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Managed Alcohol Supports Toolkit: Community of Learning Report



Acknowledgements

A special thanks go to all persons who made substantial contributions to the report.

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Revising the report critically for important intellectual content: Kerry McLean, Sarah Sandall, Shannon Shoemaker, Yaro Kiselev, Kyle Mack.

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Health Canada (Substance Use and Addiction Program) has provided financial support for this project. The views expressed herein do not necessarily represent the views of Health Canada.

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Introduction

This document is a compilation of: (a) program specific resources that Calgary’s Collaborative for Health and Home’s (CHH) Managed Alcohol Program (MAP) working group compiled as of March 2019, and (b) advice about how to offer managed alcohol supports that was shared by local agencies at a public event titled *Individualized Care Planning Through Managed Alcohol: Community of Learning* in Calgary on February 13th 2020, and recorded in detailed notes. This document is intended to assist organizations (including various supportive housing models/environments and shelters) seeking to offer managed alcohol supports to their clients. Managed Alcohol Programs are gaining prominence and recognition for their potential to improve housing stability, reduce alcohol-related harms, and even result in system cost savings; however, there is great variation in the ways that these supports are offered and little in the way of practical instruction about how to implement them. In Calgary, managed alcohol supports have been operating somewhat “under-the-radar” for several years in settings such as Alpha House’s and Trinity Place Foundation’s permanent supportive housing sites. There is a growing interest in making managed alcohol supports more widely available, and this document combines local wisdom from agencies/organizations such as Alpha House, Trinity Place Foundation of Alberta, The Alex, Carewest, and Alberta Health Services, about how to implement these services for different populations and under various conditions. These are broad guidelines based on a variety of models of service delivery; organizations/agencies planning to implement managed alcohol supports will need to make adjustments based on the needs and preferences of their distinct clientele and the resources available to them.

Certain agencies/service providers have pointed out that navigating city by-laws and zoning can pose a barrier to implementing a formalized “Managed Alcohol Program”; therefore, this document is also intended to support organizations to provide “Individualized Managed Alcohol Supports” instead. The terms “MAP”, “Managed Alcohol Program”, “alcohol management” and “managed alcohol supports” will be used interchangeably throughout this document.

Guiding Principles

- **Respect:** case managers, health providers, and service users are mutually respectful in their interactions.
- **Collaboration:** Service users actively participate in their alcohol management plan and goals with their case managers.
- **Honesty:** Service users recognize the importance of honesty regarding their alcohol management plan.
- **Trust:** Working relationships of case managers, health providers and service users are built from a place of rapport and trust. Service users' trust cannot be assumed and oftentimes needs to be earned.
- **Harm Reduction:** Program goals reflect minimizing and reducing harm related to the harmful effects of alcohol and non-beverage alcohol consumption. This may or may not involve reduction in substance use, depending on the individual service user's goals.
- **Cultural Safety:** The program supports a culturally safe and relevant environment for service users.
- **Trauma-informed:** case managers and health providers understand the prevalence of trauma, its impact on health, well-being, and behaviour, and put this knowledge into practice

Alcohol Management General Overview

- Alcohol Management is an evidence-based practice with extensive research on social and health outcomes.
- Service users may be motivated and interested in joining the program or PSH staff may encourage potential service users that may benefit from alcohol management.
- An appropriate candidate may be a resident whose alcohol use is causing serious and imminent health risks that jeopardize their housing situation and/or independence.
- Alcohol management operates as a **voluntary program**, in which the resident and staff enter an agreement to obtain, store, monitor, and dispense alcohol.
- Alcohol is dispensed in an agreed upon amount and times and intervals based on collaboration between service users and staff (e.g. case managers, health care professionals, social workers, support workers).
- Service users have the right to participate in alcohol management at their discretion; however, if the service user lacks capacity or exhibits self-harming behaviors, staff are supported in encouraging service users to re-visit their plan (i.e. reviewing the contract, revising the goals, discussing risks, etc.). Where service users have appointed guardians, they should be consulted and involved in the development of their contract/care plan.
- Wrap-around supports and linkage to community resources will be made available to address service users' social determinants of health.

Alcohol Management Goals

The objectives of managed alcohol supports include:

- 1) Service Users' Health & Wellness
 - Improve the balance of the service users' health
 - Reduction in levels and patterns of intoxication
 - Replacement of non-beverage alcohol use with safer beverage alcohol , as distributed through the program
 - Reconnection with family, social supports and community
 - Reduction, and management, of the risks associated with substance use
 - Reduced stigma experienced by service users
- 2) Healthy communities (internally)
 - Inclusion, reducing social isolation and building positive relationships
 - Increased sense of belonging
 - Improvements in quality of life
 - Balancing the needs of community with respect for service users' choice
 - Educating and supporting the service users and their families
 - Enabling participants to budget their finances for more financial stability
- 3) Social participation in the local community (external)
 - Engaging service users meaningfully in their community
 - Reconnecting services users with their community (neighbourhood, culture, etc.)
- 4) Housing Stability/Stable Tenancy
 - Permanent, safe and supportive homes for service users
 - Enabling service users to identify areas of support required for ensuring long-term housing stability
- 5) Continuity of Care
 - Enhancing cooperation, coordination, communication amongst community partners
 - Improving communication amongst service providers
- 6) System Use
 - Reduction in Emergency and EMS/ambulance visits

- Reduction in arrests and incarceration
- Reduction in police interactions
- Reduction in interactions and offences with bylaw and transit

Service User Engagement Plan

The success of Alcohol Management hinges upon the service users voluntarily participating in the program. The program should offer a safe and supportive environment where service users want to be included in the alcohol management community. Communication and engagement with service users will occur repeatedly in a variety of ways.

The service user engagement plan is multi-dimensional and could include:

- 1) Staff Preparation
 - Discussions at team meetings
 - Core training/reading to prepare staff
 - Review of protocol document with staff
 - Addressing questions/concerns (FAQs)
- 2) Service User Preparation
 - Informal conversations with potential service users (one-on-one) describing Alcohol Management
 - Planning with staff to identify who should be having these conversations and which service users should be approached
- 3) Information Meetings
 - Creating posters/signs inviting service users to the information sessions
 - Serving food at the meetings
 - Holding as many meetings as required to ensure Alcohol Management is understood and service users feel comfortable to participate
- 4) Health Professionals
 - Incorporating time for health practitioners to meet with the service users at a separate session or during one of the information sessions
 - On-site medical staff (e.g. a nurse) can discuss Alcohol Management with service users one-on-one
- 5) Peer Support
 - Encouraging Peer Support Staff to have conversations with potential participants to explain the benefits of the program further (e.g. Peer Support Staff may facilitate talking circles).
 - Including peer support staff in on-going check-ins with service users to discuss the program (on-going talking circles)

Implementation of Individualized Managed Alcohol Supports

In a permanent supportive housing environment, managed alcohol supports are often implemented and structured as follows:

- Alcohol is **stored in** clearly labeled containers in a **designated space** in a staff office. Storage for larger quantities of alcohol is held in the staff office on clearly labeled shelving.
- Alcohol **distribution schedules** and quantities are expressed in a binder in the staff office. **Service users come to the desk to get their alcohol at the agreed upon time.** Designated **staff initial** when alcohol has been dispensed in a clearly labeled binder with quantity and time of pour included.
- **Staff are responsible** for ensuring **documentation** material is up to date and to ensure that **enough alcohol is on-site.**
- Staff and the service user collaborate to shop for alcohol supply.

Features of Individualized Managed Alcohol Supports

TARGET POPULATION & ELIGIBILITY

- Individuals who exhibit extreme behavior as the result of their alcohol use are strong candidates for alcohol management. Staff can work to recruit these individuals based on the following considerations:
 - Vulnerability
 - Risk of withdrawal
 - Repeated falling and/or accidents
 - Behavior resulting in harm to self or others
 - Memory loss, dementia, and/or lacking capacity
 - Chronically disruptive behavior
 - Housing at risk due to excessive drinking
- In some programs, service users meet with a doctor once a week to determine if they are healthy enough to be on MAP
- Program participation is voluntary (opt in/out), allowing freedom of choice

CONTRACTS

- A service user will enter into a contract when they choose to participate in an alcohol management program. Typically, these contracts include:
 - An alcohol distribution plan made in conjunction with health professionals and/or support staff or case managers. Plans typically include agreed upon times of distribution and quantities of alcohol, as well as the type of alcoholic beverage offered.
 - A written agreement permitting staff to lessen or withhold an alcohol dose if there are signs of intoxication or service users are behaving in a way that is dangerous to themselves or others.
 - Details about alcohol supply/storage (staff will keep alcohol supply secure and safe in a designated area).
 - Details about when/how changes in the alcohol distribution schedule or plan may be made, and who might be involved in implementing these changes.
 - Details about how health professionals or other staff will ensure service users' physical and mental health needs are being met on the contract.
- In some settings, it is common for contracts to be modified on a regular basis, as service user needs change. Anecdotally, we know that it is rare for service users to opt out of

their contract when they are refused alcohol—most prefer to stay on the program and communicate/negotiate any changes to their contract they may need to stay on track.

- Contracts should include information about WHY managed alcohol contracts are offered and what the agency/community hopes to achieve through offering a MAP. In some managed alcohol programs, service users are also encouraged to set regular goals that they'd like to achieve through their involvement in the program. For example, a service user may want to reduce injuries, improve their health, and/or improve their relationship to other people. Other local programs opt not to have residents explicitly write out their goals, as they want to avoid any guilt or shame if they do not meet these goals. Whatever decision is made around recording/not recording service user goals, it is important that alcohol contracts reflect the needs and preferences of service users to the greatest extent possible.

PROCUREMENT

- Some programs purchase the alcohol on behalf of the service user while some service users may purchase their own alcohol.

Who covers the costs? And what if the service users cannot afford as much alcohol as they need under the program?

- Some programs rely on a combination of donations and service user funding.
- In the case of service users with a designated public trustee, there can be collaborative efforts to adjust their stipends to ensure that they are able to purchase the alcohol on their contract.
- Some programs are able to supplement alcohol for service users unable to afford it.
- Other programs focus on money management and work closely with service users to help them budget for the alcohol on their contract.
- In cases where a third party is paying rent/service fees for a service user, some programs will increase this third party payment and use the surplus funds to purchase gift cards to a liquor store for service users to purchase the alcohol on their contract.

How will the program sustain alcohol costs if the service user cannot afford to keep up the costs?

- Programs are encouraged to be creative (see examples above) so finances are not a barrier to accessing the program.

Can a program brew their own alcohol?

- The Gaming and Liquor Act does permit an adult to make up to 460 litres of beer or wine in the adult's residence for personal consumption. The legislation is very specific in that the beer and wine must be produced in the adult's residence.
- Each program will have to determine if they have the resources and/or capacity to brew their own alcohol (e.g. space, staffing).

Is there a best practice type of alcohol health-wise?

- The type of alcohol offered often varies between programs, and between service users. Service user choice and price point are likely the most important factors.

STORAGE

- Alcohol should be stored in clearly labeled containers in a secure and designated space in a staff office.

SERVICE DELIVERY

Dosing

What is the recommended/suggested dosing?

- Dosing is dependent upon various factors including but not limited to the age, previous pattern of use and/or tolerance, their preferred type of alcohol, any history of complicated withdrawal (e.g. seizures), concurrent health conditions, medications, use of other substances.
- Service users should be involved in determining the amount and pattern for dosing – they often have a good idea of what their 'tolerance' is and how much alcohol they require to avoid symptoms of withdrawal.
- The goal of the program is ensuring people are not overserved. If the service user appears intoxicated, the service provider might consider withholding their next dose. Re-assessment of dose and/or dosing schedule may be warranted, if repeated intoxication.
- If a service user is refused a scheduled dose, some may source alcohol/substances elsewhere, and staff may observe **reactive** ("defiance") drinking. This is important to keep in mind when considering whether to withhold a service user's dose and tailoring to individual needs.
- It may be a good idea to keep non-alcoholic beer or wine on-hand for service users. Sometimes they will find this to be an acceptable alternative.
- Under-dosing can also be as risky as over-dosing due to the risk of withdrawal.

Swap Programs to Reduce Harms related to Non-beverage Use

- There are also alcohol “**Swap**” programs, where individuals who are not ready to sign a contract and commit to a dispensing schedule can still reduce substance-use related harms by “swapping” non-beverage alcohol for beer or another beverage. For example, for service users who seek out non-beverage alcohol, some programs supply and offer 4 beers in exchange (2 immediately, 2 an hour later) for a bottle of mouthwash.
- Staff should adjust the dose of beverage alcohol, if they see signs of non-beverage consumption.
- Most service users drink non-beverage because of costs not because they prefer it. Money management supports (e.g. to help pace spending through the month) may help reduce non-beverage alcohol use.

How do you convert quantities and types of alcohol to an appropriate dose? How do you convert a bottle of Listerine into beer or wine?

- Dosing needs to be individualized and is determined by staff in collaboration with the service user, as detailed above, including based on signs and symptoms of withdrawal. The team of service providers may decide, with the service user’s agreement, to start with 1 standard drink every XX hours and then adjust the dose according to their behaviours, outside drinking, level of intoxication/function and withdrawal symptoms.
- If the health team is primarily responsible for dosing, frontline staff play an active role in making recommendations on dosage to the health team based on direct observations.
- There is no formula for conversion, and service users may not be able to accurately recall the quantities they are truly drinking.

Dispensing

Who dispenses the alcohol?

- Local models of managed alcohol supports vary in the extent that they incorporate healthcare professionals; in some programs, clinicians are responsible for dispensing alcohol to service users, and in others this is the work of other support staff.
- If clinicians are involved in dispensing alcohol there are specific guidelines they must familiarize themselves with (e.g. Residential Tenancy Act vs. Long-term Care Accommodation Standards, Alberta Gaming, Liquor, and Cannabis Commission).
- There are many factors to consider when planning who will dispense alcohol and how, and a wide variety of strategies to meet the needs of service users and staff (see below).

Is there a best way to dispense?

- Local knowledge and discussions between agencies suggest that there is no single “best” way to dispense. Managed alcohol providers and service users should work collaboratively to determine a means/schedule of dispensing that meets the needs of

both individual clients and their community members. In addition to ensuring that clients are met where they're at and are able to exercise some autonomy over their alcohol contracts, inviting clients and community members to actively participate in program design can aid in relationship building and promote buy-in for the program.

- Locally, several different agencies are dispensing alcohol to clients in different ways based on their diverse needs. For example, in a long-term care home or acute care setting, where individuals often have complex health conditions that require close monitoring of alcohol consumption, alcohol dispensing may be more regimented than it is in settings where clients live more independently. Some contracts will dispense specific quantities of alcohol at specific points-in-time during the day, while others might be more general (i.e.: the client will have a maximum of 8 beers per day, between the hours of 11am – 9pm).
- Some programs dispense in strict quantities intended to be ingested at a specific point-in-time, while others will allow “carries”, meaning service users can retrieve more than one “dose” and take with them for consumption at a later time. This may depend on the drinking habits and needs of individuals (e.g. does the individual have a history of binge drinking?).
- Some programs dispense into specific mugs or glassware to protect service users’ privacy (others won’t know exactly what beverage they are consuming) and prevent others from trying to access their alcohol.
- Agencies or service settings may be governed by different legislation that may also impact their method of alcohol dispensing (e.g. Residential Tenancy Act vs. Long-term Care Accommodation Standards, Alberta Gaming, Liquor, and Cannabis Commission).

Intoxication

What tools are used for assessment of intoxication? Or what strategies are successful to assess intoxication?

- Familiarity with service users helps to assess intoxication. For example, staff may assess intoxication by watching for slurred speech, changes in balance or physical movements, verbal and/or physical aggression, etc. If staff have a relationship to service users, this will increase their ability to recognize how they behave when intoxicated.
- Some programs use intoxication scales to help familiarize staff with signs of mild vs. more severe intoxication (See Appendix B)
- Some programs use clinical assessment tools, e.g. the Addiction Recovery and Community Health (ARCH) Team at the Peter Lougheed Hospital, base in-hospital provision of managed alcohol supports using pre-determined criteria.

- Formal administration of tools/assessments are appropriate in some cases; however, they can also be seen as intrusive and become a barrier to relationships and buy-in from some service users. They should be used with discretion.
- Thoroughly documenting typical resident behaviours, and signs of intoxication, can be a good strategy for ensuring that new or visiting staff are able to use these notes to inform their assessments and service provision when necessary.

Should staff acquire ProServe training to recognize intoxication levels?

- Each program can develop their own training plan
 - Relationship to/rapport with the service users is potentially as important as formal training regarding recognizing intoxication levels
- ProServe is intended to educate staff at licensed premises (restaurants, bars, retail stores) about responsible liquor sales. This training tool could be helpful but is not mandatory in sites where no liquor license is required to offer managed alcohol supports.

How do you handle a service user's alcohol request when intoxicated? How do you handle or respond to service user intoxication?

- Staff need to make judgement calls and assess risk of harm with the understanding that if the person is refused, they may try and obtain alcohol from somewhere else.
 - There are ways that some programs attempt to mitigate these challenges.
Example: holding back dosing for one hour if a service user has been out of the building; requesting client have something to eat prior to dispensing, offering a substitute beverage including non-alcohol beer or wine
- The choice around refusing a service user's alcohol request is often highly individualized. Withholding from some service users may lead to more harm, whereas it may be beneficial to other service users.
- The relationship between the staff and the service user should not be centered on ownership around alcohol but rather supporting and assisting the service user to experience less harm related to their substance use.
- Staff should actively work towards overcoming the perceived power differential around who holds the alcohol. This is about building relationship and community that is supportive of the individual's goals and those of the MAP.

What are the consequences of giving alcohol to someone who is already intoxicated? Are there any legal ramifications? Isn't this type of program going to have issues with liability?

- The goal of the program is ensuring people are not overserved. Dosages should be withheld if the service user is intoxicated to the extent that they are disruptive or a

danger to themselves or others. In such cases, dosages can be re-assessed in consultation with service users.

- Alberta Gaming, Liquor, and Cannabis does not regulate private residences. Activities within a private home fall under the criminal code.

Off-contract and Non-beverage Alcohol Consumption

How do you manage off-contract consumption?

- Reassure the service user that it's okay, rather than responding in a way that may cause shame or anger.
- It is likely that off-contract consumption will occur in the case of many service users; the best step is to work with them to discuss how their contract may be amended to reduce their need to drink off-contract

STAFFING

Levels of staff

- These vary with between agencies/organizations, based on the resources available to them.

Training

- Important for staff to have skills to assess intoxication and understand relationship/power balances between staff and participants.
- Complex mental health education aka harm reduction education (Rouleau Manor has developed to educate and train staff in harm reduction.)

Do all programs have medical support linked to them?

- This varies between programs. Some programs have more clinical support or medical oversight than others. For example, in a long-term care site, a physician may be directly involved in approving involvement in the Managed Alcohol Program, and in assessing each resident's dosage/schedule. Some programs are offered in settings with significantly fewer medical supports; non-clinical staff play a greater role in assessing intoxication and making judgements about dosing/withholding doses, based on their relationship to service users and knowledge of their behaviours and needs, particularly with regards to stabilizing housing. In some settings, social workers and/or support workers may take on the majority of these tasks.

EVALUATION

How are you evaluating MAP?

- Evaluations are likely to differ at each agency, ideally capturing the experiences of service users/patients, staff, +/- meeting the funders' expectations/requirements.

- Typically includes: Quality of life measures and risk reduction: falls, aggressive events (verbal/physical), calls to EMS and police.

What are some program outcomes?

- Fewer aggregated days in hospital
- Impact ‘risks’ associated with substance use
- Sustained reduction in alcohol use

What are some challenges of implementing MAP?

- Participant buy-in and compliance
- Building and maintaining trust between service providers and service users
- Pressure from service user’s social groups to share their alcohol
- Shame, guilt, stigma
- Storage in the office, level space and amount of time, and trying to manage giving out alcohol and medication.

OTHER QUESTIONS

How are mental health concerns affected with an individual being on a MAP?

- Improved mental health and well-being are usually goals of participation in MAP, and may be explicitly identified, or not, depending on the participants’ needs and preferences; support staff may track mental health through a variety of subjective and objective measures.
- In more medical models, the health team will complete a formal initial assessment of both their physical health and mental health concerns prior to starting MAP. They will liaise with other appropriate resources. This can be observed and documented through the Care Plan.

How is taking prescribed medications affected when on a MAP?

- All medications will be monitored by the health team, as alcohol use can impact medication metabolism.
- When developing the Care Plan all appropriate health professionals should be involved. Any family doctor connected to the service user should be informed of the MAP program and consulted.
- A goal of the program is Continuity of Care – communication between medical professionals should be emphasized.

Should MAP programs incorporate/offer nutritional supplements (e.g. Thiamine, Folate, Magnesium, Multi-vitamin)?

- Chronic alcohol use in high quantities is known to cause certain nutritional deficiencies, including but not limited to thiamine, folate, magnesium.
- Unfortunately, many programs do not have the funding to offer nutritional supplements as part of their managed alcohol supports.
- If a primary care provider prescribes these supplements, sometimes they can be covered by AISH, and agencies/organizations may be able to help advocate for service users' access to these supplements.

Can Managed Alcohol Supports be combined with Naltrexone or other pharmaceutical treatments for Alcohol Use Disorders?

- Yes, depending on the service user's underlying health, other medications, etc.

What if the service user wants to take a break from drinking?

- Staff and the health team will work to connect the service user to appropriate detoxification and recovery supports.

Isn't this type of program going to build more dependency on alcohol?

- This is harm reduction program aimed to reduce harms associated with extreme alcohol dependency.
- Supporting clients with their own goals while working to keep them safe accomplishes several things: 1) establishes a positive, supportive, and trusting relationship between the client and staff; 2) exposes clients to a relationship with unconditional positive regard, where the staff demonstrates that the client's value is not based on their behaviour, but an intrinsic self-worth. This is critical as many clients have not experienced this before.

Isn't this program just giving up on the service user?

- This program is about investing time, energy, and effort in a collaborative way with the service user to improve their quality of life and housing stability. This is a program for service users who do not want to abstain from alcohol use, or who have not been successful in any other model.
- MAP is effective because it acknowledges clients in the pre-contemplative, and contemplative Stages of Change (see Prochaska and DiClemente) and a skilled staff member should be gently encouraging clients to move further along the Stages of Change at the client's own pace. This process is not linear (clients may start acting

towards a goal of abstinence and then return to drinking) and may take years for clients to arrive at the action stage.

How do you know MAP is not working for the service user?

- Short-term indicators may include an increase in falls/frailty, repeated EMS visits, or other evidence of functional decline. Research has shown that most individuals often experience these when they start on the program but then stabilize.
- Some service users may react adversely to perceived power dynamics associated with managed alcohol supports. In many cases there are steps that can be taken to mitigate these challenges, but for some, managed alcohol may not be an appropriate course of care.

Is a short-term timeframe feasible for a MAP?

- Managed alcohol supports have been offered in settings such as hospitals or emergency shelters over short durations of time to meet immediate client/patient needs (e.g. avoiding withdrawal). This will depend on the program's objectives.

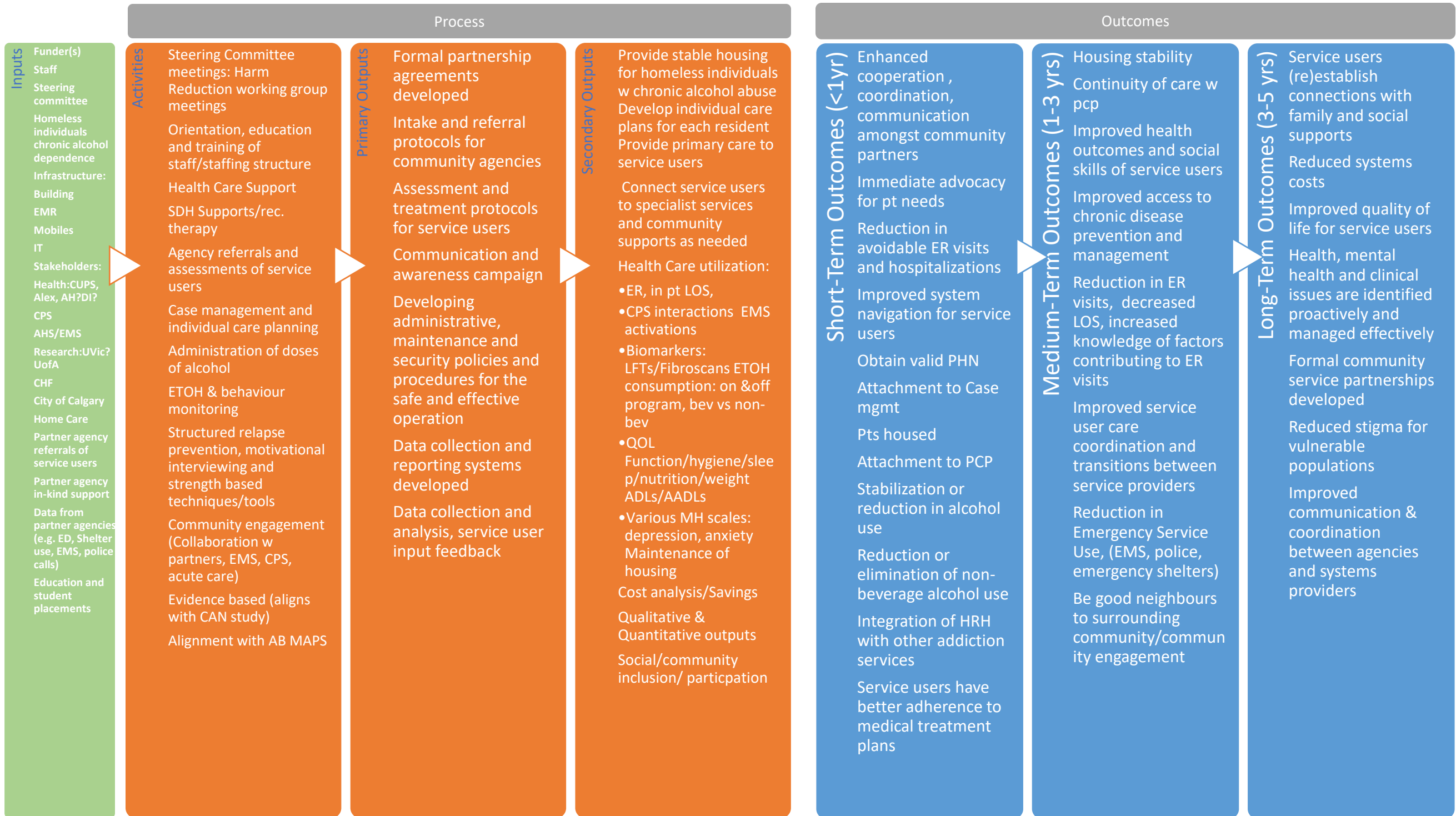
Is poly-substance use a challenge and how is it managed?

- Strong relationships with service users help facilitate transparency regarding substances being used and opportunities to mitigate harm related to use
- Pour schedules may be adapted based on the prescription medications a service user may be taking and the schedule of these prescriptions.
- In terms of illicit substance use, it is a good idea to coach and educate frontline staff on how to identify intoxication related to different substances.
- Smoking cannabis is allowed in several sites since its recent legalization; this is an area that may warrant future investigation as it relates to offering managed alcohol supports.

Is participation in Alcohol Management always accompanied by a decrease in alcohol use?

- It varies. For some service users, alcohol consumption remains constant. With other service users the use will decrease; however, this often takes time.
- The opposite is also possible for other service users. For example, for service users who are prone to "binging" rather than daily drinking, their overall consumption may increase; however, their doses may be spaced out in a way that allows them to increase their quality of life, housing stability and social participation.

Appendix A: CHH MAP LOGIC MODEL [sample]



Intox Assessment Tool

	1 Sober	2 Influenced	2.5 Intoxicated	3 Highly Intoxicated	3.5 Extreme Intoxication	4 Dangerously Intoxicated
	Requires no Assistance	Requires Minimal Assistance	Requires some Assistance	Requires 2 staff Assistance	Requires Staff Assistance with Wheelchair	Likely Requires Medical Attention
Alcohol	-Reports consuming less than 2 drinks in the past 4 hours -Appears physically unaffected	-Reports consuming more than 2 drinks in past 4 hours -Slurred speech -Lowered inhibition -Unsteady on feet	-Smell of alcohol -Delayed response -Loud, overly friendly or inappropriate behaviour -Impaired balance	-Severely impaired balance -Glazed/bloodshot eyes -Speech is very slurred -Incontinence	-Incoherent or mumbled Speech -Difficulty staying awake -Cannot support own weight to stand or walk	-Unconscious -Unresponsive -*High risk of ETOH poisoning*
Opiates	-Reports not using in the past 4 hours. -Appears physically unaffected	-Reports using in past 2 hours -Euphoric -Lethargic	-Drowsiness -Restricted pupils -Slowed response -Impaired balance/coordination	-Difficulty concentrating -Sleepiness "On the Nod" -Severely impaired coordination -Responsive to verbal stimulus and touch	-Extreme sleepiness -Not responsive to verbal cues -Responds to touch -Slowed breaths -Waxy posture	-Slow shallow breathing -Delayed or no response to physical touch -Vomiting -*High risk of overdose*
Stimulants	-Reports not using in the past 8 hours -Appears physically unaffected	-Discloses using in past 12 hours -Hyper-activity -Talkative -Clenched jaw	-Rapid speech -Tense, abrupt movement -Dilated pupils -Sweating -Fixation	-Repetitive movements (pacing, rocking) -Anxiety -Paranoid thoughts -Heart palpitations	-Incoherent, delusional thoughts -Fearfulness -Combativeness	-Psychosis -Hallucinations -Extreme Paranoia -Panic -*High risk of overdose

Assessment Questions	General Observations
When did you last use or drink? What did you use or drink? How did you use? (smoke, injection, snort) Is this new? When did you last sleep?	Pay attention to their presentation. Odor, appearance, body language. How well do they follow verbal instructions?

AUDIT

Introduction

The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol-related problems. Both a clinician-administered version (page 1) and a self-report version of the AUDIT (page 2) are provided. Patients should be encouraged to answer the AUDIT questions in terms of standard drinks. A chart illustrating the approximate number of standard drinks in different alcohol beverages is included for reference. A score of 8 or more is considered to indicate hazardous or harmful alcohol use. The AUDIT has been validated across genders and in a wide range of racial/ethnic groups and is well-suited for use in primary care settings. Detailed guidelines about use of the AUDIT have been published by the WHO and are available online: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?

- (0) Never [Skip to Qs 9-10]
- (1) Monthly or less
- (2) 2 to 4 times a month
- (3) 2 to 3 times a week
- (4) 4 or more times a week

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

- (0) 1 or 2
- (1) 3 or 4
- (2) 5 or 6
- (3) 7, 8, or 9
- (4) 10 or more

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

3. How often do you have six or more drinks on one occasion?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year





Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual.

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
<p>12 oz.</p>  <p>~5% alcohol</p>	<p>12 oz. = 1 16 oz. = 1.3 22 oz. = 2 40 oz. = 3.3</p>
MALT LIQUOR	
<p>8-9 oz.</p>  <p>~7% alcohol</p>	<p>12 oz. = 1.5 16 oz. = 2 22 oz. = 2.5 40 oz. = 4.5</p>
TABLE WINE	
<p>5 oz.</p>  <p>~12% alcohol</p>	<p>a 750 mL (25 oz.) bottle = 5</p>
80-proof SPIRITS (hard liquor)	
<p>1.5 oz.</p>  <p>~40% alcohol</p>	<p>a mixed drink = 1 or more* a pint (16 oz.) = 11 a fifth (25 oz.) = 17 1.75 L (59 oz.) = 39</p> <p>*Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.</p>