

“Basically, how their lives worked, they would wake up and look for alcohol. They would drink whatever they could find – often mouthwash – to deal with the withdrawal. Most of them would drink until they passed out and then do it all over again the next day” Wendy Muckle, Director of Inner City Health Project, Ottawa ON

# Managed Alcohol: Housing, Health & Hospital Diversion

Exploring a Managed Alcohol  
Model for the City of London

Prepared for the South West LHIN March 2011

## Executive Summary

In addition to decreasing EMS, Emergency Department, hospitalization and law enforcement utilization rates, Managed Alcohol Programs have effectively improved the quality of life, health and well-being of homeless adults consuming non-beverage alcohol. The model responds to the specialized needs of a population that, at present, is typically displaced and vulnerable in the City of London. These clients are historically refractory to traditional treatment practices and at risk of victimization, criminalization and a myriad of health conditions. Managed Alcohol does more than provide a drink an hour or a fixed address. It is the integration of onsite, continuous healthcare services together with housing, community supports and a client-centred harm reduction approach that has proven to lessen the burden on emergency services and departments, improve health outcomes and end both the consumption of non-beverage alcohol and homelessness.

The reasons and statistics to support a managed alcohol program in the City of London are numerous.

Local Emergency Medical Services are responding to 5-35 calls per week to this population. This group accounts for 3-5 Emergency Department visits every day and the London Police Service are dispatched to 15 calls each week, in response to these clients.

The costs associated with this population and their service utilization rates amount to \$1 495 780.00 annually in the City of London.

These figures don't capture the costs associated with hospitalization, time in custody or the varied and equally expensive costs absorbed by local community and social services in supporting this population. Nor do these figures begin to reflect the realities of poverty, addiction and homelessness that are the lived experience of these marginalized individuals.

Based on the evidence-based outcomes of three operational managed alcohol programs and the identified needs and service utilization rates of this population in the City of London, the following **recommendations** should be given careful consideration:

1. *Establish a 16-20 bed residential Managed Alcohol Program (MAP) in the City of London, consisting of 1 full-time registered nurse/director, 1 full-time social worker, 1 part-time registered nurse, 2 full-time registered practical nurses and 6 full-time community health/support workers.*
2. *Establish an inter-professional team consisting of London InterCommunity Health Centre, Addiction Services of Thames Valley and Mission Services of London to coordinate a nurse run team providing clinical and medical care.*
3. *Develop supportive partnerships with the City of London Community Services, London Police Service and London Health Sciences Centre.*

The annual costs associated with this model are \$943 000.00 or \$81.67 per person per day.



The connections between homelessness, health status, addictions and quality of life are complex and dynamic.

Chronically homeless adults (those who live for extended periods on the street or in the shelter system) are at greater risk of infection, violence, unintentional injury and exposure. For those lacking safe, permanent housing, over a prolonged period of time, serious chronic health conditions such as cardiovascular disease and respiratory disease, hepatitis and other liver diseases, gastrointestinal ulcers, diabetes, anemia, epilepsy, cancer, tuberculosis, head injuries, foot and skin disorders, poor oral and dental hygiene and HIV/AIDS are common. Given their poor health, accessible, effective medical care, is a key determinant of the health status of homeless population.

Alcohol abuse is as high as 53-73% in the homeless adult population.<sup>i</sup> These figures are clinically and socially significant because alcohol misuse (abuse or dependence) influences not only the health and social outcomes of these individuals but also impact their families, local communities and society at large. Alcohol dependence contributes to binge drinking, consumption of non-beverage alcohol (i.e. mouthwash, cleaning products, cough and cold remedies), violent and/or criminal behaviours, suicide, job instability, poor compliance with treatment, longer hospital stays, homelessness, public inebriation, increased emergency department visits and mortality. The World Health Organization estimates that alcohol causes 3.2% of deaths worldwide, with a global cost to health above that of tobacco. Medical consequences of alcoholism include oesophageal cancer, liver cancer, chronic ulcers, cirrhosis of the liver, epilepsy, psychotic breakdown, increased rates of hospitalization and shorter life expectancy.<sup>ii</sup>

Homeless individuals consuming non-beverage alcohol represent a subgroup within the street culture. This population is typically stigmatized by the street community, vulnerable to violence and a myriad of health conditions/complications related to the toxicity of consuming products such as: Listerine, rubbing compound, cooking sherry, antifreeze, Lysol, aftershave, hairspray and/or hand sanitizer. These products are more affordable and accessible than palatable alcohol and for some homeless, addicted adults living in extreme poverty they become products to consume. At present, treatment supports in London are inadequate in meeting the complex needs of homeless individuals consuming non-beverage alcohol.

*“Basically, how their lives worked, they would wake up and look for alcohol. They would drink whatever they could find – often mouthwash – to deal with the withdrawal. Most of them would drink until they passed out and then do it all over again the next day” Wendy Muckle, Director of Inner City Health Project*

The homeless have distinct patterns of health service utilization shaped by numerous barriers to accessing health care, including perceptions of ‘unwelcomeness’ in health care settings and the absence of health care coverage documentation. The utilization of medical services by the homeless is generally high, most often in response to symptoms of reoccurring health problems that have received prior treatment but have worsened intolerably.<sup>iii</sup> Because the homeless must focus on the immediacy of survival and often wait for health conditions to become intolerable before seeking care, conditions go untreated and worsen and when individuals do seek out care they are often referred to an emergency department, only later to be hospitalized. Their primary care is received predominantly



through hospital emergency departments whose design was not meant to provide the type of ongoing healthcare required. This leads to a cycle where acute crisis leads to brief intervention in hospital which leads to loss of residential stability, return to the street and on to the next crisis. This pattern has been associated with increased costs to health care services and is further complicated by chronic alcoholism and the inadequate treatment supports available to the homeless population.

Recent Canadian statistics show the top five reported reasons for emergency room visits by the homeless were mental and behavioural disorders, injury, poisoning, contact with health services and diseases of the musculoskeletal system and connective tissue. Furthermore, the top five reported reasons for inpatient hospitalization were mental diseases and disorders; significant trauma; respiratory diseases; digestive diseases; skin subcutaneous and breast diseases.<sup>iv</sup>

Too often persons experiencing homelessness and chronic alcoholism are seen as a source of frequent disruption in the community including frequent trips made to emergency departments, and requiring acute levels of care in hospitals. Poor management of chronic mental and physical health contributes to these high rates of health service use. In addition these patients feel a loss of self-worth and dignity and have little opportunity to regain control over their lives. Their health needs are historically misunderstood by social service agencies and their social service needs are often ignored by health care providers. Acting independently, neither health nor social service nor law enforcement agencies can address the high rates of health and emergent care service use by this population.<sup>v</sup>

In London there is limited reliable homelessness data including the number of homeless people in London at any single point in time. Reliable data related to the number of homeless people consuming non-beverage alcohol is non-existent. It should be noted that many health and treatment systems fail to collect data related to this population and as a result the visibility and needs of this population are not authenticated or documented. Although there is no reliable figure for the number of homeless people across all service sectors, there is knowledge that many sectors and services support the same individuals. Key informants, including the London Police Service, Thames Emergency Medical Services (EMS), Mission Services of London and The Salvation Army Centre of Hope have indicated they support 10-15 homeless individuals, consuming non-beverage alcohol, on a weekly or more often daily basis.

Thames EMS responds to 5-35 emergency calls to this population per week, requiring 2 paramedics and an ambulance to be out of service while assisting or transporting 1 individual. The mean time spent on this call is 54 minutes, however, the individual's acuity level and offloading times typically result in each call averaging 3 ½ hours, at a cost of \$550.00 per ambulance dispatched.

35 EMS calls/week X \$550.00/call = **\$19 250.00 per week**

OR

**\$1 001 000.00/year for EMS\***

\*approximate cost



Likewise, the London Police Service responds to 10-12 homeless individuals consuming non-beverage alcohol, at any given time. Some of these individuals have police contact 2-3 times per day. On average 15 custodial cells are occupied by this population weekly. London Police Service estimate the cost to their service is \$100.00 per officer dispatched and time spent averages 120 minutes per contact.

\$100.00 (policing cost per officer dispatched) X 15 (average number of police contact(s) per week) =  
**\$1500/week**

OR

**A minimum of \$78 000.00/ year for Policing\***

\*approximate cost

The approximate cost for a single visit to a London hospital Emergency Department is \$229.00. Hospital staff indicates this population attend at an Emergency Department 2-5 times in each twenty-four hour period. These patients are often presenting with varying health conditions and acuity levels and do not always disclose to healthcare providers they have been consuming non-beverage alcohol products. As a result, hospital records do not entirely capture the emergency department and hospitalization rates of this very specific population. The recently implemented pay for results data collection, however, will begin to better reflect the utilization rates of this group. Emergency Department staff indicate they see 3 individuals from this population regularly, sometimes daily, and that typically these patients leave the ED prior to assessment by a physician. They are most often triaged, observed and receive fluids and meals by RN staff. ED staff note that many are not seeking active treatment but attend as a result of police or EMS involvement. Rates of hospitalization vary but are often due to another health issue and not solely because of their non-beverage alcohol consumption.

\$229.00 (cost per ED visit) X 35 (number of ED visits per week) =

**\$8015.00/week**

OR

**A minimum of \$416 780.00/year for ED visits**

\*approximate cost

*A client with police and EMS contact who presents at an area ED costs \$879.00 per single incident. If this same client is hospitalized an additional cost of \$885.00 per day is incurred for an acute care bed.*



London Area Costs:

ED visits: \$229; EMS response: \$550; Hospital Bed Acute Care \$885/day; Police encounter \$100; Jail: \$155/day

These costs do not begin to capture the expenses of the numerous social service agencies in London who all absorb less visible but equally costly forms of support to those in need. An illustration of this is demonstrated by the recent referrals made to EMS and emergency departments by Mission Services of London. During a period of 81 days (January 1, 2011 – March 22, 2011) Mission Services accessed EMS services 65 times in addition to referring clients to emergency departments 86 times. The transportation cost of each one of the 86 ED visits was absorbed by Mission Services. In calculating the costs incurred by this population it is important to note that various agencies and services outside of the health sector also assume costs and expenses in relation to the health of these clients.

***The approximate total cost for local policing, EMS and Emergency department services is \$1 495 780.00 annually.***

In 2007-08 Ontario's healthcare system spent more than \$2.5 billion on mental health and addiction services, including hospital care, community-based programs, medications and physician services. Mental health and addictions cost Ontario another \$2.3 billion in law enforcement services.

Three communities in Ontario have developed and implemented a creative, effective and cost-saving model of care to better respond to the healthcare, housing and treatment needs of this population. In implementing managed alcohol programs these communities have been better able to care for a target population who suffer from numerous chronic physical and mental health diseases, while lessening the burden on emergency services, hospitals, and law enforcement and simultaneously producing a safe and affirming environment for clients. Each program varies slightly in terms of size, staffing and site; however, all three provide consistent housing, continuous health care, aid with activities of daily living and 5-7 oz. of alcohol per hour from 7:30 a.m. until 9:30 p.m. All three programs serve clients who have been homeless typically for 15-20 years, with a long history of drinking (30 plus years), non-beverage alcohol consumption and refractory alcoholism. Many of these clients indicated that when given a choice between keeping their alcohol and having a bed in a shelter, they would choose to keep the alcohol.

The Seaton House Annex Harm Reduction Program, located in and operated by the City of Toronto, was the first managed alcohol program in Ontario, commencing in 1996. The largest of the three existing programs, Seaton House has 100 managed alcohol beds and 28 infirmary care beds housed together on



one floor, within a larger homeless shelter of 600 beds, situated in the Annex community of Toronto. Serving chronically inebriated homeless males, the program has responded to a population considered placeless. Clients in this program have historically been unable to sustain themselves in the community, unable to succeed in abstinence based or traditional harm reduction models and unable to secure or maintain permanent housing for a myriad of personal, systemic and medical reasons. This population has been difficult to place and stabilize. The Annex provides permanent and transitional housing in addition to infirmary and palliative care. Staffed by case workers and registered nurses on a 24 hour basis the Annex has access to medical staff through St Michael's Hospital and serves as teaching program and site for St. Michael's. As a result of the onsite, accessible and continuous health care provided by two full-time nurses, physicians and psychiatrists, emergency department visits have decreased by 93%, and emergency medical service calls by 96%, since its inception in 1996. In 2010 the program diverted 8000 emergency department visits, saving an estimated cost of \$3300/day/client for EMS, police and hospitalization in the City of Toronto.

The managed alcohol and health care programs support each other. Their experience has been that clients who have access to alcohol in a controlled environment and when receipt of healthcare is not contingent on abstinence are more interested in their own healthcare and more compliant with medical interventions than was the norm in their often previous, involuntary access to health care. Through increasingly regular contact with physicians and nurses clients begin to have a more 'normal' experience of healthcare whereby they have the opportunity to meet with a physician or nurse to address their healthcare needs on an ongoing basis. This partnership also provides members of the healthcare community an opportunity to gain some insight into the specialized healthcare needs of this population.

Despite the success and services of the Annex program, 12-24 managed alcohol residents die per year in the program. Another 5-10 MAP clients yearly in each of the Ottawa and Hamilton programs. These deaths are typically caused by the culmination of chronic alcoholism, pre-existing health conditions and many years spent living in poverty and on the street. The average age of a MAP client is 48 years, in a group whose average age of mortality is 52 years.

Residents of the Annex have access to wine the program purchases from a local winery that produces and delivers wine at relatively low cost to the client of \$0.50/210ml, or, palatable alcohol provided by the client. The onus is on the client to attend at the designated hourly time to obtain their drink. Case workers, with Smart Serve training, assess residents prior to each drink and will refuse to serve them if they are already intoxicated or are eligible for their next drink within 45 minutes. Clients who consume alcohol in the community are not served in the program. A careful balance is maintained between serving enough alcohol to keep the client engaged, but not so much that they become more than moderately intoxicated or so little that a seizure is induced. Individualized, client centred planning and astute assessment skills are essential to striking this balance.

Clients average 6 drinks per day, 9 drinks less per day than they are permitted to have. In this and the other two provincial managed alcohol programs, clients not only stop consuming non-beverage alcohol,



they consume less alcohol than is available to them and in some cases stop consuming alcohol altogether, opting instead to drink apple or grape juice hourly. The option to detoxify from alcohol is always presented; once stabilized in the program; a few participants in all three programs have successfully been medically detoxified and received housing, a formidable accomplishment considering the severity of an on-average 35 year addiction in which clients drank daily to unconsciousness. This appears attributable to tempering alcohol consumption in a safe environment, which makes alterations of behaviour, including detoxification, possible.

The Shepherds of Good Hope opened its managed alcohol program in 2001 in the City of Ottawa. Modeled after the Annex the Ottawa program has 38-50 managed alcohol beds and provides residential services to both men and women. This model is unique in that it has two sites and two steps. Twelve - sixteen assessment beds are located within the larger homeless shelter situated within Ottawa's downtown core. Another 30 beds are located at The Oaks, a 2<sup>nd</sup> stage housing complex, outside of the downtown area. New clients coming into the managed alcohol program receive housing, support services, healthcare and managed alcohol in one of the 12-16 assessment beds. This allows the client to transition into the program without exposing existing clients to street entrenched behaviours or triggers. Once the client is engaged and space is available s/he is moved into The Oaks. The Oaks is a permanent housing complex that offers each client private accommodation and includes two independent apartment style units. Both sites are staffed twenty-four hours a day and have access to nursing and medical care. A physician attends twice weekly and a full time registered nurse is on site at The Oaks, in addition to community case workers from the mental health and addiction sectors. While Shepherds of Good Hope is the lead social service agency, a close partnership exists with Ottawa's Inner City Community Health to provide the medical and community nursing piece.

Wine is brewed on site at the Oaks and with the resident's participation so that distributing it is not in contravention of the Liquor Licence Act. Like the Annex, alcohol is available to residents on an hourly basis and clients are assessed prior to receiving each drink.

Claremont House, located in Hamilton, is the youngest of the three MAPs, becoming operational in 2005. With 16 beds, including 1 palliative care bed, Claremont House provides communal housing to men and some outreach services to women in the community. While the lead agency for Claremont House is Wesley Urban Ministries this program has a close relationship with St. Joseph's Healthcare and is located on the hospital's campus, outside of the downtown core. Two full-time registered nurses are attached to the program together with social service, personal support and social workers. A physician is on site 3-5 times per week and hospital staff and services are readily accessible to Claremont House staff.

Residents here are offered beer purchased by the program and like both the Annex and the Oaks, staff report that residents at Claremont House typically do not consume a drink each hour and when they do drink are often drinking near beer or 'special blends', consisting of half alcohol and half water or juice.



All three programs report that MAP clients ultimately stop consuming non-beverage alcohol.

These three sites attribute much more than housing or alcohol to their success. While housing is immensely beneficial for health, it is difficult to maintain without appropriate skills. Part of the success of these MAPs has likely been due to the supportive housing provided, but housing alone would not have prevented alcohol-seeking, consumption and the harm therefrom. Likewise, while the provision of palatable alcohol certainly engages the client's participation and is key to their on-going engagement, alcohol alone would not have diverted hospitalizations, decreased the criminalization of this population and improved their overall health. It is the implementation and integration of health services and treatment programming within a residential setting that has been critical to the successful service delivery and care provided by managed alcohol programs.

*"I'm not in jail. I'm not being chased all the time. I can sit down and relax and have a cigarette and a drink without being bothered. You couldn't ask for better living than what I got now"* Ron Kirkpatrick, resident of Shepherds of Good Hope

It is important to note that a sense of community and positive peer support has developed within the existing MAPS. For clients historically displaced by communities, families and systems, the MAP community is a welcoming, inclusive and accepting one. Staff credits this sense of belonging as integral to both individual and program victories. Interview narratives collected from the three sites, yield a rich description of how the managed alcohol community represents a radically different experience of security, safety and hope that was otherwise absent on the street. The program environment is predominantly experienced as a means to regain a sense of self-control, health and stability. The program, conceived in this way, is a radically new social environment, induces processes of self-care and provides new avenues of respect and dignity.<sup>vi</sup>

Although treatment with detoxification and abstinence is the best option from a health prospective, the likelihood of rehabilitation among people both alcoholic and homeless is low. Obstacles to sobriety include psychiatric illness, poor social support, lack of stable housing, duration of addiction and refusal of treatment. Harm reduction is a practice to reduce the adverse health, social and economic consequences of substance use without requiring abstinence. The harm reduction approach seeks to (1) minimize the personal harm and adverse societal effects that alcohol dependence can lead to, (2) provide an alternative to zero-tolerance approaches by incorporating drinking goals (abstinence or moderation) that are compatible with the needs of the individual, and (3) promote access to services by offering low-threshold alternatives, which enable clients to gain access to services despite continued alcohol consumption. Following these objectives, MAPs serve chronic alcoholics (with a consistent history of consuming non-beverage alcohol) controlled amounts of alcohol on a daily schedule, as a way to ensure that individuals consume safe alcoholic beverages in a safe environment.



Studies have found that MAPs can reduce drinking, the number of hospital admissions, ED visits, and police incidents while improving the overall health of homeless individuals suffering from alcoholism. These studies demonstrate that controlled access to alcohol, in a safe environment may be the most effective treatment for: (1) retaining vulnerable populations in treatment programs, (2) decreasing their alcohol consumption, and (3) show some evidence of effectiveness towards other relevant outcomes such as decreasing criminal activity, seeking regular medical care, and improving quality of life.

In the first empirical study and assessment of a Canadian managed alcohol program, researchers found that the number of monthly police encounters for participants in the Ottawa program fell to 8.8 from 18.1 a month, and the number of emergency department visits fell to 8 from 13.5 a month.<sup>vii</sup> Police encounters decreased by 51% and ED visits by 36%. Use of ambulance services, hospital admissions and ED visits all showed a decreasing trend, as did diagnoses of intoxication, trauma and convulsion. Subjects noted that a typical day's consumption was difficult to estimate; most described drinking all the alcohol that was available and would drink until they lost consciousness. For all 17 participants in this study, the absolute amount of alcohol consumed was found to decrease, from an average of 46 drinks per day to 8. Eleven of the participants reported a markedly decreased consumption of beverage and non-beverage alcohol, and most reported improved sleep, hygiene, nutrition and health. The majority were reported to attend scheduled medical

appointments and compliance with medication, defined as taking it as prescribed at least 80% of the time, was noted for 88% of subjects. When life satisfaction was measured by means of the Diener's Satisfaction With Life Scale a median score of 22 was noted, consistent with feeling "slightly satisfied" with life.<sup>viii</sup>

*"Here were guys who lived to drink. We were able to convince them not to drink while taking this medication because it would severely damage their liver. All of them either stopped or severely cut back on their drinking. We had a 100% success rate in getting rid of the tuberculosis."*

*Art Manuel, Program Supervisor*

An incident that is indicative of the success of MAP's and their integrated healthcare programs occurred during a tuberculosis outbreak in the Annex in 1997. Annex clients who were exposed to TB were required to receive prophylactic treatment. Traditionally in the homeless population at large the compliance with a medication regime was approximately 44%. The success rate of the treatment in the Annex was 100%.

The Annex MAP reports emergency department visits have decreased by 93%, and emergency medical service calls by 96%, since its inception in 1996. In 2010 this program diverted 8000 emergency department visits, saving an estimated cost of \$3300/day/client for EMS, police and hospitalization in the City of Toronto.

In Dr. Tomislav Svoboda's study of the Annex MAP he determined that over a five year period, Annex clients, as a group, experienced significant reductions in time spent in prison and under community supervision. Significant mean impacts included: 85% drop in prison days and 96% drop in community supervision.



In a study by the Ottawa Police Service 23 managed alcohol clients in conflict with the law were tracked both prior to admission and while in the program. This group had a total of 1074 incidents involving police contact between 2001 and 2007, at an approximate cost of \$121 362.00. This same group had a total of 53 incidents involving police post admission, at a total policing cost of \$5989.00. Twelve of the 23 clients tracked had no police contact post admission, 5 individuals had less than 5 incidents involving police during this period and 4 individuals had police contact between 5-10 times during this same five year timeframe.

In a comparison study completed in Hamilton in 2007, the service utilization of a group of 21 homeless and addicted individuals was documented. In 16 weeks this group had 18 hospitalizations, 31 EMS calls, 49 emergency department visits (resulting in 35.5 days spent in hospital), 61 police encounters and 52 days spent in custody. This group was juxtaposed to the 28 residents and outreach clients of Claremont House who, in a 52 week period, had 6 emergency department visits, 0 EMS calls, 3 hospitalizations (resulting in a total of 11 days in hospital), 10 police encounters and 5 days spent in custody. Claremont House also reports a 98% medication compliance rate during a 12 month period; medication compliance is defined as agreeing to take medications at least 80% of the time. Eighteen months of outcome data demonstrate that the frequency of emergency room use, hospitalizations, EMS service use, police encounters and time spent in jail among the Claremont patients is clearly much less than the high rates of service use among those who receive care in emergency rooms and hospitals from the streets. Claremont House data indicates the total costs incurred by clients, not in their program, for ED visits + EMS + Hospitalizations + Police encounters + days spent in jail + palliative care equals \$816 431.00 for a 12 month period. In contrast costs incurred by Claremont House residents for these same services in this same period total \$24 595.00<sup>x</sup> - **A savings of \$791 836.00.**

Collectively the findings from these various studies indicate managed alcohol programs are an important clinical and cost-effective tool in managing chronic alcoholism among the homeless.

All three programs, through the provision of integrated nursing, medical, rehabilitation and social services have:

- reduced use of emergency rooms;
- reduced days spent in hospital;
- provided a needed referral source for emergency rooms, hospitals, long term care and community health services;
- managed patients with multiple and highly complex physical and mental chronic health problems;
- improved the Quality of Life for the target population;
- prevented communicable diseases;
- reduced use of police and EMS services
- conducted early detection and treatment of health problems; and
- improved compliance with taking prescribed medications.



The effective development and delivery of a London MAP will be contingent upon leveraging the strengths of individual community partners through a collaboration of health and social service providers, together with police, shelter staff and addiction workers.

The ideal model will consist of:

- Permanent and fixed housing
- 24/7 nursing care
- Health assessment & monitoring
- Health promotion
- Management of chronic diseases
- Palliative care
- Primary medical care
- Harm reduction strategies
- Psychiatric care
- Psychotherapy
- Rehabilitation services
- Stage based motivational counselling
- 24/7 social services
- Inter-professional learning for health sciences residents and undergraduate students

In London an inter-professional team consisting of Addiction Services of Thames Valley, London InterCommunity Health Centre and Missions Services of London could effectively coordinate a nurse run team to provide clinical and medical care.

Addiction Services of Thames Valley could provide clinical skills and the capacity to effectively manage and deliver treatment services in partnership with the London InterCommunity Health Centre, contributing community nursing and medical care. An effective working relationship currently exists between these two agencies and both have agency capacity and the clinical skill set to develop and deliver this program. Numerous local stakeholders indicated support of the project if these agencies were in a leadership role. Mission Services of London has valuable frontline residential experience and existing relationships with

population. Mission Services source and be able to lend the project based on their services. Together all three experience providing experience barriers to care homelessness and/or including addictions and inter-professional team, in

*“At the end of the day in this environment we’re able to minimize the amount of alcohol they use, reduce the harm they experience related to their alcohol, and reduce the harm society experiences because of their alcohol abuse. Participants have been able to improve their health and social lives. Their hygiene improves. Their nutrition improves and we can immunize them”* **Dr. Jeffrey Turnbull**

the London homeless would be a primary referral insights and experiences to knowledge of residential agencies have extensive services to those who including, poverty, complex health conditions mental health. This primary combination with



secondary community supports; London Police Service, City of London Community Services, area hospitals and tertiary supports; HIV/Aids Connection, London CARES, The Salvation Army – Centre of Hope, CMHA, WOTCH, CCAC would ideally collaborate to provide further services and programs as needed.

The program team should include doctor(s), registered practical nurse(s), registered nurse(s), social worker(s) and community health or support workers (i.e. social service workers, personal support workers) with experience and/or an interest in working with this population. Competent staff with the ‘right’ skills and an approach to care that promotes respect is essential. The ideal model would include the following frontline staff:

1 FTE nurse/director + 1 FTE social worker/case manager + 2 FTE RPN’s + 6 FTE community health/support workers to act as client care workers + 1 PTE RN, coupled with regular weekly onsite physician care of 6 hours per week.

A 16-20 bed facility would be an appropriate sized program to respond to the current needs and anticipated volume within the community. London can learn much from the experiences of Claremont House. While located in the larger municipality of Hamilton (pop.714900), Claremont’s 16 bed program is at capacity and unable to respond to the demands for service in Hamilton. Each year Claremont House is unable to accept 10-15 referrals. Service providers in London, already identify 10-15 different individuals as appropriate referrals to a managed alcohol program and another 5 individuals are identified by service providers within the South West LHIN’s catchment area of Huron/Perth and Grey/Bruce counties. This current service need, coalesced with an anticipated and escalating demand for service, suggests 16-20 beds would most effectively respond to the needs within the City and surrounding areas.

The City of London Community Services has expressed interest in a managed alcohol program and a willingness to partner and further discuss funding for residential beds. In the recently commissioned Community Plan on Homelessness the City is tasked with exploring shelter specialization needs, including respite/infirmarary care, palliative care and wet shelters. The implementation of a local managed alcohol program would respond to these specialized needs and dovetail with the City’s direction. In this same plan it is noted that that domiciliary hostels are under-utilized in London, and this trend of under-utilization must be reversed. Domiciliary hostels provide a unique opportunity to address the housing needs of a segment of the population, based upon their measured and analyzed presenting needs and unique circumstances. Domiciliary hostels are an important aspect of available housing – not just a shelter bed – which must be maximized in order to achieve the shelter reductions envisioned in the London Community Housing Strategy.<sup>x</sup> A managed alcohol program, funded as a domiciliary hostel (at approximately \$45.00/person/day), would both reduce shelter bed use and address the housing needs of a segment of the population, effectively integrating housing, homeless programs and services as encouraged in the community’s plan.



There exist several possible sites and locations to house a MAP within the City of London. Several locations and properties were suggested during the consultation process but a further community and stakeholder consultation would need to take place to determine a location. Ideally, the site would be within the City of London and accessible by public transit. There is merit in locating the program away from street entrenched neighbourhoods, as evidenced in both Hamilton and Ottawa. A local model should stand alone from existing agencies and sites. Careful and creative consideration should be given to co-locating the program within established services. Co-location with crisis or withdrawal management beds may pose challenges to the program, however, co-location with respite or infirmity beds may be an effective and innovative sharing of services. Many innovative possibilities exist within the community for collaboration, sharing and partnership.

***Annualized costs associated with delivering this program in the City of London include the following:***

\$345 000.00 for 1 FTE social worker, 6 FTE community support workers and 1 PTE house manager		
+ \$355 000.00 for 1 FTE registered nurse (director), 2 FTE RPNs, 1 PTE RN and physician & medical services;		
+ \$55 000.00 for food;		
+ \$80 000.00 for the production/purchase of alcohol;		
+ \$48 000.00 for housing costs and expenses;		
+ \$60 000.00 for program costs and equipment		
<hr/>		
=	<b>\$943 000.00 Annual Program Budget</b>	<b>or \$81.67 per person per day (at 20 beds and including Domiciliary funding )</b>

One time capital and start-up costs may range between \$500 000.00 to 700 000.00 depending on the site, renovations, equipment and program needs.

The development of a London managed alcohol program is in alignment with many of the goals and principles of the Ministry of Health and Long-Term Care’s 10-Year Mental Health and Addictions Strategy. In fact, the managed alcohol model is, in many ways, an example of ‘where we want to be’ as defined in the Strategy. MAPs already focus on recovery and harm reduction. MAP care is already person-driven, proactive and ongoing. Providers and programs are working collaboratively, services are integrated and coordinated and there already exists a culture of improvement and innovation embedded in the MAP model and delivery.



The Strategy recognizes current provincial mental health and addiction services are not well integrated with the other health and social services such as family health care, home care, long-term care services, infectious diseases, chronic disease management, hospital, crisis, social and housing. The managed alcohol model is predicated on the **integration** of health care, treatment, housing and community supports. It is the marriage of these services that, as evidenced in existing MAPs, has led to successful program outcomes and client triumphs. Implicit in the very concept and practice of a managed alcohol program is a commitment to integration, collaboration, communication and person-directed service and supports. All of which are highlighted in the strategy as key to transforming the system and improving services.

One of the many goals of the strategy is to provide high quality, effective, integrated, culturally competent, person-directed services and supports for Ontarians with mild to complex symptoms of mental illness and/or addictions and their families. The managed alcohol model does just this.

The Strategy encourages the promotion of **safe housing** and environments and submits that stable, safe, and supportive housing improves health and well-being. The continuity of housing provided by a MAP responds to and recognizes the important co-relation between stable, supportive housing and improved health.

The integration of healthcare, addictions and mental health services in a managed alcohol setting serves to reduce the **stigma**, identified in the Strategy, that exists in the current structure of mental health and addictions services – which are quite separate from the rest of the health care system. This separateness perpetuates stigma by reinforcing that mental illness and addictions are “different” and somehow more shameful than other health problems. By integrating health care with treatment and housing the managed alcohol model reframes the experiences of addiction, poverty and homelessness within a broader social context.

The Strategy advises providers to **tailor services to meet local needs** and explains local, needs-based planning can help engage the community, identify individuals and groups at high risk of mental illness and addictions, and tailor services to meet their needs. When communities can identify people who are vulnerable, they can provide services and supports tailored to local needs that help people build strengths, participate in their communities, become more resilient and improve their health. Population-based health promotion and disease prevention programs can build community resilience. Managed alcohol is a program designed and tailored to meet the needs of a local and very specific vulnerable community.

The Strategy suggests the system must provide and develop a range of evidence-based services and person-directed approaches to care that supports client recovery and meets the needs of a diverse population at all ages and stages of life. **Diversity** in programming and delivery is important. Managed alcohol responds to a unique population refractory to traditional treatment and services. This program meets the needs of an unambiguous population and reflects diversity in treatment on the continuum of



care. Managed alcohol meets people on their own terms. It is an integrated and **person-directed** model providing a mixture of services to fit the needs of the client. It is a **harm reduction** practice. Individuals are supported regardless of where they are in their journey to reduce the health, economic and social harms associated with problematic substance abuse. MAPs are supportive communities that provide the determinants of health, and promote well-being and both physical and mental health.

The Strategy clearly identifies '**where we want to be**' and explains we need to move the focus from treatment *TO* recovery and harm reduction, from reactive and episodic care *TO* proactive and on-going care, from providers and programs working in isolation *TO* providers and programs working collaboratively and finally, away from operating in separate silos *TO* integrated and coordinated services. Managed alcohol programs are in unison with these directives. Implicit in the MAP concept is a focus on harm reduction and recovery. Managed alcohol care is both on-going and pro-active and collaboration, integration and coordination of services are fundamental to the program. The managed alcohol practice and concept align seamlessly with the Province's Strategy and initiatives. Simply put.

**The managed alcohol model exemplifies where we want to be.**

This report reflects many voices from the community, including: persons with lived experience, front line workers, executives and managers of homeless and community services and first responders such as police, ambulance and emergency departments. The development of this report is built upon the best available information from these service providers and included:

- More than 13 interviews with persons with lived experience
- A review of more than 300 pages of research.
- A series of consultations and key informant interviews were conducted with 43 people using a semi-structured interview process. The interviewees came from the following agencies: London InterCommunity Health Centre, Addiction Services of Thames Valley, Thames Emergency Medical Services, Mission Services of London, London Police Service, WOTCH, City of London Community Services, Regional HIV/AIDS Connection, London Homelessness Outreach Network, London Health Sciences Centre, Street Connection and The Salvation Army – Centre of Hope.



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- <sup>ii</sup> MuckleW, Oyewumi L, Robinson V, Tugwell P, ter Kuile, A. Managed alcohol as a harm reduction intervention for alcohol addiction in populations at high risk for substance abuse. *Cochrane Database of Systematic Reviews* 2007, Issue 4. Art. No.:CD0006747.
- <sup>iii</sup> Semogas D, Sanford S, Evans J, Cleverly K, Richardson J, Singh N. A comparison of social service utilization among chronically homeless individuals with substance use disorders and previously homeless individuals housed in a supported-living, managed alcohol facility: patterns and estimated costs.
- <sup>iv</sup> CIHI Report 2007
- <sup>v</sup> Semogas D, Sanford S, Evans J, Cleverly K, Richardson J, Singh N. A comparison of social service utilization among chronically homeless individuals with substance use disorders and previously homeless individuals housed in a supported-living, managed alcohol facility: patterns and estimated costs.
- <sup>vi</sup> Semogas D, Sanford S, Evans J, Cleverly K, Richardson J, Singh N. A comparison of social service utilization among chronically homeless individuals with substance use disorders and previously homeless individuals housed in a supported-living, managed alcohol facility: patterns and estimated costs.
- <sup>vii</sup> Podymow T, Turnbull J, Coyle D, et al. Shelter –based managed alcohol administration to chronically homeless people addicted to alcohol. *CMAJ* 2006;174(1);45-9.
- <sup>viii</sup> Podymow T, Turnbull J, Coyle D, et al. Shelter –based managed alcohol administration to chronically homeless people addicted to alcohol. *CMAJ* 2006;174(1);45-9.
- <sup>ix</sup> Semogas D, Sanford S, Evans J, Cleverly K, Richardson J, Singh N. A comparison of social service utilization among chronically homeless individuals with substance use disorders and previously homeless individuals housed in a supported-living, managed alcohol facility: patterns and estimated costs.
- <sup>x</sup> London Community Plan on Homelessness November 2010

