The Resuscitation of a New Orleans Substance Abuse Treatment Agency After Hurricane Katrina

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On August 28th, 2005, Hurricane Katrina (Katrina) closed the entire New Orleans substance abuse treatment system, leaving people in need of treatment, including those in the treatment already, without services. Since then, the New Orleans substance abuse treatment system has re-opened in a flurry, with staff members attempting to establish order with what resources exist.[1] The period of reconstruction after Katrina presents an opportunity to examine how substance abuse treatment agencies have begun to operate in new ways. This report describes Katrina's impact on the clinical operations of the largest residential substance abuse treatment facility in New Orleans. Specifically, our intent is to briefly delineate how this facility operated clinically before Katrina, and how the concepts of therapeutic community were introduced into this facility to mitigate the stressors associated with a post-Katrina environment.

Previous disaster research. Post-disaster research suggests that Katrina may have had major effects on people in New Orleans with substance abuse problems.[2–5] As a result, treatment agencies may have to modify operations and resource allocation to accommodate a post-Katrina clientele with significant potential for increased impairment that may necessitate more intensive and longer treatment. For example, research has shown that providing health care in a post-disaster environment may lead to (a) a reduction in staffs' ability to address clients' post-disaster treatment needs, as well as (b) an increase in staffs' own post-traumatic stress symptoms.[6–7] Thus, substance abuse agencies may see an increase in staff taking sick leave,[2] physical and/or emotional exhaustion and low morale,[8] as well as regression to less effective intervention techniques.[9] During recovery from Katrina, New Orleans' substance abuse agencies face the unprecedented task of rebuilding a treatment system and treating a potentially more severely impaired and chronic clientele with potentially unstable staff.

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Bridge House: Pre-Katrina. Bridge House, Inc. is Louisiana's largest residential substance abuse treatment program. Bridge House has treated New Orleans's indigent residents with substance abuse problems since 1957. Bridge House is a not-for-profit (501.c.3) organization that, prior to Katrina, employed 80 staff members and had the capacity to treat 130 adult men. Approximately 75% of Bridge House funding was generated through in-house businesses (e.g., used car sales, thrift stores). Six years ago, Bridge House operated from a traditional treatment philosophy where counselors routinely used a confrontational approach by pressuring clients to accept themselves as *alcoholics/addicts*. If clients did not commit to one year of treatment and remain abstinent from substance use, they would receive ultimatums from counselors that led to the withdrawal of services for non-compliance. This clinical approach was not idiosyncratic to Bridge House, but representative of traditional substance abuse treatment.[10–11]

Bridge House also operated from a loose organizational structure; it lacked the infrastructure and characteristics that organizational research has shown to be key to effective and sustained organizational change.[8] Improvement efforts were unstructured and haphazard. Moreover, counselors and clients were minimally involved in the improvement process, and they typically viewed improvement efforts as a separate function within the organization. Thus, organizational improvement efforts were fragmented and their effects were unclear and difficult to sustain.

However, by August 2005, Bridge House was an example of an improving organization. The transition began in 2000 when Bridge House was awarded a grant to support the implementation of an evidence-based relapse prevention treatment curriculum. The model became the core treatment curriculum at Bridge House. Subsequently, Bridge House participated in a Center for Substance Abuse Treatment project. This project facilitated the adoption of motivational interviewing, an evidence-based counseling style.[10] Motivational interviewing (MI) replaced the traditional confrontational approach as the core clinical style at Bridge House. Bridge House also implemented a client database including the Drug Evaluation Network System software.[12] Finally, for the past three years, Bridge House has participated in the national Network for the Improvement of Addiction Treatment, an alliance of 40 drug abuse treatment programs using a Rapid Cycle Change model to increase early treatment retention and admissions/utilization, as well as to reduce treatment wait-time and no-shows.[13]

These changes at Bridge House were not singular events but components of a gradual shift toward organizational operations based on continuous quality improvement technology. However, on August 28th, 2005, Katrina put a halt to this development. The Bridge House facilities sustained wind and water damage; moreover, the Bridge House businesses (used car lots, multiple thrift stores) were flooded, looted, and vandalized.

Bridge House: Post-Katrina. During the six weeks following Katrina, Bridge House existed without electricity, gas, water, or sewage service. A majority of the buildings constituting the Bridge House campus had sustained significant hurricane-related damage. There were no clients and the staff had dropped from 80 to 3 people. In early October 2005, Bridge House administrators met with external consultants to discuss whether Bridge House could be resuscitated. The consultants proposed that the current Bridge House situation might be an appropriate time to reassess the strengths and weaknesses of the Bridge House program and might present an opportunity to

introduce a major change into the organization's structure. After a discussion of this proposal, the program director was asked to consider allowing the future post-Katrina clients to take primary responsibility for their own self-governance by having them develop their own formally constituted therapeutic community.

Eventually, Bridge House administrators decided to reopen, believing that the benefits to be derived from making the client component of the organization into a semi-autonomous subsystem, while relatively simple, would significantly enhance overall Bridge House treatment. For example, clients would be led to assume significant responsibility for supervision of their own actions and the behaviors of the group as a whole. Second, clients would have the opportunity through social interaction to develop their self-esteem and self-efficacy. As a result, the behaviors of clients, both open and clandestine, would be monitored much more closely. The expectation was that such dynamics would facilitate a cohesive community where clients operate with respect for self and others, as well a sense of responsibility for the recovery of self and others. Bridge House administrators believed a strong sense of community was critical to helping clients cope with the additional stressors of receiving treatment in a post-Katrina environment.

To work, the seed ideas spelling out the desired characteristics of a client community were initially provided to a small number of clients, who formed the nucleus of the community group. These clients were then asked to formulate a set of community policies and procedures to cover all major categories of community and individual client interactions. The materials developed were then assembled into a logical sequence of topics, codified, and made into a handbook. The clients were then instructed to meet together each day and work out the details of their community. This enabled the nascent community's social capital to accumulate slowly enough that it was molded and reshaped under the watchful eyes of both the clinical staff and the consultants. The clinical staff and consultants modeled their interactions with the clients after the tenets of the aforementioned motivational interviewing (MI).

The acceptance of the therapeutic community model by Bridge House was eased by the fact that the administration had been working over the previous three years to introduce changes using the Rapid Cycle Change (RCC) model techniques to improve various organizational and clinical processes and outcomes. The RCC model is based on five actions that research has shown to distinguish organizations that successfully change and improve versus those that do not: (a) select key problems, (b) involve the client, (c) involve outside experts, (d) use rapid cycle testing, and (e) pick a powerful change leader.[13]

The first step for an agency using the RCC model to guide their improvement involves answering the following question: *What are we trying to accomplish?* In this case, the answer was *implementation of a therapeutic community*. From this point, agency clients and staff were integrally involved in planning, implementing, and evaluating the progress of the therapeutic community. This involvement included the community meetings mentioned above, as well as focus groups facilitated by clinicians. Regular solicitation of feedback from key stakeholders provided the community leaders with valuable information that was used to adjust community policy and procedures. Additionally, external consultants helped the community's progress by identifying ways to custom-

ize the community policy and procedures optimally. When appropriate, the external consultants also provided technical assistance and training to support the identified changes. The importance of involving outside experts was to learn from their successes and failures. Outside experts were often able to take a comprehensive view of the situation, a perspective that fostered fresh ideas for community improvement within a post-Katrina environment. Changes to community policy and procedures identified through the above process were implemented in a rapid cycle (2 to 4 four weeks). Thus, the community used rapid cycle testing as long as the changes were resulting in desired outcomes (e.g., fewer rule infractions, increased group attendance). Finally, at the heart of the RCC model is the *change leader*. A change leader is a person who will serve as a champion or "cheerleader" for a programmatic change or set of changes. A change leader, in this case the clients leading the community, facilitated the RCC process from a position of pro-social influence and respect within the client community.

This process began on November 16th, 2005 when Bridge House reopened its doors to clients. During the first two weeks, the average daily census counted five clients. All clients followed the same daily routine, rising at 6:00 am, eating, engaging in silent meditation, and then being transported to a Bridge House retail outlet where they worked for eight hours a day sorting inventory, stocking shelves, and/or working sales. Upon returning each evening, clients ate dinner and then held a one-hour community meeting, first with the consultants and clinicians present. The consultants shared with the clients the basic attributes of what a client-based therapeutic community would look like structurally, and how it would function on a day-to-day basis. The clients were provided model handbooks and asked to develop a handbook of policy and procedures that they would use to govern their community. Since then, clients have continued with the community development process; Bridge House has been steadily admitting clients since November 2005.

Bridge House: Today. Currently, Bridge House has the capacity to treat 75 adult men at one time. Post-Katrina Bridge clients who also attended Bridge House programming prior to Katrina have consistently stated that the new Bridge House is a significantly better program, a program that is more client-centered. Clients have stated they feel more empowered and more responsible for their recovery due to the structure of the therapeutic community. Many clients have expressed the sense that the Bridge House client community provides a *safe place*, away from all the post-Katrina stressors in the city. The therapeutic community has proven helpful for traumatized clients, including one who was having difficulty dealing with the "image of dead bodies floating in Katrina's floodwater." Finally, Bridge House recently subsumed another New Orleans based residential treatment agency that was unable to restart operations after Katrina. As a new subsidiary of Bridge House, this facility is now fully operational. Thus, in addition to serving 75 men, Bridge House now serves 25 women.

Bridge House is one of the few New Orleans' substance abuse treatment providers that have successfully resuscitated themselves since Katrina. Natural disasters are not a question of *if* but a question of *when*. Substance abuse treatment agencies can learn from Bridge House about the barriers and facilitators to surviving in a post-disaster environment, and about the opportunities for improvement they may present.

Acknowledgments

Notes

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