Managed Alcohol Programs: MAP-ping Out The Northwest Territories' Response to Alcohol Use Disorders in Homeless Populations

Angela Roy, BSN Year 4, School of Health and Human Services, University of Victoria at Aurora College

November 30, 2022

Problem Statement

Alcohol use disorder (AUD) and alcohol-related harms are common issues concerning homeless individuals due to the various health and social inequities commonly impacting this demographic [1,2]. Harms include health deterioration and impaired psychosocial functioning usually from dangerous drinking patterns and non-beverage alcohol (NBA) consumption [3, 4, 5, 6, 7, 8, 9]. Currently, territorial addiction programs require total abstinence or residency in existing managed alcohol programs (MAP) which are unengaging or inaccessible to many homeless individuals in the NT [4, 10, 11, 12].

Research Question

Would the implementation of a non-residential MAP elicit better recovery outcomes in homeless individuals with an AUD than conventional abstinence-based programs?

Methodology

A literature review was conducted using CINAHL complete. Ten studies published between 2006-2022 were selected. Key terms used to conduct this research include the following: homeless adults, alcohol use disorder, managed alcohol program, harm reduction, and abstinence-based treatment.

Results

Compared to abstinence-based addiction programs, MAPs were preferred by and for homeless populations due to the harm reduction approach used to normalize drinking patterns, lower NBA use, decrease the utilization of health and social services, as well as increase the quality of life and health of program participants [4, 5, 6, 7, 8, 9, 11, 12, 13, 14].

The four qualitative articles explore the perspectives of homeless subjects and some program workers on MAPs and abstinence-based programs, establishing the qualitative basis of these results. The six quantitative studies selected evaluate the health and social benefits of MAPs, looking at numbers of emergency room (ER) visits, hospital admissions, police interactions, liver function tests (LFTs), total drinking days, alcohol consumption, and NBA use. From these studies, advantages and disadvantages of both MAPs and abstinence-based programs have been established as the following:

	Advantages	Disadvantages
Abstinence-Based Programs	• Provides basic needs (shelter, food, etc.) [12, 13] • Allows for breaks from daily hardships of being homeless [12, 13] • Opportunity to form positive social connections [12]	Ineffective engagement and hesitancy to commit for the following reasons [4, 8, 12]: • 'All or nothing' approach is a barrier for this population [11, 12, 13] • Oppressive power dynamics [12, 13] • Institutionalization [12, 13] • Disregard for client autonomy [11, 13]

Managed Alcohol Programs	• Client-centred approach that promotes autonomy and informed decision-making [4, 7, 11, 13]
	• Adaptability and individualization of recovery goals [7, 9, 11, 12, 13]
	• Enhanced participation in meaningful activities [6, 7, 11, 12]
	• Greater sense of well-being and confidence [8, 11]
	• Positive social connections [6, 8, 12]
	• Improved health [7, 8, 14]: sleep [4, 6], hygiene [4, 6], nutrition [4, 6, 7], and medical and medication compliance [4, 6]
	• Facilitated continuity of care [4, 7, 13]
	• Decreased NBA use [4, 6, 7, 8, 9, 14]
	• Stabilized drinking patterns [4, 6, 7, 8, 9, 14]
	• Reduced utilization of health and social services
	  • Police interactions [4, 7, 8, 9]
	  • ER visits [4, 7, 8, 9, 14]
	  • Hospital admissions [4, 7, 8, 9, 14]
	• LFTs decreased or remained stable during program participation [4, 7, 8, 9]
		• Increased total alcohol consumption in some cases [7, 8]
		• Chronic health effects of AUD remain [8]
		• Fewer ER visits, but more alcohol-related complaints [14]

Other Findings

- There is a need for including the target population in decision-making regarding addiction programs [4, 7, 9, 11, 12, 13]
- MAPs are adaptable to individual client needs and to population needs [4, 7, 9, 11, 12, 13]

Limitations

- Limited research about cost-effectiveness of MAP implementation
- Findings do not include Indigenous perspectives
- Limited information about non-residential MAPs

Key Recommendations

Research

NT-based research to explore Indigenous perceptions of MAPs vs abstinence.

Clinical Practice

Collaborate with homeless population for planning and implementation of a MAP.

Policy

Advocate for the implementation of a non-residential MAP, possibly within existing homeless shelters.

Education

Educate health care and shelter workers to avoid medical bias of abstinence when addressing addiction.

Literature Cited

1. Crabtree et al. (2018)
2. Falvo (2011)
3. Westenberg et al. (2021)
4. Podymow et al. (2006)
5. Henssler et al. (2020)
6. Pauly et al. (2021)
7.Vallance et al. (2016)
8. Stockwell et al. (2018)
9. Stockwell et al., (2021)
10. Ivsins et al. (2019)
11. Collins et al. (2019)
12. Collins et al. (2016)
13. Henwood et al. (2015)
14. Zhao et al. (2021)

Acknowledgments

I would like to acknowledge Marc D. and Shane G. for their vulnerability in sharing their lived-experiences of being homeless and living with addiction in the NT. Special thank you to Andréanne Robitaille for her guidance throughout this project, and Kyra Hanninen for her assistance with creating this poster.

Further Information

Email: angela_roy@myauroracollege.ca