

Scale up of Managed Alcohol Programs



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In the landscape of illicit drug harm reduction and alcohol policy, there are few options for those impacted by the harms of high risk or illicit drinking (unsafe settings, unsafe sources such as non-beverage alcohol and unsafe patterns of consumption) and/or severe alcohol dependence. These harms are not new but are being escalated during the response to COVID-19, creating a surge of unmet need and propelling interests in the development of Managed Alcohol Programs (MAPs) across Canada and elsewhere.

In this bulletin, we provide some beginning guidance and suggestions for organizations looking to initiate or scale up a MAP. There is substantial and growing evidence that MAPs are a unique intervention to reduce harms related to high risk drinking, severe alcohol dependence, homelessness and poverty (1-4). Please see www.cmaps.ca for more detailed information on the Canadian Managed Alcohol Program Study (CMAPS). This guidance is based on six common elements of MAPs (5), CMAPS research on implementation and outcomes as well as extensive experience and wisdom of the CMAPS community of practice. This bulletin focuses on frequently asked questions received by the CMAPS team.

REFERENCES

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PROGRAM GOALS & ELIGIBILITY



What are the program goals?

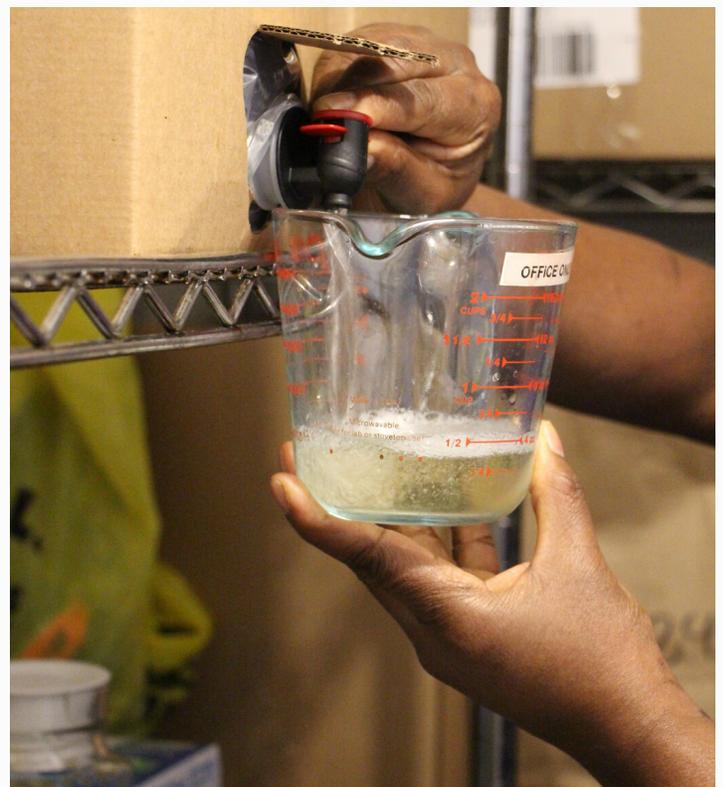
MAPs are harm reduction programs intended to reduce harms of high-risk drinking or severe alcohol use disorder often coupled with ongoing experiences of homelessness or poverty. Program goals should be first and foremost to reduce the harms of substance use. Harms of high risk drinking and severe alcohol use disorder include risks in the external environment related to violence and assault as well as harms related to unsafe sources of alcohol such as non-beverage alcohol, unsafe patterns of drinking, or complicated withdrawal.

There are many different MAPs, including community day programs, residential models located in shelters, transitional and permanent housing and hospital-based programs. Outside of hospital-based models, the majority of community MAPs are operated by local non-profit societies through multiple sources of funding. Depending on the location of the MAP and the health of clients, there are varying degrees of professional healthcare involvement. The most common is provision of primary care by physicians and nurses either on site or through community outreach.

What is the program eligibility?

General eligibility criteria for a MAP include that the person has a longstanding and ongoing pattern of high-risk drinking and is at high risk for alcohol-related harms. These harms may be related to homelessness, risk of homelessness and/or illicit or “survival drinking.” Eligible individuals will also not have succeeded in abstinence-oriented treatments for alcohol use disorders despite multiple attempts and remain unable or unwilling to stop drinking.

Eligibility can be based on assessment of harms associated with alcohol use (e.g. drinking in public spaces that increase risk of violence and assault, frequent interactions with police and emergency services, amount and type of consumption including binge drinking and non-beverage alcohol, as well as the impacts resulting from related stigma). Specific criteria are established by each program to determine who they aim to serve. For example, specific clientele or settings (e.g. in long-term care, male-only, Indigenous-led, peer-led). To date, there are no programs that cater exclusively to women or those who identify as LGBTQ.



ALCOHOL PROCUREMENT & FUNDING

Where can alcohol be purchased from?

Alcohol may be purchased 1) from retail vendors; 2) through arrangements with local breweries and distillers at reduced/wholesale pricing and/or by donation. Additional options to reduce cost of sourcing alcohol are 3) using a UBREW or UVin company or 4) brewing the alcohol on site.



How can the alcohol be funded?

Alcohol may be funded by a combination of client contributions and program subsidies. Funding the costs of alcohol is one of the most challenging aspects of setting up and running a MAP. There are limited avenues for purchasing alcohol outside of retail vendors. U Brew or brewing onsite can reduce costs and enhance participant involvement.

How should alcohol be stored?

Storage of alcohol is an important consideration and locked storage is critical for client safety. Options include onsite storage in a staff-monitored area in housing or day programs, similar to any medication storage or money management systems. Staff and clients should both sign off on paperwork to establish the client received their alcohol, whether a dose is administered onsite or for takeaway consumption. This can be helpful to manage situations when questions arise as to whether or not the client has received alcohol.

ALCOHOL DELIVERY & ADMINISTRATION

Who will provide the alcohol? At what interval will alcohol be provided and of what type?

Much of this can be determined through development of an individual managed alcohol plan (iMAP) tailored to each client. An iMAP can be developed by individuals for themselves, in collaboration with a peer support or other harm reduction worker or with a clinician. Alcohol delivery and provision should be accompanied by wellness checks. Primary care providers may be consulted regarding general alcohol management as needed especially in relation to interactions with medications and healthcare needs.

The iMAP should be adapted to the individual client's current needs, health status and drinking patterns. See EIDGE/CISUR for Safer Drinking Tips and other resources at www.cmaphs.ca. Part of building the iMAP is to identify the frequency and type of alcohol based on an assessment of harms and benefits. Administration of alcohol may vary from 1-2 to up to 12 times per day. Daily quantity should not exceed levels of usual alcohol consumption prior to MAP entry. Frequency of administration should be based on clients ability to self-manage. The focus should always be on enhancing the capacity of individual clients to build their capacity to safely self-manage their alcohol consumption. Screening for intoxication, withdrawal and other health risks at the time of alcohol delivery or administration is important to promote overall safety and wellness. If needed, the iMAP may be adjusted. Such screening can be done by appropriately trained individuals including harm reduction workers, & housing staff. The CMAPS project has collated assessment and screening resources from many established MAPs that are available by joining the CMAPS Community of Practice at www.cmaphs.ca.

FOOD & ACCOMMODATION

How will food and accommodation be provided?

MAP programs often provide basic social determinants of health such as food and housing. Meals may be offered several times a day. Program participants are often involved in meal planning and preparation. Food is important to overall health. Often individuals with high levels of alcohol consumption have nutritional needs that are unmet in part due to drinking but also due to income and other factors such as lack of spaces for cooking. Housing is a critical piece for preventing alcohol related harms. MAPS can be an important aspect of Housing First Programs. Being in a MAP has been found to increase housing stability. Permanent housing options are preferred so that individuals are able to stay regardless of their tenure on MAP.

SOCIAL & CULTURAL CONNECTIONS

What kind of social and cultural connections will be available?

Substance use is often a response to trauma and other difficult life circumstances. Drinking is a social activity and social connections are important to mental health and well-being. An important aspect of managed alcohol programming is the ability to access appropriate social and cultural supports that enhance client wellbeing. Such supports and activities should be designed by and for individuals in the program with lived experience. Once individuals are stabilized they often reconnect with self, family and others.

PRIMARY CARE & CLINICAL MONITORING

How should primary care be involved? When should clinicians be consulted? What clinical monitoring should be done?

It is important that clients have access to primary care (e.g. nurse, nurse practitioner, or physician) on a regular basis to address ongoing primary care needs. Individuals entering into a MAP may be disconnected from primary care but have extensive primary care needs and in some cases may have complex health issues. Registered nurses are well suited to support assessment and development of iMAP in consultation with physicians on specific medical issues. Nurse practitioners and/or physicians are important for timely diagnosis and to provide medical management and routine clinical monitoring such as blood and liver function tests.

PROGRAM EVALUATION

Should we plan for program evaluation? What should we consider in planning for evaluation? What about research?

Program evaluation is an important aspect of planning and scaling up any MAP. There are many resources available to support program evaluation for the purposes of program improvement. Program evaluation provides important information about how a particular MAP is working and what might be done to improve it. Some potential areas for program evaluation include: describing the characteristics of people in the program, severity of use, changes in alcohol-related harms over time or changes in patterns of consumption. Client intake, assessment, iMAPs, and daily alcohol consumption records can be reviewed and collated as per each organization's procedures and protocols. Program evaluation is not necessarily the same as research although there is some overlap. Research generally involves contributing to a broader body of knowledge using rigorous research designs, more in-depth data collection and analysis and is often done through third parties or collaborations between programs and academic researchers such as the CMAPS project.