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Coronavirus: why managed alcohol programmes are essential for problem drinkers who are homeless

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People who are homeless are being particularly affected by the coronavirus pandemic. Common health problems such as respiratory disease put people who are homeless at more risk and self-isolation is impossible if you are living on the streets or in temporary accommodation. Those dependent on alcohol are at even greater risk as they need to continue using to prevent withdrawal, which can lead to serious health problems and sometimes death. But lockdown and self-isolation are challenging if you need to get a hold of alcohol.

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A Managed Alcohol Programme is a harm-reduction initiative that offers regularly dispensed alcohol alongside medical care, financial, housing and social support to people who have been drinking for many years, and who move between homeless hostels, hospitals and the criminal justice system. Key dimensions of MAPs also include primary care services and clinical monitoring.

MAPs were created in Canada in the late 1990s to deal with a crisis situation when three men froze to death in Toronto. Since then, a further 23 MAPs across 13 Canadian cities have been established providing vital support to vulnerable people.

Bernie Pauly and colleagues at the University of Victoria in British Columbia have been looking into the effectiveness of MAPs in Canada. Their findings show that MAPs improve the safety, stability, mental and physical health, housing, relationships, life skills and self-esteem of programme participants. They can reduce alcohol-related harms and, in some cases, consumption. Importantly, MAPs are also beneficial to the state in terms of significantly reduced ambulance call outs, hospital admissions and time in police custody.

We recently conducted a study to explore whether MAPs could be implemented in Scotland. We believe that similar services are urgently required in Scotland, and in the UK more widely, particularly during the current coronavirus pandemic.

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Managed Alcohol Program shows promise



Coronavirus and MAPs in Scotland

In Canada, MAPs operate in a variety of guises – drop-in programmes, shelters, hostels and permanent accommodation. Alcohol provision also varies in relation to timing and quantity of dosing, from an hourly standard drink to a daily ration. Programme rules are similarly diverse with emphasis on staff management of clients' alcohol consumption. MAPs run community activities and may serve meals, given the importance and challenges of good nutrition, and provide healthcare professionals on or off site to monitor participants.

Our own study involved in-depth interviews with three groups: those working in government and the NHS, charity services and those who would potentially benefit from MAPs. We also examined the case notes of 33 people in eight charity homelessness services to gain a better understanding of people who might be eligible for MAPs in Scotland.

Our findings highlight key components that services would need to take into account if MAPs were to be implemented in the current pandemic, and more generally. In terms of settings, as with Canadian services, MAPs could be provided in either residential or drop-in places, depending on the needs of a specific group, and what was available. While coronavirus has meant many homelessness services closing, many others have changed the ways that they operate to continue providing essential services.



MAPs are intended to reduce harm not change people. Shutterstock

MAPs could be provided alongside important social distancing practices, via volunteer deliveries for example. It is important to stress that MAPs can be staffed by those already working in the field, and in services already being provided. Compassion and a non-judgemental approach are essential here, as the main purpose is to try to reduce harm, not change people.

As a starting point, participants for a MAP should be confirmed as alcohol dependent. Then a drinking plan can be developed collaboratively between an individual, service staff and clinicians. This would usually state the person's preferred alcohol type, daily dose, frequency, and how wider health and social care needs are to be addressed. Specialist medical advice could either be provided on site or, in the current situation, virtually.

There are additional key components which would need to be implemented if MAPs were to work in the longer term, rather than as a response to the current pandemic, such as helping people to develop new life skills, social and community connections, and the capacity to exit MAPs, should they wish to move on. Any new MAPs put in place as an urgent response to COVID-19 must also involve careful planning for after lockdown, to ensure that people are not put at greater risk when they leave the service.

The message from our research is clear. MAPs are necessary in Scotland and should be included as part of a system of care to reduce alcohol-related harm among one of our most vulnerable groups. In the current pandemic, the introduction of MAPs has the potential to reduce risks of virus infection and transmission by providing more stability and helping people with the safer management and supply of alcohol. This way no one is forced to break lockdowns to manage dangerous withdrawal. This will be something we will be examining in our new research project on managed alcohol programmes in the context of COVID-19 in Scotland.

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Health + Medicine Editor



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