

Scoping the feasibility and acceptability of Managed Alcohol Programmes for people who are homeless with severe alcohol problems in community-based, third sector services in Scotland.

Research briefing

Alcohol use among people who are homeless

Harmful use of alcohol affects millions of people worldwide, with high morbidity and mortality rates (1). In Scotland, rates of alcohol use and alcohol-related harm are high, with more than 1100 deaths attributable to alcohol in 2018 (2). Alcohol use disorders (AUDs) are not equitably spread across the population, with some groups being more vulnerable than others. People who are experiencing homelessness are at a particularly high risk of alcohol use and associated harms, including experience of extreme social inequalities (3,4). Alcohol use can be the reason for people becoming homeless, a response to trauma, poverty and difficult life circumstances, or be a way of coping with their current situation (3,5,6). People experiencing AUD and homelessness are vulnerable to a range of acute harms (alcohol poisoning, seizures), chronic health conditions (liver disease, cancers), premature death, poor mental health, assault and injury, and almost inevitable social exclusion (7). For many people who experience homelessness and AUD, abstinence-based treatment programmes are hard to comply with because of often unrealistic or undesirable goals (8). Thus, alcohol harm reduction approaches are essential for this group.

Managed Alcohol Programmes (MAPs)

Managed Alcohol Programmes (MAPs) are a harm reduction approach specifically for people experiencing homelessness and AUDs. MAPs provide alcohol in measured, regular doses throughout the day, as well as a range of other supports including health and housing. They have been developed in countries such as Canada and Ireland for people who experience homelessness and AUD who find it hard to engage with higher threshold addictions services (6). Several studies in Canada have had promising results, with participants experiencing: fewer withdrawal seizures; reduced alcohol-related harms; improvements in relationships, quality of life, wellbeing and safety (9); lower alcohol intake (10); ability to retain their housing throughout the study period (11), alongside evidence of cost-benefits (12). MAPs have been described as “a safer physical environment” (9; p.6), and as places for healing and reconnection (13). While there are services across the UK which provide measured doses of alcohol, none are officially operating as MAPs, and no evaluations have been conducted. The aim of this study was to scope the feasibility and acceptability of MAPs in Scotland.

The study

A mixed-methods study was conducted in Scotland in 2019. It involved 29 in-depth interviews with three groups: strategic stakeholders (from seven organisations across Scotland), service staff (from two third sector organisations), and potential beneficiaries who were individuals accessing homelessness services. In addition, case notes were reviewed from 33 people in eight third-sector homelessness services to scope the target eligible population in Scotland. Data were extracted on demographics, alcohol use, and physical and mental health characteristics. Ethical approval for the study was granted by University of Stirling’s General University Ethics Panel (GUEP, paper 695), and by The Salvation Army’s Research Ethics Committee, and Turning Point Scotland (our two study partner organisations).



The target population

Case note reviews revealed high levels of alcohol use, related harm, poly substance use, and mental health problems. Key findings in terms of participant challenges and needs were:

- 54% reported physical health problems, with most reporting a long term physical illness
- 97% reported mental health problems, with depression, anxiety, and post traumatic stress disorder being the most common
- Everyday alcohol use was reported for 26 people (79%)
- Alcohol was consumed at very high levels, with most consuming between 10 and 50 units per day
- 75% experienced daily withdrawal symptoms
- Most people had previously been in alcohol treatment or alcohol detoxification
- 51% had experienced alcohol related hospital admissions in the past
- Alcohol related cognitive impairments were reported for a third of people
- More than half of people used drugs as well as alcohol, with heroin, benzodiazepines, cocaine and cannabis being most common.

The need for MAPs in Scotland

Interview participants were clear that alcohol harm reduction services like MAPs are necessary in Scotland and are missing from current service provision. MAPs were viewed as potentially benefitting those who are unable to stop drinking, and people who regularly experience alcohol withdrawals. The focus on drug-related deaths and harm reduction approaches in Scotland meant that alcohol was viewed as being neglected in terms of policy and service provision. Views were expressed of a lack of support for those experiencing homelessness and AUDs, often due to unrealistic demands placed on people to become abstinent in order to access accommodation.

According to participants, MAPs would be well suited to those who are currently excluded from services, viewed as 'disengaged', and for whom traditional services are unsuitable. Participants' overall view of those people requiring MAPs were people who had tried other services and interventions, and those who have struggled to keep tenancies, because their alcohol dependency is too severe for them to continue to engage. There was also a view that many of these individuals had experienced traumatic circumstances and had difficulties developing relationships, something that also affected their ability to access services. Concerns were also raised around the potential for non-beverage alcohol use in this group of people. Given the high rates of poly-substance use among this population, the challenges of managing alcohol and drug use within a MAP were highlighted, in terms of providing alcohol to those who are under the influence of drugs, and the potential associated risks.

The key components of MAPs in Scotland

Participants discussed a range of key components to be considered if MAPs were introduced in Scotland. These were:

- Settings;
- Staffing;
- Alcohol distribution and consumption;
- Autonomy and rules;
- Wellbeing and holistic care;
- Individualised care.

Settings

Both residential and drop-in settings were suggested as viable options for MAPs in Scotland. Some viewed residential settings as being able to provide round-the-clock care and support which would be necessary for some people. However, concerns were raised about the institutionalised nature of residential settings, and many participants highlighted the need for flexibility. Drop-in settings were preferred by most participants because they were seen as low threshold, were flexible, and could provide a good transition from the streets into residential settings, particularly for those perceived as leading chaotic lifestyles who might not be ready or able to engage in the potential restrictions of a residential setting. Participants were clear, however, that people's housing situation would also need to be addressed if they were accessing a drop-in service. In addition, MAPs would have to take into account the potentially different needs of those accessing them, particularly women, those from ethnic minorities and those identifying as LGBT+. In terms of women's needs, there were concerns about women's safety in mixed MAPs, due to past experiences of abuse and violence by men.

Staffing

There was much discussion regarding the complexities of running MAPs and the need for such services to be staffed by well-trained people. Participants' main concerns around staffing were in terms of managing people's alcohol consumption, and the potential risks around refusing someone alcohol. There was a sense that staff should be working with people to manage alcohol use in a compassionate and non-judgemental way, as well as being highly trained, for example in motivational interviewing, trauma-informed care and challenging behaviours. The involvement of peers, or those with lived/living experience, was also seen as important, because such individuals could provide hope, greater understanding of people's needs, and facilitate better engagement.

Alcohol distribution and consumption

One of the most complex components of potential MAPs is managing the provision of alcohol to clients in practice. All participants agreed with the key concept of MAPs as providing alcohol in managed doses throughout the day. Some participants agreed that more frequent distribution of alcohol would be required (such as every 90 minutes), while others thought that three to four times per day would be sufficient. Many were in agreement that provision should be flexible, both in terms of timings and type of alcohol served. Participants were also concerned about whether clients would drink outside the MAP, an acknowledged issue in Canadian MAPs that can be addressed through accurate assessments, dosing and other protocols. These concerns revolved around people drinking too much and then incidents occurring within the MAPs. Thus, careful consideration is required on a range of factors including individual need, alcohol use, setting and provision of staff.

Autonomy and rules

Self-determination and autonomy are important for MAP clients and that needs to be balanced with programme rules and protocols. There would need to be a balance between rules within a MAP and facilitating autonomy, in terms of levels of support and structure available to clients. For some study participants, an overly rigid approach was perceived as concerning, with many preferring a flexible approach within MAPs. This includes negotiation and planning in a client-centred manner, in terms of alcohol consumption, management of people's money, purchasing alcohol, and allowing people to leave the service. Autonomy was considered very important, with a need to provide opportunities for people to develop self-efficacy and self-esteem noted.

Wellbeing and holistic care

MAPs must provide more than just alcohol. The need for holistic care, taking into consideration people's physical and mental health, housing, finances, skills development and social activities was recognised. There was a view that healthcare professionals should be on site to help with the assessment of various physical health problems, but that such a service would have to be provided on a full-time basis. Several participants also felt clients should be encouraged and supported to attend mainstream health services, to develop independence. In terms of general wellbeing, participants were supportive of the suggestion of providing social activities within MAPs as a way of reducing boredom and social isolation, building self-esteem, developing relationships and providing a focus other than drinking. It was also suggested that the provision of food in MAPs could have two connected benefits: improving the health of those experiencing homelessness and AUDs, and as a social activity for people. A range of health and wellbeing activities would be required as part of a successful MAP.

Individualised care

Different types of MAPs and different approaches in MAPs might be required for different people, depending on their needs and level of alcohol use. Of course, a 'one size fits all' approach would not work in a MAP. Alcohol use would need to be tailored to individuals, depending on their alcohol consumption, preferences, body size etc. Support provided would need to be tailored, in terms of benefits, budgeting, skills, housing, physical and mental health and social activities. It would be essential at the beginning of a programme for individuals and staff to work collaboratively to develop individualised programmes of care. Individuals' journeys through the MAP would need to be carefully planned and exit strategies to be identified collaboratively. There was a concern that MAPs could be seen as a place for people to come and die, and some participants were clear that people would need support to move on from the MAP, when they are ready to do so, for example by linking them with mainstream services, housing and other relevant opportunities.





Implications for policy and practice

- MAPs are required in Scotland as a harm reduction approach to managing alcohol related harm among a vulnerable population of those who are homeless
- MAPs would need to take into account the high rates of poly substance use and mental health problems of the population
- MAPs can be provided in residential and/or drop in settings, depending on local need. However, drop in settings would need to provide support in ensuring clients also have suitable housing
- MAPs should be staffed by well trained, compassionate and non judgemental staff
- Lived and living experience of homelessness and AUDs is essential in developing and operating MAPs
- Flexible approaches to alcohol distribution and consumption are required, working collaboratively with clients to ensure their needs are met
- Health and social care services should play a key role in MAPs, in providing support for physical and mental health problems, housing, finances, skills development and social skills
- The provision of social activities is also important, as a way of alleviating boredom and isolation, and developing relationships
- Supporting people to develop self esteem and self efficacy would be important
- Individualised care and support is essential, to ensure that MAPs meet the needs of those involved
- Journeys into and out of MAPs must be planned and done collaboratively between staff and clients.

About this research

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References

1. World Health Organization. Global status report on alcohol and health. Geneva; 2018. Available from: <https://apps.who.int/iris/bitstream/handle/10665/274603/9789241565639-eng.pdf?ua=1>
2. National Records of Scotland. Alcohol deaths. Edinburgh; 2019. Available from: <https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/alcohol-deaths>
3. McVicar D, Moschion J, van Ours JC. From substance use to homelessness or vice versa? *Soc Sci Med*. 2015;136–137:89–98. doi: 10.1016/j.socscimed.2015.05.005
4. Fountain J, Howes S, Marsden J, Taylor C, Strang J. Drug and alcohol use and the link with homelessness: Results from a survey of homeless people in London. *Addict Res Theory*. 2003;11(4):245–56. doi: 10.1080/1606635031000135631
5. Johnson G, Chamberlain C. Homelessness and substance abuse: Which comes first? *Aust Soc Work*. 2008;61(4):342–56. doi: 10.1080/03124070802428191
6. Pauly B, Vallance K, Wettlaufer A, Chow C, Brown R, Evans J, et al. Community managed alcohol programs in Canada: Overview of key dimensions and implementation. *Drug Alcohol Rev*. 2018;37(S1):S132–9. doi: 10.1111/dar.12681
7. Luchenski S, Maguire N, Aldridge RW, Hayward A, Story A, Perri P, et al. What works in inclusion health: Overview of effective interventions for marginalised and excluded populations. *Lancet*. 2018;391(10117):266–80. doi: 10.1016/S0140-6736(17)31959-1
8. Carver H, Ring N, Miler J, Parkes T. What constitutes effective problematic substance use treatment from the perspective of people who are homeless? A systematic review and meta-ethnography. *Harm Reduct J*. 2020;17. doi: 10.1186/s12954-020-0356-9
9. Pauly B, Gray E, Perkin K, Chow C, Vallance K, Krysovaty B, et al. Finding safety: A pilot study of managed alcohol program participants' perceptions of housing and quality of life. *Harm Reduct J*. 2016;13(1):15. doi: 10.1186/s12954-016-0102-5
10. Stockwell T, Pauly B, Chow C, Erickson RA, Krysovaty B, Roemer A, et al. Does managing the consumption of people with severe alcohol dependence reduce harm? A comparison of participants in six Canadian managed alcohol programs with locally recruited controls. *Drug Alcohol Rev*. 2017;37(S1):S159–66. doi: 10.1111/dar.12618
11. Stockwell T, Pauly B, Chow C, Vallance K, Perkin K. Evaluation of a Managed Alcohol Program in Vancouver, BC: Early Findings and Reflections on Alcohol Harm Reduction. Victoria; 2013. Available from: <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.688.1437&rep=rep1&type=pdf>
12. Hammond K, Gagne L, Pauly B, Stockwell T. A cost-benefit analysis of a Canadian Managed Alcohol Program: A report prepared by the Centre for Addictions Research of British Columbia for the Kwae Kii Win Centre Managed Alcohol Program. Victoria; 2016. Available from: <https://www.uvic.ca/research/centres/cisur/assets/docs/report-a-cost-benefit-analysis-of-a-canadian-map.pdf>
13. Pauly B, Brown M, Evans J, Gray E, Schiff R, Ivsins A, et al. “There is a Place”: Impacts of managed alcohol programs for people experiencing severe alcohol dependence and homelessness. *Harm Reduct J*. 2019;16:70. Doi: 10.1186/s12954-019-0332-4