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A Randomized Control Trial of a Chronic Care Intervention for Homeless Women With Alcohol Use Problems

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ABSTRACT

A clinician-randomized trial was conducted using the chronic care model for disease management for alcohol use problems among n = 82 women served in a health care for the homeless clinic. Women with problem alcohol use received either usual care or an intervention consisting of a primary care provider (PCP) brief intervention, referral to addiction services, and on-going support from a care manager (CM) for 6 months. Both groups significantly reduced their alcohol consumption, with a small effect size favoring intervention at 3 months, but there were no significant differences between groups in reductions in drinking or in housing stability, or mental or physical health. However, intervention women had significantly more frequent participation in substance use treatment services. Baseline differences and small sample size limit generalizability, although substantial reductions in drinking for both groups suggest that screening and PCP brief treatment are promising interventions for homeless women with alcohol use problems.

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1. Introduction

There is a substantial prevalence of substance abuse among homeless women, including both alcohol and drug use. At the same time, there is limited gender-specific research on how to best address prevention and treatment of addiction problems among women, and especially among such high risk populations as homeless women (National Research Council, 2010). Studies of homeless women surveyed on the street or in shelters over the past two decades have shown that between 31% and 41% have a lifetime alcohol abuse, or dependence problem, and up to 82% have a substance use disorder inclusive of both drugs and alcohol (Bassuk, Buckner, Perloff, & Bassuk, 1998; Nyamathi, Longshore, Galaif, & Leake, 2004; Roberston, Zlotnick, & Westerfelt, 1997; Torchalla, Strehlau, Li, & Krausz, 2011; Wenzel et al., 2004, 2009). A recent study that screened 461 women receiving primary care in a health care for the homeless clinic, found 43.8% reported hazardous drinking in the last year (Upshur, Weinreb, & Bharel, 2013). Further, studies of the homeless have found that a substance use disorder, or continued consumption of alcohol or illegal drugs, have an effect on housing stability, length of homelessness, and ability to exit homelessness (Bassuk et al., 1997; Bird et al., 2002; Folsam et al., 2005; Gregorie, 1996; Reardon, Burns, Preist, Sachs-Ericsson, & Lang, 2003; Sosin & Bruni, 1997; Weinreb, Rog, & Henderson, 2010; Zlotnick, Tam, & Robertson, 2003).

Despite wide recognition of substantial substance use issues in the US, access to services and engagement in addiction treatment is limited. The National Survey on Drug Use and Health in 2003–2004, for example found that only 7% of the 19 million adults with a need for alcohol treatment actually received treatment (Willenbring, 2007). However, homeless individuals may have even more barriers to accessing addiction services than other populations. For example, lack of stable housing may result in inability to use outpatient treatment (Wenzel et al., 2001), women with social networks consisting primarily of substance users often are discouraged to engage in treatment (Kertesz et al., 2006), and high rates of co-occurring mental health problems, common in homeless populations, are associated with less use of substance abuse treatment (Gonzalez & Rosencheck, 2002; Wenzel et al., 2001). In addition, clinicians in health care settings working with the homeless population may presume that their patients have less ability and motivation to take advantage of addiction services (Wen, Judak, & Hwang, 2007). However, a recent study that examined motivation to address drug and alcohol problems among homeless women compared to low income women without a homelessness experience, found no differences in motivation to reduce alcohol or drug use between these groups of women (Upshur et al., 2014). Nevertheless, while specialized health care services are available for homeless individuals (Section 330 (h) of the Public Health Service Act), providers in these settings, as well as

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general medical care, struggle with how to best engage patients in addiction treatment.

Women seem to have particular barriers to engaging in addiction services because traditional treatment models have been male-oriented and male-dominated (Gessler, Bormann, Kwiatkowski, Braucht, & Reichardt, 1995; National Women's Resource Center for the Prevention and Treatment of Alcohol, Tobacco and Other Drug Abuse & Mental Illness, 1997; Zerger, 2002). On the other hand, women, including homeless women, use primary health care more frequently than men (Stein, Andersen, Koegel, & Gelberg, 2000), and women with addiction problems are more likely to follow detoxification by linking to primary care when supported to do so (Saitz, Larson, Horton, Winter, & Samet, 2004). There is also evidence that women feel that primary health care is less stigmatizing than specialty services for substance use or mental health concerns (Green, 2006).

Health care reform in recent years has similarly moved in the direction of providing more comprehensive services for mental health and substance abuse in primary care. For example, there is current support for the importance of primary care settings to address alcohol use problems by providing screening, brief intervention, and treatment referrals (Solberg, Maciosek, & Edwards, 2008). One model that has recently been promoted as a framework for addressing drug and alcohol problems and other health risk behaviors in primary health care settings is the collaborative care/chronic illness model (CCM) (Hung et al., 2007; Saitz, Larson, LaBelle, Richardson, & Samet, 2008; Watkins, Pincus, Taniellian, & Lloyd, 2003). The CCM was initially focused on diseases such as diabetes, which require patient engagement in managing the condition, and frequent physician monitoring (Wagner, Austin, & Von Korff, 1996). Watkins et al. (2003) and Saitz et al. (2008) both point out the characteristics alcohol use disorders have in common with other chronic medical diseases to support the notion that the CCM has promise to address alcohol problems in primary health care settings. These include the long term and relapsing nature of alcohol use disorders, the unpredictable course of symptoms, complex origins, the need for patient-initiated care/collaboration, behavioral supports, and frequent monitoring. The premise is to reorganize the typical pattern of delivering acute or episodic care to individuals with chronic illnesses, by proactively managing care and engaging patients in collaboration in their health care maintenance.

The current study implemented the CCM in a small pilot, clinician randomized trial, to treat women who screened positive for hazardous drinking during a primary health care visit in a health care for the homeless clinic. To date there are limited trials of the CCM addressing alcohol use disorders in primary care, and none that addresses the specific needs of homeless women who have significant need for effective treatment options. The study was called Project RENEWAL: Research and Evaluation on NEW ALcohol Treatment Interventions for Homeless Women. The study hypotheses were that: 1) the CCM would significantly increase initiation, engagement, and retention in alcohol treatment for the intervention group compared to the usual care group over the 6-month follow up period; and 2) there would be significant effect sizes favoring intervention women on drinking amounts, mental and physical health, and housing outcomes to justify further research and dissemination of this treatment intervention.

All participants provided informed consent, and the study was conducted in accord with the standards of the university institutional review board for research on human subjects.

2. Materials and methods

2.1. Site and recruitment methods

Project RENEWAL was conducted in a federally qualified health center in the northeast that is one of a national network of 208 health care for the homeless grantees (Health Care for the Homeless Program, 2011). Subjects were women seeking primary health care services and who met the following study criteria: 1) screened positive for hazardous drinking using a validated alcohol use screening instrument; 2) had an assigned primary care provider (PCP) at the site or were willing to agree to receive on-going primary health care at the site; 3) were English speaking; 4) were 18 years of age or older; 5) were not receiving on-going residential or outpatient substance abuse services or HIV case management at time of study entry; and 6) were not actively psychotic at study entry.

Women with clinic appointments over a 1 year period were screened in the clinic waiting room using the AUDIT-C, 3-item alcohol screening instrument frequently used in primary care settings (Bradley et al., 2007; Bush, Kivlahan, McDonell, Fihn, & Bradley, 1998; Fiellin, Reid, & O'Connor, 2000; Frank et al., 2003; Gordon et al., 2001). A one-page back to back sheet included demographic questions and the three AUDIT items on the front, along with a box to check if they were willing to discuss participation in a study and provide contact information. The back of the sheet had 11 additional questions with yes/no responses designed to establish whether their alcohol use met the DSM-IV definition of abuse or dependence (National Institute on Alcohol Abuse & Alcoholism, 2005). The AUDIT-C questions were modified in two ways: 1) the amount of drinks required to indicate binge drinking was lowered to the level hazardous for women (4 or more drinks instead of 5 or more drinks), and 2) the description of alcohol included use of substances such as cough syrup and mouthwash which are often used in the homeless population. (For more information about the screening process please see Upshur et al., 2013). Clinic staff scored the responses, and women whose score was 4 or greater (range was 0–12), were asked to fill out or decline the study contact information, and to complete the back of the form to assess symptoms of alcohol abuse or dependence. This score was one point above the minimum score indicating hazardous drinking in order to assure study referrals were women with significant alcohol consumption issues. All forms were then attached to the patient paperwork provided to the clinician at the health care visit.

2.2. Randomization and study enrollment

The research design was a clinician randomized design. All PCPs (MDs, PAs and NPs) who provided on-going primary care services at the clinic were randomly assigned to intervention or usual care condition by a computer program. There were 15 clinicians in the study. All patients of the clinic were routinely assigned a PCP, and therefore, the intervention status of study participants depended on their assigned clinician's status. Study enrollment occurred at a primary care visit after Project RENEWAL screening was launched in the clinic, and after a positive screen (score of 4 or more) and agreement to be contacted by the study research coordinator (RC). At the end of the health care visit, the PCP or nurse was asked to call the on-site research office. The RC or a volunteer would then escort the potential participant to the research office to discuss Project RENEWAL, complete informed consent, and the baseline study interview. Prior to completing the consent and interview a pre-screening process was used to verify eligibility based on all study criteria (described above). In addition, current sobriety was checked by using a salvia blood alcohol screening kit. Women who did not have time to complete study enrollment or who were intoxicated at the time (blood alcohol level > .08), were asked to return at an appointed time to complete enrollment.

2.3. Intervention and usual care

The Project RENEWAL intervention consisted of: 1) providing evidence-based training and supports to the medical leadership and randomized intervention PCPs; 2) modifying the electronic medical record (EMR) to provide alcohol screening results and alcohol-specific notes for PCP and care manager (CM) visits; and 3) training a CM specifically designated to provide intervention participants with alcohol

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