

COMMENT

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# Practical considerations for residential-managed alcohol programs: lessons from Ottawa Inner City Health

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## Abstract

**Background** Alcohol Use Disorder (AUD) is a leading contributor to global morbidity and mortality, disproportionately affecting people experiencing homelessness. Managed Alcohol Programs (MAPs) represent a harm reduction-based strategy for individuals with severe AUD and homelessness, providing controlled amounts of alcohol alongside comprehensive health and social supports. While evidence of MAP benefits continues to grow, important questions remain about how best to integrate social and medical care, and how to tailor services to align with participants' goals, values, and broader social and structural contexts.

**Main body** This commentary explores the operational strategies and clinical practices of the Ottawa Inner City Health (OICH) MAP, which has been running since 2001. We describe how the program is embedded within supportive housing and leverages an interdisciplinary team—including peer workers and an Indigenous healer—to deliver person-centered care. Key components include structured alcohol delivery tailored to individual needs, meal provision, social supports including life skills training, medication administration and comprehensive physical and mental health services. Clinical care is tailored to participants' day-to-day circumstances, challenges, and goals in managing their AUD, with particular attention to hygiene and nutrition, proactive screening for health decline, and timely management of common health complications. The program operates through strong partnerships with community organizations, pharmacies and subspecialists, to enable integrated, coordinated care. Collaborative and trauma-informed approaches reduce reliance on emergency care and foster a sense of dignity, stability, and community.

**Conclusion** MAPs have evolved from experimental interventions into internationally recognized harm reduction models. The OICH MAP demonstrates how the integration of housing, healthcare, and social supports can address the complex needs of individuals experiencing homelessness and severe AUD. However, challenges remain in scaling these models, refining screening protocols, and developing evidence-based policy frameworks. This commentary offers practical insights to inform the effective operation of MAPs and calls for continued research and dialogue to ensure they remain adaptable, sustainable, and aligned with the realities of the populations they serve.

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## Background

*Alcohol use disorder (AUD)* is a major contributor to morbidity and mortality worldwide [1, 2]. Patients with severe AUD and homelessness frequently present to hospitals for unmet care needs, highlighting both the limitations of conventional treatment approaches and the significant burden placed on acute care resources [3–6]. While approaches that focus solely on alcohol reduction or abstinence may be helpful for some, they often fail to address the complex interplay between addiction, mental illness, chronic disease and housing instability that characterizes individuals with severe AUD and significant structural vulnerability [7–9].

*Managed Alcohol Programs (MAPs)* offer a radically different, harm reduction-based approach for individuals with severe AUD whose needs are not being met by conventional care [10–12]. Initially developed in response to the preventable deaths of individuals turned away from shelters due to alcohol consumption, MAPs provide regulated doses of alcohol, in a structured setting, alongside comprehensive health and social supports [11, 13]. This model aims to stabilize alcohol consumption and reduce alcohol-related harms including reliance on non-beverage alcohol (i.e. hand sanitizer or mouthwash) and unsafe withdrawal [11, 14, 15]. Studies have demonstrated that MAPs can reduce emergency department (ED) visits, hospitalizations, police contacts, and consumption of non-beverage alcohol, while improving housing stability, quality of life and access to health care [4, 10, 12, 14–18].

Despite increasing recognition of MAPs as an effective harm reduction strategy, **implementation of MAPs varies widely**, and include emergency shelter-based models, permanent supportive housing, hospital in-patient programs, day programs and outreach services [11, 12, 19]. Programs also differ in types of alcohol beverages, dosing schedules and the degree of medical oversight [11, 12, 19]. While the 2023 Canadian Operational Guidelines for MAPs [13] provides a general guiding framework, **important questions remain** on the day-to-day delivery of integrated social and medical care: *How should MAPs be structured to optimize health outcomes? What are the most effective strategies for integrating social and medical care? And how can these programs be designed to align with participants' experiences and goals?*

*The Ottawa Inner City Health (OICH) MAP*, launched in 2001, has gained international recognition for its innovative harm-reduction model [20–23]. Initially located in a shelter for individuals experiencing homelessness, the program expanded in 2010 to include a permanent housing component through collaboration with its housing partner, Shepherds of Good Hope. Since 2021, the shelter-based site has closed, and the program operates exclusively within a housing model across two permanent supportive housing locations [24, 25]. Individuals

with severe alcohol use disorder (as defined by DSM-V diagnostic criteria) who demonstrate evidence of harm to their selves or their community, have unstable housing and have experienced a lack of success or interest in abstinence-based programs are eligible for entry, and can be referred by shelter staff, community workers, or individuals from law enforcement or the justice system.

In this commentary, we highlight practical strategies from the OICH MAP to offer insights into the day-to-day operation of a housing-based MAP model that provides holistic care for this marginalized population.

## Main text

### Beyond alcohol management: Building a comprehensive model of care

#### *Supportive housing*

OICH's MAP is delivered within supportive housing programs that provide 24/7 housing and healthcare staffing to support residents to maintain stable housing. The two sites have the capacity for up to 97 residents [24, 25]. Prospective residents are considered based on their healthcare and housing needs. The decision to offer a bed to a client on the waiting list is made collaboratively by the healthcare and housing teams. The supportive housing sites include residents who are not enrolled in MAP; however, notably, these residents are still eligible to receive health care from OICH, which serves as the sole onsite healthcare provider.

Participants sign a lease with the housing partner, pay rent (typically with income from government-provided social supports), and are informed of their rights and responsibilities upon entry, including expectations regarding respectful conduct toward staff and fellow residents. Participants are permitted to spend time away from the program and are encouraged to coordinate any extended absences with staff to help ensure their health and safety. On-site supports for all residents include physical and mental health assessments, medication administration, meals and snacks, peer support, money management, counseling, activity programming, case management, and life skills training. Over time, some residents choose to discontinue participation in MAP as their AUD improves or enters remission. In such cases, clients are offered the option to remain in the supportive housing program and can continue benefiting from the on-site supports if desired.

#### *Inter-disciplinary teams*

OICH facilitates integrated, patient-centered care through extensive collaboration between healthcare providers, case workers and housing staff. Each site has its own nurses, personal support workers, case workers and housing staff. Physicians, peer workers and an Indigenous healer provide support at both sites as needed. Peer

workers—individuals with current or previous experiences of homelessness or unstable housing, who may also have a history of AUD or polysubstance use—play a key role, accompanying clients to medical and social care appointments and providing emotional support. Peer worker involvement also helps improve adherence to a wide range of interventions. The interdisciplinary, team-based approach at OICH enables holistic care by addressing health needs within the broader context of social determinants of health.

#### ***Health system integration and collaborative care***

OICH strategically partners with local hospitals, pharmacies, and community organizations to ensure seamless care transitions and minimize unnecessary ED visits. Access to onsite medical staff reduce reliance on hospital-based care, recognizing that past trauma or stigma may lead to reluctance in engaging with hospital services. The MAP sites are also located near community medical imaging centres, which reduces wait and travel times for clients concerned about withdrawal. Shared care models enable timely access to subspecialty services, while transportation supports (i.e. taxi vouchers and accompanying peer workers) reduce logistical barriers to medical appointments. OICH physicians regularly collaborate with subspecialists, co-ordinating on-site or virtual consultations to overcome logistical challenges. The collaboration with a community pharmacy enables daily delivery of medications and provides free access to nutritional supplements that would otherwise not be funded under most participants' provincial health insurance.

To provide the most comprehensive harm reduction possible, OICH's MAP sites are also connected with its hospice program, where MAP can continue to be administered. While end-of-life care is delivered at a MAP site whenever possible, this is not always feasible depending on clients' care needs. In such cases, clients are offered the option to be transferred to the OICH hospice, while continuing their participation in MAP, allowing them to avoid having to choose between MAP and an end-of-life care environment. The OICH hospice program is also used for intensive outpatient care for MAP clients when an acute illness temporarily affects their ability to live at their usual MAP site—for example, during recovery from a musculoskeletal injury that limits mobility or a decline in functional status while undergoing outpatient cancer treatment.

#### ***Staff training***

Training for staff at OICH's MAP sites is informed by the historical experience from the partner organizations involved and the recommendations outlined in the Canadian Operational Guidance for Managed Alcohol Programs (COGMAP) [13]. Staffing and training involve

three separate employers: nurses and peer workers employed by OICH, shelter staff employed by the housing partner, and personal support workers employed by a home and community care organization. All employees receive discipline-specific training on the topics described in COGMAP, including trauma-informed care, cultural safety, and harm reduction [13]. Nurses, peer workers, and personal support workers complete supplementary training as outlined in COGMAP, including education on recognizing alcohol withdrawal, providing care for people experiencing homelessness, and facilitating interpersonal conflict resolution among clients [13]. Nurses and peer workers also receive specialized training in motivational interviewing and in managing overlapping substance use disorders commonly encountered among MAP participants.

#### ***Flexibility in alcohol provision practices***

Intake and stabilization of new MAP participants are guided by their self-reported amounts of alcohol and other substance use, history of withdrawal and detoxification attempts, use of non-beverage alcohol, medical and mental health history, and an interdisciplinary assessment involving housing staff, client care workers, nursing staff, and, when needed, a physician. Alcohol is dispensed at controlled intervals (up to 15 administrations per day). In select circumstances, participants may be provided alcohol outside of the usual intervals to manage withdrawal symptoms and prevent unsafe alcohol-seeking behaviours. However, rigid policing of external alcohol use is avoided to preserve trust and focus on participant-centered goals. Participants may also be refused alcohol if they appear intoxicated, comparable to other licensed commercial vendors of alcohol. The alcohol doses and frequency of administration may be adjusted by staff, to address cravings, withdrawal and/or unsafe behaviours while avoiding intoxication. The team may re-evaluate participants with frequent intoxication and/or concern for harmful substance use in addition to their alcohol consumption to ensure that they can continue to participate in the program safely, while offering any necessary changes in support.

The only alcohol provided by the program is wine, produced on-site by the housing partner and securely stored. Daily supplies are kept in a staff-only area behind a wrap-around desk in a common space. Each alcohol pour is documented and given directly to the individual participant. Participants may also purchase and surrender their own alcohol for administration in standard drink equivalents.

#### ***Nutrition as harm reduction***

Chronic alcohol use is often accompanied by severe nutritional deficiencies. At OICH's MAP, daily thiamine

and nutritional supplements are provided alongside on-site meals. Nutritional intake is monitored to identify and support participants who are struggling to meet basic dietary needs or whose limited food intake may increase their risk of alcohol-related morbidity.

#### ***Proactive screening and tailored health monitoring***

Regular health assessments by nurses and physicians help identify early complications such as liver disease, cardiovascular issues, diabetes and infections. Participants receive weekly health assessments from nurses and biannual laboratory testing to evaluate liver, cardiovascular, and renal health. They are also routinely screened for hepatitis B/C, HIV, and syphilis, with vaccinations offered as needed. Nurses are trained to detect and manage common complications that occur in the MAP population, including neuropathy, edema and foot infections, and to facilitate early intervention through medical directives. Staff closely track falls and unexplained intoxication episodes to help detect potential early signs of physical or cognitive decline, such as neuropathy or hepatic encephalopathy. Hygiene check-ins (ensuring clients are bathing at least weekly) also serve to unmask other health issues, including mobility challenges or cognitive concerns.

Crucially, medical assessments are tailored to the complex realities of MAP participants—specifically their advanced co-morbidities, the physiological effects of ongoing alcohol use, and their individual goals and circumstances. This approach ensures that assessments provide clinically meaningful insights. For instance, when vital signs are needed, they are not routinely checked before the first alcohol pour of the day, recognizing that individuals may experience transient morning hypertension and tachycardia due to mild alcohol withdrawal upon waking.

#### ***Adapting clinical guidelines for MAP clients***

Traditional medical guidelines often overlook the realities of MAP participants, particularly their socio-economic vulnerability and ongoing high amounts of alcohol consumption. At OICH, medical care is guided by individual values and preferences. Medication regimens are often simplified (e.g. preferentially choosing once-a-day long-acting formulations) and screening for alcohol-related complications (e.g. cirrhosis or hepatocellular carcinoma) is approached with flexibility, focusing on patient goals rather than rigid protocols. This approach also considers the stigma and trauma that some participants may have experienced in traditional clinical settings [26].

#### ***Mental health and social connection***

Addressing the psychological and social dimensions of AUD is critical. Mental health services are embedded within OICH, with support from mental health nurses

and a psychiatrist. Recognizing the impact of social isolation on health outcomes, the OICH MAP fosters community through peer support initiatives and structured social events, seeking to reinforce clients' feelings of dignity and belonging. MAP staff also organize an annual gathering where participants may invite family and friends, to assist in cultivating connections with relatives and the broader community.

#### ***Embedding advance care planning***

Though many MAP participants face life-limiting conditions, advanced care planning is often overlooked in this population [27]. At the OICH MAP, goals-of-care discussions—particularly following hospitalizations or a new life-limiting diagnoses—are prioritized. Formal Provider Orders for Life-Sustaining Treatment (POLST) are completed for all residents to ensure their preferences are clearly documented and respected across care settings.

Residents are also supported to make individualized choices that reflect their goals and values. For example, while some clients choose to taper alcohol slowly over time, others prioritize maintaining a stable level of consumption to minimize withdrawal-related risks, while acknowledging that this approach may limit longevity. Similarly, some participants with cirrhosis opt for regular diagnostic imaging every 6 months for hepatocellular carcinoma screening (consistent with general cirrhosis guidelines), while others prefer to forgo these investigations. Documenting and respecting these individual choices are key elements of patient-centered care.

Establishing emergency contacts for clients is also prioritized early in the OICH admission process, recognizing that MAP participants often have complicated social situations and may be isolated or reluctant to involve family in medical decisions. With the client's consent, staff work to identify a substitute decision-maker; this sometimes includes contacting other providers in the client's current or past care network (i.e. social services, financial groups, religious organizations), assisting with online searches, or involving a public guardian as a last resort.

#### ***Policy and funding considerations***

Sustaining and scaling MAPs requires supportive policy frameworks that align healthcare, housing, and social service mandates. The COGMAP provides a comprehensive overview of key considerations prior to program implementation. Initial support from local healthcare organizations (hospitals and community care), social services, law enforcement, and relevant levels of government—fostered through education on how MAPs can reduce the harms of AUD and improve participants' lives—was instrumental in the creation of OICH's MAP [23].

An important component of OICH's continued success is its collaborative funding model, which draws on contributions from both healthcare and housing sectors, reflecting the integrated nature of participants' needs. However, this model presents jurisdictional challenges, especially regarding responsibility for funding the provision of alcohol, which is delivered as part of a therapeutic harm reduction approach. Costs at OICH are minimized because the housing partner prepares the alcohol on-site, avoiding the need to purchase it from commercial suppliers.

Embedding MAPs within supportive housing requires ongoing coordination, stable funding, and shared accountability. In the absence of clear policy direction, MAPs rely on local leadership, cross-sector partnerships, and flexibility to secure resources and adapt operations for effective MAP delivery. As MAPs expand internationally, policy frameworks must clearly define roles, funding responsibilities, and ethical parameters to ensure sustainability while upholding participant autonomy and dignity.

## Conclusion

The evolution of MAPs from a novel intervention to an internationally recognized harm reduction model has been remarkable. When delivered thoughtfully, MAPs can reduce acute care utilization while also restoring dignity, stability, and a sense of community for those most at risk. However, critical gaps remain – particularly in developing tailored screening protocols, integrated care models, and policy frameworks that address the day-to-day complexities of MAP implementation. Refining and scaling MAPs to **remain adaptable, evidence-based and closely aligned with the realities of the individuals they serve** is essential to maximizing their impact and ensuring long-term sustainability. We hope that this commentary contributes to the ongoing dialogue and inspires the harm reduction community to strengthen the evidence-base around the practical elements of MAP implementation.

## Author contributions

A.M and G.S. developed the initial concept. All authors were involved in the review and revision of the manuscript and approved the final submission.

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## Data availability

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

## Declarations

## Competing interests

The authors declare no competing interests.

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