychiatric services
  (7^{+} contacts/yr)
- Setting ideal for comparisons as residence and substance treatment is identical – level of psychiatric service is independent variable

Methodology

- All MAP clients will be examined at 3 time intervals (intake, 3 months, 12 months)
- Repeated measures designed
  - Trained interview staff
  - Independent Reviewer – MD blind to group assignment or treatment
  - Psychometric (standardized) testing

Measures – Client Functioning

- **Psychiatric Symptoms**
  - Brief Psychiatric Rating Scale (BPRS-E)
- **Behavior Problems**
  - Cohen Mansfield Agitation Inventory
- **Quality of Life**
  - Wisconsin Quality of Life Scale (Provider and Client Questionnaires)

Independent Review

- **Mental Status**
  - MMSE *(Folstein scoring criteria)*
- **Global Assessment of Functioning**
  - DSM-IV GAF scale

Standardized Testing

- **Wisconsin Card Sort**
- **Delis-Kaplan EFS**

Measures – Process

- **Alcohol Consumption Record**
  - Daily log of type and location of consumption
  - Blood alcohol levels
- **Health Care Utilization**
  - Record of any acute or specialized medical care services
- **Psychiatric Nurse Practitioner Service Inventory**
  - Case notes from each intervention
  - Used to code range and Intensity of Service Delivery

Profile of Participants

- **T1 = 80 participants**
- **T2 = 63 participants**
- **Mean age = 49**

- 88% male
- 24% post-secondary education
- 24% used ER in past year
- 20% Hepatitis C

<u>Diagnostic Profiles</u>

- ETOH dep. 100%
  - 88% use other substances too
- Depression 71%
- Bipolar 10%
- SCZ 9%
- GAD 6%
- Personality d/o 5%

Clinical Outcomes

- Following psychiatric treatment:
  - Significant reduction in psychiatric symptoms (measured by BPRS)
  - Significant improvement in mental status (MMSE)
  - Significant reduction in aggression (CMAI)
  - No significant change in global assessment of functioning

Main Points of Discussion

- Areas of significant improvement – consistent with American findings
- No change in functioning may be due to multiple components in rating scale (psychological, social, vocational function)
  - Need to study changes in these domains over longer time period
- Limitations – not measure all areas of life, client attrition, not able to compare results to level of service received

Future Directions… Moving Research Forward

- Expansion of front-line clinicians as interviewers
  - Building an enthusiasm for evaluation research!
- Funding opportunities for expansion of measurement
  - Consideration of an additional interval of measurement
- Sharing the project model with newly developing programs

In Summary


Shepherds of Good Hope
Les Bergers de l'Espoir
www.shepherdsofgoodhope.com
CANADIAN MENTAL HEALTH ASSOCIATION
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE
Ottawa Inner City Health

The Evolution of Managed Alcohol

- Started as a 10 bed pilot project at one site
- Custodial model providing a high level of service (food, cleaning, health care)
- Expectations centered on changing behaviors related to excessive alcohol use
- Program grew, split and will probably split again
- Program run by clients with help of staff
- High level of health care, low level of other services
- Focus on healthy living

Different challenges

- Seniors
- Acquired brain injury
- FASD
- Development delay

What Did We Learn

- To have a healthy respect for the disease and deficits that the person lives with
- To have high expectations for a better life
- To actively apply what we learn from all sources to improve our capacity to help

And still to go. . .

- What is the best approach for people with cognitive impairments?
- Is there a treatment regime which would allow people to live more independently?