October 11, 2016

Managed Alcohol Programs in the Community – What do they Enable?

COMMENTARY

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A Common Trade-off demonstrates Need for MAPs:

Twenty years ago in Toronto, individuals who experienced homelessness and severe alcohol dependence had to make the choice between a meal and a bunk at the shelter while abstaining from alcohol or staying on the streets. In 1996, this trade-off was linked to the freezing deaths of three men, which many advocates saw as both distressing and preventable (1). Public discussions and the resulting coroner's report highlighted the inaccessibility of basic health, rehabilitation and shelter supports for individuals with severe alcohol dependence (1). The report recommended that a "wet shelter," which allowed individuals to consume alcohol on the premises, be established (1) at Seaton House, Toronto's largest men's shelter.

Today, what started as a small program at Seaton House, run by Art Manuel, a shelter provider, and Dr. Tomislav Svoboda, a family physician and associate scientist at St Michael's Hospital, has become an internationally-recognized harm reduction practice in providing client-centred services to individuals with severe alcohol addiction (Thomas Svoboda, 2016, oral communication, 9th August). Yet despite MAPs' effectiveness in reducing harm, ongoing advocacy, research evaluation, and knowledge translation has been required to counter the skepticism of some policy makers and service providers who believe MAPs only enable addictive behaviour (2).

"When people get upset about the notion that we are serving people alcohol, I explain that we are giving them access to healthcare that they would otherwise be rejected from," says Dr. Svoboda. "It's about providing rather than withholding services."

Homelessness, Alcohol Dependence and Aging:

Alcohol use is as high as 53 – 73% in homeless individuals (3). Long-term alcohol use leads to many serious physical and cognitive difficulties that may complicate the aging process (4). For those who experience homelessness and concurrent alcohol use, health needs may often go unmet (5), life expectancy is shorter (6), and the need for continuing care

supports may be required earlier in the aging process (7). Alcohol use also masks and may exacerbate underlying cognitive impairments (8). Thus individuals who present with severe alcohol dependence may be doubly marginalized – requiring ongoing neuro-rehabilitative and medical treatments, yet being less likely than others in the community to receive them. Severe alcohol dependence can also lead to public health care costs due to the high rates of emergency service use and incidents requiring police involvement (9,10).

A Growing Evidence Base for a Harm Reduction Approach:

Managed Alcohol Programs (MAPs) provide regular, controlled access to alcoholic beverages to individuals who have severe alcohol dependence. Since being established in Toronto twenty years ago, they have been gaining traction across Canada and internationally. A growing body of research evidence demonstrates improvements in quality of life and decreased rates of harm commonly associated with severe alcohol use (11-13). Despite these outcomes, by and large the health and social systems still work within an abstinence-based model which precludes individuals who have severe alcohol dependence from receiving standard rehabilitation, housing, and health supports (Thomas Svoboda, 2016, oral communication, 9th August). For example, restrictions exist on accepting aging individuals with histories of aggression and current substance use dependence into public long-term care homes or rehabilitation programs. With an ever-expanding aging population, there are inevitably more individuals with these needs (4,5). MAPs may provide a feasible, client-centred option by providing continuing-care supports to aging individuals with severe alcohol dependence.

A Cochrane review (11) completed in 2012 concluded that no randomised controlled trials, the highest level of research evidence, have assessed the effectiveness of MAPs as an intervention; although a number of lower quality studies have provided promising results (12,13). The authors of the Cochrane review report that MAPs have "been shown to retain vulnerable people in treatment programmes, decrease alcohol consumption and improve social functioning (decreasing criminal activity, while increasing quality of life and the seeking of medical care)" (11). Since the review's publication in 2012, several other mixed methods studies have been published which describe residents' satisfaction with this type of service (14,15). In these studies, the MAP environments were described as safe places that enabled recovery and decreased stigma. Due to the growing evidence base, as well as ongoing evaluation of operating programs, there are now seven MAPs nationwide (Thomas Svoboda, 2016, oral communication, 9th August). Despite positive outcomes, individuals with alcohol dependence and homelessness still experience exclusion from many health and social services.

"There are few services in the community for this population... We lose more people through attrition (death), than to community residential placements," says Dr. Svoboda.

Community-Based MAPs Need to Provide Integrated Supports across the Life Span:

In response to this trend, one year ago, Art Manuel House, named for one of the late founders of the first MAP, opened its doors to 10 individuals. Unlike the

shelter-based program at Seaton House, this MAP also provides high support housing with 24/7 staff support in a community setting. Dr. Svoboda reports that an expansion of community-based MAPs combined with a range of residential options is required to meet the growing needs of this population.

However, with the slated demolition of Seaton House in June 2017 (16), individuals who currently receive services through the MAP may need to find supports elsewhere, says Dr. Svoboda. Although the George Street Revitalization Project, to be built on the current Seaton House site, will eventually include a MAP and supportive housing options, the estimated two-year construction time means that further community-based programs are required in the interim (16).

On a national scale, MAPs are still few and far between and their ability to support the health and rehabilitation needs of residents varies widely between programs. In terms of what's needed for the future, Dr. Svoboda explains that "There's clearly a need for a different type of service. We can't place anyone in a nursing home or even in a rehab facility where they will have access to a behaviour therapist, physiotherapist, or an occupational therapist, because of their addictions. It's a complex interplay between rehabilitation and housing and it needs to be set in the community where individuals can access it."

Moving forward, Dr. Svoboda hopes MAPs can be combined with a range of residential options from outpatient to high support settings. In order to expand the reach of MAPs, an evaluation of these programs against a control group who does not receive treatment may be required for further large-scale funding. Considering the dire needs of this aging population and the growing evidence supporting the harm-reducing effects of MAPs, it is unfortunate that their wider acceptance and implementation may have to await the outcomes of future research.

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