Ministry of Health
Policy Instrument

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Deputy Minister
Ministry of Health

MINIMUM NURSE TO PATIENT RATIOS

OVERVIEW

Nursing is complex work, often undertaken in challenging environments, that requires substantial skill and emotional resilience to effectively and appropriately care and meet the needs of patients as well as their families. In caring for patients and addressing the demands of their work environment, nursing includes direct clinical care, education, research, administration, and development and implementation of policy across a continuum of care. Nurses play an important role caring for patients while managing a range of demanding professional and organizational priorities, critical to the functioning of the health system. These roles and expectations have implications and need to be accounted for in determining staffing models.

In support of this, it is essential to create policies, procedures, and processes that support a vibrant, healthy workplace that is supportive of quality professional practice; supports a healthy work-life balance in the context of a demanding role; and provides a safe workplace environment free from violence. Two key factors that enable a vibrant workplace are its culture and leadership. An organization's culture needs to be based on strong people-values where there are policies and procedures that support and enable a healthy, productive, diverse, equitable, culturally safe, and inclusive work environment. Leadership from the top of a health organization is important, but alone does not mobilize the workforce and create a healthy organization. It is necessary for health organizations to have a vision which is patient-centered, while enabling a working environment that positions the health care team for success.

To that end, the Ministry of Health has committed to establishing a minimum nurse to patient ratio policy inclusive of Registered Nurses (RN), Licensed Practical Nurses (LPN) and Registered Psychiatric Nurses (RPN), which is informed by patient census, acuity, and nursing responsibilities essential for a healthy and vibrant healthcare system.

POLICY OBJECTIVE

The BC Ministry of Health (the Ministry), working in consultation with the Nurses' Bargaining Association (NBA), Health Organizations[1], and the Health Employers

[1] Regional Health Authorities, Providence Health Care, and Provincial Health Services Authority

Association of BC (HEABC), has committed under a Memorandum of Understanding (MOU) to developing and implementing minimum nurse-to- patient ratios (mNPR) in hospital-based care, long term care (LTC) and assisted living (AL), and community and non-hospital care settings across the province.

Evidence from other jurisdictions has found mNPRs improve the quality of care, patient outcomes, and level of satisfaction for patients and their families; improves working conditions, job satisfaction, and the recruitment and retention of nurses; and facilitates more effective team-based care.

The objectives for B.C.'s mNPR policy as outlined in the MOU are:

1. Validate, implement, and evaluate minimum nurse to patient ratios (exclusive of Charge designations) in hospital-based care with a bed baseline of 10,000 beds.

2. Implement and evaluate an expanded direct care supervision (Charge) model to support safe nursing practice.

3. Develop, implement, and evaluate a standardized staffing approach for clinical supports and supervision excluded from the hours of care per day in long-term care and assisted living.

4. Develop, implement, and evaluate a nurse-to-client case management ratio or workload tool to support a standardized staffing approach for community and non-hospital care services.

The provincial Executive Steering Committee (ESC), comprised of representatives from the Ministry, the NBA, Health Organizations, and HEABC, is the primary forum for the Ministry's engagement with partners and is tasked with providing recommendations to the Ministry regarding the development, implementation, and adoption of mNPRs. Five working groups focused on planning, implementation, communications; monitoring and evaluation; and retention and recruitment, will provide the ESC with mNPR policy recommendations for endorsement to present to the Ministry.

Expected Impact on Patient/Population Outcomes/Service Attributes

mNPRs have been shown to improve patient outcomes and improve patient and provider experiences in other jurisdictions. Similar outcomes are anticipated for B.C., in alignment with the objectives outlined above. It is expected that implementing mNPR will meaningfully enhance health outcomes (incl. quality and safety of care) and the experience of those who deliver nursing care (incl. efficiency and quality environments).

Measurable expected impacts include:

1. **Quality of care:** improve patient outcomes (mortality, length of stay, other

nursing-sensitive indicators)

2. **Efficiency**: less reliance on overtime, less sick time, and lower utilization of agency nursing.

3. **Quality Environments**: increased job satisfaction for nurses, more consistent nursing workloads, and lower rates of stress among nurses.

4. A workforce which will be able to sustainably meet the ratios through comprehensive provincial efforts, such as the BC Health Human Resource Strategy and Provincial Health Human Resources Coordination Centre, on nursing recruitment and on retention of professionals already providing nursing care.

SCOPE

The Ministry is committed to establishing an mNPR policy inclusive of Registered Nurses (RN), Licensed Practical Nurses (LPN) and Registered Psychiatric Nurses (RPN). mNPRs will be implemented across the B.C. public health care system as developed, in all settings operated by Health Organizations, including their private and non-profit Long-Term Care/Assisted Living contracted sites, as per the objectives outlined in the MOU. Private health care settings, such as physicians' offices are excluded from this policy. See Hospital Based Ratio Care Area Definitions attached as Appendix A.

This policy provides direction to the Health Organizations on mNPR. In implementing mNPR, employers are still required to the follow the terms of the Provincial Collective Agreement and the provision of all relevant legislation.

This policy directive is established for the B.C. Hospital-Based Care settings, listed below:

SETTING	RATIO
General Medical/Surgical Inpatient (Adult/Pediatric)	1:4 24/7
Rehabilitation	1:5 Day/Evening 1:7 Night
Palliative	1:3 24/7
Focused (Special) Care (Adult/Child)	1:3 24/7
High Acuity/Step Down (Adult/Child)	1:2 24/7
Intensive Care (Adult/Child)	1:1 24/7

POLICY DIRECTION

mNPR for Hospital-Base Care Settings

1. Health Organizations will establish, meet, and maintain a minimum nurse to patient ratio for all hospital-based care settings within B.C. Health Organizations.

2. Each ratio is unique and its applicability for daytime, evening, night, and weekend shifts is noted in the table above.

3. Ratios are absolute at the unit level and prescribe the total number of nurses to be scheduled per shift. The implementation of mNPRs will strive to ensure that patient assignments are always regularized and in ratio. At times patient assignments will not be in ratio due to unforeseen changes in patient acuity and/or intensity requiring nursing teams to work together to ensure safe patient care while immediate efforts are undertaken to secure additional workload to bring patient assignments on the unit into ratio. The charge nurse plays a key role in coordinating patient assignments.

4. The number of nurses on any given unit is calculated based on the established/base number of beds on a unit. If the base bed allocation of a unit is modified, then the number of nurses will be adjusted to maintain the ratio. The calculation of mNPR staffing needs for a unit must include break relief over and above the ratio; whereas, leaves, including (but not limited to) vacation, sick time, education, and union leave are calculated in the ratio and as part of standard workforce planning requirements. Any time additional patients above the bed base are admitted to the unit (overcapacity beds), every reasonable effort will be made to call in additional nursing staff, including for overtime, to bring the unit back up to the required ratio.

5. For units with a routine mix of patient populations (e.g., medicine and focused care), the unit ratio will be determined in one of two ways: For Mixed Patient Population with assigned beds (i.e., where a unit can identify the total assigned beds for each patient population) all designated ratios can be applied; for Mixed Patient Population without assigned beds (i.e., where a unit is unable to identify the total assigned beds for each patient population) the ratio providing the highest number of nurses will be applied to all beds.

6. Units currently funded or operating higher than assigned ratio will hold without any changes for 4 months and then evaluate. Any changes to the baseline staffing following evaluation will be submitted to the Ministry.

7. Hospital-based units will have a charge nurse to provide clinical leadership and to work with unit nurses to ensure quality practice and learning environments. The charge nurse will have the responsibility and authority to identify a patient safety concern and request additional resources in collaboration with leadership based on their professional judgment.

8. Adult medical/surgical units will have a 24/7 charge nurse *without assignment*. A hospital unit with an existing charge structure / rotation without assignment will continue without change. Charge nurses will facilitate the coordination of break relief and can, by exception, assist with break relief in rare circumstances. Charge nurses will not be responsible for providing break relief on a consistent basis.

9. If additional nursing staff are required due to overcapacity or changing patient needs (e.g. workload), the charge nurse will submit a request as per organizational procedure. If the charge nurse feels all reasonable efforts to support safe, quality, nursing practice are not supported, they will escalate concerns to the organizational Chief Nursing Officer (CNO). CNOs will provide JRIC with a summary of all escalated concerns. The Ministry, in consultation with the NBA, will evaluate the charge nurse structure in hospital sector units in January 2025, and share recommendations with the ESC, accordingly.

10. The overall proportion of each nursing designation at the site will not change without prior agreement at the Joint Regional Implementation Committee (JRIC). Where the JRIC is unable to reach agreement, decisions will be escalated as per escalation process.

11. When filling vacant baseline shifts every reasonable effort will be used to first fill with the same designation and specialty training (e.g. RN with Rn, ERQ with ERQ) prior to securing a different designation or level of training. Site level nurse designation and qualification data will be shared with the MOH and/or NBA upon request.

12. When considering additional nurses, decisions will be based on patient presentation, acuity, and demand, consistent with the established scopes of practice for RNs, LPNs, and/or RPNs and direct care nurse input.

13. The established team of nurses on any hospital-based care setting will continue to work together in collaboration with other health care professionals to meet patient needs across the unit during their shift. mNPR does not change the context of team-based care, rather the ratio states the minimum number of

nurses required on a unit.

14. All hospital-based care setting units will create a respectful environment for patients by striving to address power imbalances in the health care system by providing person-centered, accessible, culturally safe, trauma-informed care.

15. For issues that are not resolved at the local level, an agile process for escalation and resolution will be in place; to begin, and while acknowledging that the provincial ESC is not always available to resolve all issues in a timely manner, issues can be escalated through the mNPR centralized inbox, upon which they will be shared with the Provincial Chief Nursing Officer for preliminary review and triage, as appropriate. All issues will be collated, tracked and trended to ensure matters in question receive due care and attention, are managed consistently, and communicated to all partners effectively. The escalation process will be reviewed by ESC in January 2025, as appropriate.

IMPLEMENTATION TARGETS AND CONSIDERATIONS

Expectations

The Health Organizations will be provided with a mNPR Implementation Instruction Manual outlining the required implementation steps. The Health Organizations will submit implementation plans to the Ministry for review and approval. The Ministry will share the implementation plans with ESC for endorsement. The JRICs will be expected to execute the implementation plan at the health authority level.

The Health Organizations will implement mNPR in a manner that demonstrates cultural safety and humility, is anti-racist, supports principles of diversity, equity and inclusion, and considers the social determinants of health in response to *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care* report.

Timelines

The Ministry expects the Health Organizations to be implementing hospital-based care ratios with the general adult medical or surgical mNPR, being first, in Fall 2024. Implementation of the other hospital-based care ratios (listed above) will be initiated during the late Fall of 2024.

mNPR ADMINISTRATION AT HEALTH ORGANIZATION LEVEL

Health Organizations must clearly identify and report to the Ministry the number of beds for each services area ratios are set for in this policy directive. The Health Organizations must report the number of beds they have at each of their respective sites, at the unit level, via a standardized process.

The number of identified beds and units at a site level cannot be changed without expressed written approval from the Ministry of Health. If a Unit goes beyond its pre-documented base and surge beds, nurse allocations will be adjusted to maintain the minimum nurse to patient ratio. Bed changes will be conducted via a formalized process with the Ministry's Hospital and Provincial Health Services Division.

The JRICs will be established and have clear and transparent processes in place to ensure a standardized and consistent implementation of this policy directive, at every applicable site/unit across the Province.

The Health Organization will be responsible to implement, monitor, and maintain mNPRs in consultation with the JRICs and report progress and results quarterly to the Ministry of Health, which will collaborate with the provincial Executive Steering Committee to address any gaps, issues or needs.

MONITORING AND EVALUATION

Performance Metrics

The Ministry will consult with the NBA, HEABC, and Health Organizations to develop metrics which will be used to report on the success of the initiative on a quarterly basis and will support the continuous quality improvement process. The performance metrics will be used to measure the expected outcomes of the service attributes of effectiveness, efficiency, safety, and quality environments. The three performance metric categories for the mNPR initiative include: patients, nurses, and the health system.

The performance metric categories will each have complementing metrics contributing to periodic evaluation and reporting of the mNPR initiative. They will provide insight on the measurable expected impacts stated in the policy.

Monitoring and Evaluation

Ratios will be monitored via pre-established reporting mechanisms and submitted to the Ministry for analysis and integration into the quality improvement process. Metrics will be tracked and shared with the NBA via the provincial ESC.

REVIEW & QUALITY IMPROVEMENT

Information from quarterly evaluation reporting will be used to understand the performance of the initiative, areas of success, and areas for continuous quality improvement.

This policy will be refreshed as needed and formally reviewed three years from the date of implementation and/or following completion of the summative evaluation.

Appendix A – Care Area Definitions

ADULT MEDICAL / SURGICAL UNIT DEFINTION

mNPR Ratio – 1:4

DEFINTION – General adult medical or surgical unit (Med/Surg) refers to:

- A multi-day inpatient unit in which either of the following are cared for:
  (i) patients with an acute or chronic illness or an injury; and/or
  (ii) patients pre-operative and/or recovering from (surgery) surgical intervention; or
- A short stay (*observation*) patient care area

INCLUDED	EXCLUDED
• Observation Areas: ED Admitted Patients	• Monitored beds (telemetry/coronary) • Critical Care (adult, neonatal, psychiatry) • Specialty Unit (higher level of care but not critical care) • Maternity • Emergency • Psychiatry Inpatient • Rehabilitation • Designated Alternative Level of Care Units • Surgical Services (OR, PARR) • Ambulatory Units • Roving Nursing Teams • Surgical Day Care • Palliative

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PEDIATRIC MEDICAL / SURGICAL UNIT DEFINITION

mNPR Ratio – 1:4

DEFINITION – General pediatric medical or surgical unit refers to:

- A multi-day inpatient unit which is organized, operated, and maintained to:
  (i) deliver comprehensive, interdisciplinary, family-centred, age specific, pediatric care for infants, children, and youth newly admitted up to their 17th

birthday (16 years + 364 days) and receiving ongoing care up to their 19th birthday (18 years + 364 days);

a. Patients up to their 19th birthday may be newly admitted to the pediatric service if essential for their medical care.

(ii) diagnose and provide treatment for pediatric patients with a broad range of low to medium acuity/complexity medical conditions (including psychosocial issues) that require hospitalization, stabilizing and referring/transferring, as necessary

NOTE- The definition of pediatric general medical/surgical is consistent with a standard, formalized definition for pediatric services in the BC context, as outlined by Child Health BC in their *Children's Medicine Services: [Brief & Full] Tiers of Service to Support Operational Planning* documents. These are products of an interdisciplinary working group comprised of a representative(s) from each of BC's Health Authorities, the BC Pediatric Society, a Child Development Centre, Child Health BC, and family physicians.

ADULT FOCUSED (SPECIALTY) CARE UNIT DEFINITION

mNPR Ratio – 1:3

DEFINITION – Adult focused care unit refers to:

a) A multi-day inpatient unit which is organized, operated, and maintained to provide care for:

(i) a specific medical condition; and/or

(ii) a specific patient population.

b) Services provided in these units are more specialized to meet the complex acute and chronic needs of patients with the specific condition or disease process than that which is required on medical/surgical units.

NOTE - A decision was reached by consensus on the BC mNPR Planning Working Group that the definition for focused care from California's minimum nurse-to-patient ratio regulations (termed 'specialty care')[1] was most consistent with focused care wards in BC. The term 'focused care' was chosen to prevent confusion with the term 'specialty' because specialty care does not always require specialty training for nurses.

Units **included** within this definition include but are not limited to: acute stroke, coronary care, cardiac telemetry, hematology, oncology, renal (dialysis), complex medical care, transplant, and neurosurgery.

Units **excluded** from this definition include but are not limited to: labour, birth, & post-birth care, perioperative areas (i.e. operating room, post-anesthesia care/recovery unit),

intermediate care/step-down, intensive care (ICUs), cardiac ICU, inpatient psychiatric, and alternate level of care (ALC).

PEDIATRIC FOCUSED (SPECIALTY) CARE UNIT DEFINITION

mNPR Ratio – 1:3

DEFINITION – Pediatric focused care unit refers to:

- A multi-day inpatient unit which is organized, operated, and maintained to diagnose and provide treatment for pediatric patients with a high acuity and/or relatively common high complexity medical conditions (including complex psychosocial issues)
    (i) for the Enhanced Subspecialty Regional Pediatric Service: the range of conditions is dependent upon the types of subspecialists available
    (ii) for the Provincial Subspecialty Service: there is additional capacity to diagnose and provide treatment for high complexity medical conditions, many of whom require care from multiple subspecialty teams

NOTE - A decision was reached by consensus on the BC mNPR Planning Working Group to use the term 'focused care', preventing confusion with the term 'specialty' because specialty care does not always require specialty training for nurses. The definition of pediatric focused care is consistent with the pediatric services in the BC context, as outlined by Child Health BC in their *Children's Medicine Services: [Brief & Full] Tiers of Service to Support Operational Planning* documents. These are products of an interdisciplinary working group comprised of a representative(s) from each of BC's Health Authorities, the BC Pediatric Society, a Child Development Centre, Child Health BC, and family physicians.

Excluded: Pediatric Critical Care and Neonatal Intensive Care Units

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CRITICAL CARE: ADULT INTENSIVE CARE UNIT (ICU) DEFINITION

mNPR Ratio – 1:1

DEFINITION – Adult intensive care unit refers to:

- A multi-day inpatient unit which is organized, operated, and maintained to provide specialized care for patients who:
    (i) have complex, life threatening medical problems requiring urgent and intensive treatment using life support technologies and interprofessional collaboration among clinicians; and
    (ii) meet Levels 2 or 3 of Adult Critical Care

NOTE- The definition of critical care is consistent with a standard, formalized definition for critical care in the BC context, as outlined by Critical Care BC. Levels of Adult Critical Care refers to the levels of adult critical care developed by the British Columbia Critical Care Working Group under Critical Care BC.

Level 2 refers to patients who require continuous monitoring (Q1-2hr VS) with technological support for one system and monitoring of another, which may involve chronic failure. Patients may require ventilation (invasive or non-invasive). Patients may have experienced major trauma or surgery but have stable vasopressor requirement, resolving delirium, stable complex wound management, or require extended and frequent post operative monitoring.

Level 3 refers to patients who require intensive and continuous monitoring (Q15 min - 1hr Vital Signs (VS)) with technological support for two or more systems, such as advanced ventilation (invasive or non-invasive), Continuous Renal Replacement Therapy (CRRT), Extracorporeal Membrane Oxygenation (ECMO), or acute specialized neurological monitoring and treatment. Patients may have multisystem failure with co-morbidities, fluctuating vasopressor dependence, acute delirium, or have experienced major trauma or surgery and require specialized interdisciplinary involvement, including complex wound management.

CRITICAL CARE: PEDIATRIC INTENSIVE CARE UNIT (PICU) DEFINITION

mNPR Ratio – 1:1

DEFINITION – Pediatric intensive care unit refers to:

- A multi-day inpatient unit which is organized, operated, and maintained to provide specialized care for pediatric patients who:
  (i) have complex, life threatening medical problems requiring urgent and intensive treatment using life support technologies and interprofessional collaboration among clinicians; and
  (ii) meet Levels 2 or 3 of Pediatric Critical Care

NOTE - The definition of critical care is consistent with a standard, formalized definition for critical care in the BC context, as outlined by Critical Care BC. Levels of Pediatric Critical Care refers to the levels of pediatric critical care, as outlined by the Provincial Health Services Authority (PHSA) in the *Pediatric Critical Care in British Columbia: Defining & Describing Care Standards*. This document was produced with the collaboration of Pediatric Critical Care Specialists from BC Children's Hospital and Victoria General Hospital, along with BC Critical Care Health Improvement Network, Child Health BC and the Provincial Health Authorities.

The Levels of Pediatric Critical Care refers to the patient care needs and should be aligned to the right service available.

Level 2 refers to pediatric patients who require continuous supervision and may need invasive and non-invasive ventilatory support or support for two or more organ systems, for example, major trauma (major trauma is defined as an ISS score >12. Thus, some major trauma patients may be cared for in a level 2 tertiary centre). Sometimes, the child will have one organ system needing support and another suffering from chronic failure. Usually, children receiving level 2 care are intubated to assist with breathing. Level 2 patients are at risk of deteriorating and requiring Level 3 support.

Level 3 refers to pediatric patients who require intensive supervision and continuous monitoring at all times, with two or more organ systems needing technological support. This includes advanced invasive respiratory support. A child may undergo complex therapeutic and monitoring procedures, such as invasive and non-invasive ventilation requiring advanced renal support; children who have suffered multiple trauma; or children who have undergone complex major surgery or require extracorporeal life support (ECLS).

CRITICAL CARE: ADULT HIGH ACUITY UNIT (HAU) DEFINITION

mNPR Ratio – 1:2

DEFINITION – Adult high acuity unit refers to:

- A multi-day inpatient unit which is organized, operated, and maintained to provide specialized care for patients who:
  (i) have complex, life threatening medical problems requiring urgent and intensive treatment using life support technologies and interprofessional collaboration among clinicians; and
  (ii) meet Level 1 of Adult Critical Care

NOTE- The definition of critical care is consistent with a standard, formalized definition for critical care in the BC context, as outlined by Critical Care BC. Levels of Adult Critical Care refers to the levels of adult critical care developed by the British Columbia Critical Care Working Group under Critical Care BC.

Level 1 refers to patients who require closer observation (Q4hr VS), than is available in an acute ward, with one system risk / monitoring. Patients may require noninvasive ventilation (NIV) to prevent deterioration, when expected resolution is within 24 hours. Patients may require long term ventilation / weaning but are stable otherwise and have an established respiratory rehabilitation plan. Patients may require telemetry or mobility /

rehabilitation initiation, post-operative monitoring, or stable wound management with a care plan.

CRITICAL CARE: PEDIATRIC HIGH ACUITY UNIT (HAU) DEFINITION

mNPR Ratio – 1:2

DEFINITION – Pediatric high acuity unit refers to:

- A multi-day inpatient unit which is organized, operated, and maintained to provide specialized care for pediatric patients who:
  (i) have complex, life threatening medical problems requiring urgent and intensive treatment using life support technologies and interprofessional collaboration among clinicians; and
  (ii) meet Level 1 of Pediatric Critical Care

NOTE - The definition of critical care is consistent with a standard, formalized definition for critical care in the BC context, as outlined by Critical Care BC. Levels of Pediatric Critical Care refers to the levels of pediatric critical care, as outlined by the Provincial Health Services Authority (PHSA) in the *Pediatric Critical Care in British Columbia: Defining & Describing Care Standards*. This document was produced with the collaboration of Pediatric Critical Care Specialists from BC Children's Hospital and Victoria General Hospital, along with BC Critical Care Health Improvement Network, Child Health BC and the Provincial Health Authorities.

The Levels of Pediatric Critical Care refers to the patient care needs and should be aligned to the right service available. Level 1 refers to pediatric patients who require closer observation and monitoring than is usually available in a general children's ward. For example, the child may need support from one organ system (excluding invasive ventilation), minor trauma, continuous heart rate or invasive blood pressure and respiratory monitoring, advanced analgesic techniques, or hemodynamic support (e.g., vasoactive infusions). Level 1 patients are at an increased risk of deteriorating to a level two or three care need.

PALLIATIVE CARE UNIT DEFINITION

mNPR Ratio – 1:3

DEFINITION – Palliative care unit refers to:

- A multi-day inpatient unit which is organized, operated, and maintained to provide complex pain and symptom management, complex discharge planning, and/or

emotional, social, practical, spiritual, grief, and bereavement support and care for people living with acute or advanced life-limiting illness and for people at the end of life, family, friends and others affected by someone's life-limiting illness or death.

NOTE - The definition aligns with the consensus definition published in January 2024 by the BC Centre for Palliative Care and the BC Hospice Palliative Care Association for defining care provided by hospice societies, which includes in inpatient units.[2] Click here for more information about the consensus-based approach.

The definition has been modified to emphasize the role of pain and symptom management and complex discharge planning in inpatient palliative care. This definition applies to inpatient palliative care units and is distinct from community-based hospice care.

REHABILITATION UNIT DEFINITION

mNPR Ratio – 1:5 (day & evening), 1:7 (night)

DEFINITION – Rehabilitation unit refers to:

- A multi-day, interdisciplinary inpatient unit which is organized, operated, and maintained to:
  (i) provide rehabilitation of patients following stabilization of their acute medical issue; and
  (ii) improve functions of patients with musculoskeletal and neuromuscular conditions due to injury or illness, or following surgery, so that they may be safely discharged.

NOTE - The definition aligns with the description of inpatient rehabilitation units in both Interior Health and Fraser Health and has been modified to specify the causes of conditions (injury, illness, surgery).

Excluded: Rehabilitation services provided for mental health conditions and/or for drug or alcohol addiction.