



# AOTA Evidence Briefs

## Substance-Use Disorders

*\*A product of the American Occupational Therapy Association's  
Evidence-Based Literature Review Project*

### SU 9

## **Case management may improve the financial and residential stability of chronic public inebriates and reduce their use of alcohol**

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Cox, G. B., Walker, R. D., Freng, S. A., Short, B. A., Meijer, L., & Gilchrist, L. (1998). Outcome of a controlled trial of the effectiveness of intensive case management for chronic public inebriates. *Journal of Studies on Alcohol*, 59, 523–532.

#### **Level: IA2a**

Randomized control trial, 20 or more participants per condition, moderate internal validity, high external validity

#### **Why research this topic?**

“Chronic public inebriates,” people with an extensive history of alcohol abuse and of unsuccessful participation in the treatment system, are a major public health problem. They “exhibit a combination of personal and socioeconomic problems, including homelessness, unemployment and poverty . . . , increased health and psychiatric problems . . . , increased cognitive impairment . . . and increased mortality” (p. 523). Although they are small in numbers, they represent a large cost in services. Standard approaches to treatment of them have not generally been successful.

#### **What did the researchers do?**

Cox, Walker, Freng, Short, Meijer, and Gilchrist (1998), variously affiliated with the Oregon Health Sciences University (Portland), Community Network Services (Seattle), the University of Washington (Seattle), and the King County Division of Alcohol and Substance Abuse Services (Seattle), decided to test the effectiveness of intensive case management, conducted by social workers, with a group of chronic public inebriates who were homeless or at risk of becoming so. “Case management” in this instance was “a long-term, open-ended outreach-oriented service focused primarily on system advocacy and linkage activities” (p. 525).

The researchers drew participants for their study from a pool of people who used the services of the King County (Seattle) Detoxification Center with high frequency. All the participants were homeless or at risk of homelessness. The researchers made a deliberate attempt to include more than a representative number of women and Native American men in their sample. To meet the criterion of high frequency, these people had to have had at least 4 admissions to the center in the year preceding the study. Other men included in the study had to have had at least 10 admissions.

In total, 298 participants were recruited (241 men, 57 women). Their average age was 42.9 years. Forty-four percent were White, 16% Black, 33% Native American, and 7% Hispanic.

The participants were randomly assigned to case management or standard treatment (not described in the article). Case management involved efforts by social workers to strengthen the participants’ social and personal skills and encourage their autonomy. The participants helped determine priorities among their needs and interests, and they were expected to take a strong role in addressing their problems. The social workers handled 15 participants each, on average. The goal for all participants was “to stabilize [their] financial condition and housing status and to encourage them to reduce substance use” (p. 525). In practice, the case managers spent most of their time acquiring housing for the participants and helping the participants maintain themselves in the housing. Frequency and duration of treatment varied widely because the intervention was based on the individual needs of the participants.

The outcome areas of interest were as follows: *improvement of financial stability* (as measured by total income from public sources, reported via the Addiction Severity Index); *improvement of residential stability* (as measured by nights spent by the participants in their own place for the preceding 60 nights, reported via the Personal History Form); and *reduction of alcohol use* (as measured by number of days drinking for the preceding 30 days, reported via the Addiction Severity Index). Measures were taken in interviews before the study began and at 6-month intervals for 2 years. One hundred ninety-three participants completed the first three follow-up interviews, 157 participants completed all four interviews.

### **What did the researchers find?**

The case management group improved **significantly** (see *Glossary*) more than the **control group** (see *Glossary*) on all three measures. “The results held whether the three variables were analyzed jointly or separately and for alternative measures of drinking and homelessness” (p. 523). The control group also showed marked improvement, however.

### **What do the findings mean?**

For therapists and other providers, the findings suggest that case management can improve the financial and residential stability of chronic public inebriates and reduce their alcohol use. The benefits do not generalize much to psychological or interpersonal functioning or to self-reported health.

Given that the control group also improved, an important question is whether case management is a cost-effective intervention. That is, does it produce sufficient savings in other public programs to offset its cost? Further research is needed on this issue.

### **What are the study’s limitations?**

The study has two limitations. First, it relied heavily on self-report. Thus some of the data gathered may have been unreliable, invalid, or **biased** (see *Glossary*). Second, reviewers may have introduced some bias into the data collection because they were aware of the circumstances from which the participants came.

## **GLOSSARY**

**biased/biases**—Biases are systematic errors within a study. When a study is biased, the means of treatment and/or control groups are artificially inflated or reduced. This artificial inflation or reduction can cause the study’s results to be incorrect; the treatment will appear to have an effect, when in reality it does not, or vice versa. Many of the limitations reported in these evidence briefs are related to biases.

**control group**—A group that received special attention similar to that which the treatment group received but did not receive the treatment.

**significance (or significant)**—A statistical term that refers to the probability that the results obtained in the study are not due to chance but to some other factor (e.g., the treatment of interest). A significant result is likely to be generalizable to populations outside the study.

Significance should not be confused with clinical effect. A study can be statistically significant without having a very large clinical effect on the sample. For example, a study that examines the effect of a treatment on a client’s ability to walk may report that the participants in the treatment group were able to walk significantly longer distances than those in the control group. However, after reading the study one may find that the treatment group was able to walk, on average, 6 feet, whereas the control group was able to walk, on average, 5 feet. Although the outcome may be statistically significant, a clinician may not feel that a 1-foot increase will make his or her client functional.

■ Terminology used in this document is based on two systems of classification current at the time the evidence-based literature reviews were completed: *Uniform Terminology for Occupational Therapy Practice—Third Edition* (AOTA, 1994) and *International Classification of Functioning, Disability and Health (ICIDH-2)* (World Health Organization [WHO], 1999). More recently, the *Uniform Terminology* document was replaced by *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2002), and modifications to *ICIDH-2* were finalized in the *International Classification of Functioning, Disability and Health* (WHO, 2001).

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For more information about the Evidence-Based Literature Review Project, contact the Practice Department at the American Occupational Therapy Association, 301-652-6611, x 2040.



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