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To cite this article: Tessa Parkes, Hannah Carver, Catriona Matheson, Tania Browne & Bernie Pauly (2021): 'It's like a safety haven': considerations for the implementation of managed alcohol programs in Scotland, *Drugs: Education, Prevention and Policy*, DOI: [10.1080/09687637.2021.1945536](https://doi.org/10.1080/09687637.2021.1945536)

To link to this article: <https://doi.org/10.1080/09687637.2021.1945536>



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Published online: 02 Jul 2021.



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'It's like a safety haven': considerations for the implementation of managed alcohol programs in Scotland

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ABSTRACT

Alcohol use disorders (AUDs) are not equitably spread across the population, with some groups, such as people who are experiencing homelessness, being more vulnerable to AUDs due to social inequalities, stigma, and complex social and structural processes. Managed alcohol programs (MAPs) are a harm reduction approach first developed in Canada for those experiencing AUDs and homelessness with positive results. This study aimed to describe the factors that should be considered when implementing MAPs in Scotland. Qualitative data were collected in Scotland via semi-structured interviews with 29 individuals in a range of roles, including strategic informants ($n = 12$), service staff ($n = 8$), and potential beneficiaries ($n = 9$). Vignettes were used to support data collection. Data were analysed using Framework in NVivo. Participants highlighted six considerations to inform the implementation of MAPs in Scotland: the importance of individualized care; provision of alcohol; holistic care and a focus on well-being; types of settings and service models; staffing; and autonomy and rules. Future research should focus on piloting MAPs in a range of service contexts, using different models of care and settings, to develop an enhanced understanding of their effectiveness in addressing harms and promoting well-being for those experiencing AUDs and homelessness.

ARTICLE HISTORY

Received 19 April 2021
Revised 11 June 2021
Accepted 16 June 2021

KEYWORDS

Alcohol; homelessness; alcohol use disorders; harm reduction; managed alcohol programs; qualitative research; Scotland


Introduction

Alcohol and homelessness are inextricably linked: alcohol may be a way of coping with the challenges of homelessness, a response to other difficult life circumstances, or the reason for homelessness (Johnson & Chamberlain, 2008; McVicar et al., 2015; Pauly et al., 2018). Those experiencing homelessness are at increased risk of developing alcohol use disorders (AUDs) and experiencing a range of acute and chronic related harms, including seizures, assaults and injuries, liver disease, cancers, mental health problems, and early death (Fountain et al., 2003; Luchenski et al., 2018; McVicar et al., 2015). Treatment options for this group are limited and, for many, abstinence-based treatments are difficult to access and comply with. This is due to people being unwilling or unable to stop drinking, compounded by a lack of suitable housing and social support (Carver et al., 2020). Alcohol harm reduction approaches are therefore essential to keep people safe, reduce harms, and enable people to develop relationships with services.

Alcohol harm reduction is somewhat limited compared to the evidence base for illicit drug harm reduction (Kouimtsidis et al., 2021). Many drug harm reduction approaches exist, from micro-level interventions like needle exchanges to macro-level policies like legislation (Rhodes, 2009). Typically, alcohol harm reduction strategies focus on recreational

drinking, usually by young people, students, and those drinking in night-time economy settings (Ivins et al., 2019). As such, those who experience the most harm in relation to alcohol use, those with AUDs, are unlikely to benefit from such approaches (Ivins et al., 2019).

Managed alcohol programs (MAPs) are evidence-based alcohol harm reduction approaches specifically developed for those experiencing the dual challenges of AUD and homelessness. Initially developed in Canada in the late 1990s, they have grown in prominence in recent years and now exist in Ireland, with plans to develop MAPs in Australia (Ezard et al., 2018; Holmes, 2019), Scotland (Carver et al., 2021; Scottish Housing News, 2020), and Portugal (Fuertes et al., 2021). Within MAPs alcohol is provided in measured, regular doses throughout the day, along with other supports, such as housing, healthcare, and community activities (Pauly et al., 2018). MAPs can exist in a range of settings, typically day programs, shelters/hostels, transitional and permanent housing (Pauly et al., 2018). Research on MAPs in Canada has identified a range of positive outcomes for those involved. For example, alcohol intake has been shown to reduce overall (Stockwell et al., 2018), along with less harmful patterns of alcohol use, including less use of non-beverage alcohol, and declines in severe intoxication and drinking in unsafe spaces (Stockwell et al., 2018; Vallance et al., 2016). In addition, alcohol-related harms, including withdrawal seizures, have reduced (Pauly et al.,

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2016), and participants have reported improvements in relationships, quality of life, well-being, safety, and retention of housing (Pauly et al., 2016, 2019; Stockwell et al., 2013). Importantly, there is also evidence of cost-benefits (Hammond et al., 2016), reduced police contact, and fewer emergency room admissions (Vallance et al., 2016). The most recent outcomes study has shown reduced harms for those on a MAP and a deterioration in liver status on leaving (Stockwell et al., 2021).

Key features of MAPs have been detailed by Pauly and colleagues (Pauly et al., 2018). MAPs typically have very clear eligibility criteria, which commonly include: harmful drinking patterns; homelessness; multiple attempts at treatment, and/or high police/emergency department usage; and a program goal of reducing alcohol-related harm. MAPs are generally funded by housing and health services, or through clients' own funds, and there may be money management support for clients. Regular dispensation of alcohol is a key component of MAPs but can vary across services, with some providing alcohol every 60–90 min and others providing alcohol on a daily basis. In some MAPs, alcohol type is standardised, in others, individuals can have a choice. Food and accommodation are also typically provided as part of a MAP, recognising the importance of offering a choice of housing options where abstinence is not required (Pauly et al., 2013). Where accommodation is provided it can be in the form of shelters, transitional, or permanent housing. While some MAPs are provided as day programs, housing support is available recognising that non-residential programs might also create 'gateways' to other health, housing, and wider supports. MAPs can also be provided as part of Housing First initiatives (Pauly et al., 2013). Often there are strong linkages with primary care services within MAPs, and clinical monitoring about alcohol use and harms is common. MAPs also involve a range of social and cultural connections to alleviate boredom and develop skills. Many MAP participants in Canada are Indigenous people (from 9 to 100% in some MAPs; Canadian Institute for Substance Use Research, 2020) and particular activities are provided to help people connect/re-connect with their culture. Finally, the involvement of people with lived experience/peers is of importance in MAPs (Pauly et al., 2018, 2021).

MAPs fit within a wider context of harm reduction and treatment responses. In a recent meta-ethnography (Carver et al., 2020), a range of components were highlighted with regards to treatment which was perceived as effective for those experiencing problem substance use and homelessness. These included facilitative service environments; access to both harm reduction and abstinence-based treatments; compassionate and non-judgemental support; interventions that are long enough in duration; choices in treatment options; and opportunities to (re)learn how to live. These should be provided within a context of good relationships, person-centered care, and an understanding of the complexity of people's lives. While MAPs vary considerably as we have outlined above, all have the potential to embrace all of these components and more.

Despite the clear rationale, growing evidence base, and need for MAPs, they are limited outside of Canada. In

Scotland, the harms associated with alcohol use are high, and alcohol is a key public health concern, with 83% of people being current drinkers (Scottish Government, 2020a). Around 6.5% of all deaths in Scotland were caused by alcohol in 2015 (NHS Health Scotland, 2018) and, in 2019, Scotland had the highest rates of alcohol-specific deaths for men in the UK (Office for National Statistics, 2021). For people who are experiencing homelessness, the risks are even greater: 14% of deaths among the 'ever-homeless' cohort were due to alcohol-related conditions (Vaughn et al., 2018), and there are limited opportunities for those who require alcohol harm reduction. In 2019/2020 homelessness affected more than 51,000 people in Scotland (Scottish Government, 2020b).

In a related paper (Carver et al., 2021) we presented study findings regarding the need for MAPs in Scotland due to high levels of alcohol consumption, mental health problems, and polysubstance use amongst a small cohort of clients living in hostel accommodation whose case records were reviewed. Those experiencing mental health issues tend to have challenges accessing primary and secondary healthcare and MAPs have the potential to address some of these concerns with healthcare professionals being on-site or well-connected to the service (Pauly et al., 2018). MAPs were perceived as a necessary option for individuals who had exhausted other treatment options and needed alternative approaches. In this current paper, we present qualitative study data concerning factors that should be considered if and when MAPs are developed in Scotland. In making sense of our findings we draw on relevant literature and theory, such as Duff's 'enabling environments' (Duff, 2010) and Pauly et al.'s (2013) community-level policy framework on the role of harm reduction in addressing homelessness.

Methods

A mixed-methods study was conducted to examine the potential target population for MAPs and the views of a range of stakeholders regarding the need and potential for MAPs in Scotland. This current paper reports on qualitative data from the study concerning implementation considerations and draws on semi-structured interviews with a range of stakeholders: those working in commissioning-type roles or leadership in third sector organisations (strategic), those working in third sector homelessness services (staff), and those who would meet the eligibility criteria for accessing MAPs (potential beneficiaries/clients). While the possible benefits of MAPs would be felt wider than those using the service, we recognise that service users/clients would experience the most direct benefits from such a service. Data were collected in eight homelessness services in Scotland. Face-to-face and telephone interviews were conducted by HC and TB with strategic participants ($n=12$), staff participants ($n=8$), and potential beneficiaries/clients ($n=9$).

Strategic participants were identified through researcher networks of relevant national, statutory and third sector organisations. Purposive sampling was used to select individuals based on gender, role, and organisation to ensure the

inclusion of a wide range of views and experiences. Staff participants were recruited through managers in the eight services and were purposively sampled to ensure a range of genders and organisational roles (managers and frontline staff). Strategic and staff participants were invited to participate by email. Potential beneficiary/client participants were identified by staff in services and asked if they would participate in an interview, using purposive sampling to try to identify a range of genders and experiences of alcohol use and treatment. All potential participants were provided with an information sheet and assured that participation was voluntary. Written informed consent was granted by all participants before the start of the interview.

Interviews were conducted in workplaces or homelessness services (drop-in settings or hostels), were audio-recorded with permission, and were on average 38 min in duration. Interview schedules differed for each group and covered particular components of MAPs that would need to be considered for implementation (see Appendix 1 for full schedules). Three vignettes were used in all interviews to provide short descriptions of MAPs as an aide to stimulate more in-depth discussion (Jackson et al., 2015) (see Appendix 2). At the end of each interview, participants were provided with a debrief sheet to provide further information about the study and support available. Potential beneficiary/client participants were given a £10 shopping voucher to thank them for their time. These vouchers are used regularly by the research team, rather than cash, as required by ethical approval committees. Detailed fieldnotes were taken after the interviews to capture researcher experiences of the interview process as a way of enhancing reflexivity (Maharaj, 2016). This supported small changes to the interview schedule and vignettes to enhance clarity, and to help with the interpretation of data.

Data were transcribed in full and analysed using Framework (Ritchie & Lewis, 2003) in NVivo 12. The transcripts were combined into one dataset, read in full, and coded line by line. An initial thematic framework was developed after coding five transcripts and used to code the remainder. Both HC and TB were involved in developing the coding framework, with TB coding the majority of interviews and HC and TP checking for clarity/coherence. Data were arranged into themes and sub-themes relating to the implementation components of MAPs. Finally, relevant literature was drawn upon to make sense of the study findings. Ethical approval for the study was granted by the University of Stirling's General University Ethics Panel (GUEP, paper 695), the Ethics Subgroup of the Research Coordinating Council of The Salvation Army, and Turning Point Scotland.

Results

A total of 29 interviews were conducted with 12 strategic participants (seven female, five male); eight third sector staff (five female, three male, from six services); and nine potential beneficiaries (one female, eight male, from five services). Table 1 below provides an overview of participant characteristics.

Table 1. Participant characteristics.

Participants and organisations	
Strategic informant participants ($n = 12$)	
Government	$n = 4$
Health	$n = 5$
Third sector homeless organisations	$n = 3$
Staff participants ($n = 8$)	
Third sector homeless organisation A	$n = 3$
Third sector homeless organisation B	$n = 5$
Potential beneficiary participants ($n = 9$)	
Third sector homeless organisation A	$n = 2$
Third sector homeless organisation B	$n = 7$

This paper reports on key considerations necessary for the implementation of MAPs in Scotland, according to study participants. Six themes are presented: the importance of individualized care; provision of alcohol; holistic care and a focus on well-being; types of settings and service models; staffing; and autonomy and rules.

The importance of individualized care

Participants were clear that MAPs could not effectively operate if they were a 'one size fits all' approach to this client group. Instead, they believed MAPs should be tailored to individual needs, levels of consumption, support requirements, and long-term goals and outcomes. It would therefore be essential for individuals and staff to work collaboratively to develop individualized programs of care, including journeys through the MAP and potential exit strategies. There was a view that different types of MAPs and different approaches in MAPs were needed:

Different citizens using the service could be at a different stage on a journey and the needs are all different, aren't they? (Strategic participant 3, Government)

MAPs should be tailored to individuals, depending on their alcohol consumption preferences (type, frequency, etc.), and any support provided would also need to be tailored, for example in terms of welfare benefits, budgeting, skills training, housing requirements, physical and mental health, and social activities. Potential beneficiary participants talked about the need for different options, given that what works for some will not be suitable for others:

Everybody is going to differ, you know, so you are going to have to judge or work with whoever you are working with to figure that out. (Potential beneficiary participant 6, Third Sector Homeless Service B)

Some staff/strategic participants talked about the importance of working collaboratively to develop individualized programs of care from the start:

It's not about us saying, 'oh you should be doing this, you should be doing that.' We are not here to judge, you are an individual person, they have made that choice, that this is what they want to do. It's about trying to support them in a safe way. (Staff participant 18, Third Sector Homeless Service D)

You'd have to treat each person individually and have that initial kind of contact about what their needs are, what would help them, what do they think would help them. (Strategic participant 1, Government)

Regarding exit strategies, participants were clear that people should receive support to move on from the MAP when they are ready to do so, and collaboratively:

... trying to make sure that people are using mainstream services as much as possible, topping that up with specialist if required. Because what we are all hoping for is for people not to end up staying in somewhere like [residential MAP] for the rest of their life, but that they are able to be properly moved on to other accommodation, settled accommodation that they can get supported in and linked in to like GP services. Just make sure that they've got all the advice around them. (Strategic participant 7, Government)

One participant highlighted the need to support people to develop skills in decision making about their future options, encouraging them to make decisions for the next steps, and develop related 'life' skills:

The challenge comes, I guess, whether this is palliative care or whether this is a facility that people come into and move on from. If it is there for move on then there may need to be a bit more input in terms of housing and housing support and an opportunity for people to move into budget management, starting to manage their own drinking, and some sort of way of people progressing. Clearly what you want people to start thinking about... how they would manage their own drinking if they moved on. I am not saying that we should have facilities that only focus on move on, and that we should be putting time frames on it and all those sorts of things. I think that's perhaps not the way to engage with this group. But I suppose there is just the thought, well, what about move on? What would be the next step for people who didn't want to stay in this sort of setting forever... felt they might want to change their lifestyle and start to do something different. (Strategic participant 4, Government)

This participant recognises the need to have provision for individuals who might want to stay within a MAP for the long-term with no pressure to move on, alongside provision for those who might see a MAP as a stepping-stone towards more independent living. Within this theme, participants recognized that there needed to be a broad set of program goals within MAPs that related to harm reduction with individuals then able to set their own specific goals within these. It was acknowledged that there would be a need to accommodate multiple and often competing goals which might sometimes be in tension.

There was recognition from staff and strategic participants that many individuals eligible for a MAP would have experienced violence and trauma in their lives and may commonly have issues with trust and relationships. Services that were long enough in duration to allow people to develop trust were noted to be important. There was a view that many or most existing services for this group of people attempted to move people on too quickly, which did not work for those that needed secure and longer-term relationships:

People who have long-term trauma... it would take time... so they are maybe not getting the same chance to get... to build up that therapeutic long-term relationship because it's shorter work really. (Strategic participant 4, Government)

This relates to a subsequent theme on the importance of taking a holistic approach and understanding the life circumstances of the individuals using the services.

Provision of alcohol

Unsurprisingly one of the most frequent themes to emerge in the data was the issue of the provision of alcohol to clients and how this would be managed in practice. All participants agreed with the concept of MAPs being a service that provided alcohol in managed doses throughout the day. Some participants expressed the view that more frequent distribution of alcohol would be required, such as every 90 min, while others thought that three or four times per day would be sufficient. Many believed that provision would have to be flexible, in terms of such timings. Participants from all groups felt that there should be a choice in the type of alcohol provided.

I am not in a position to know whether the glass every ninety minutes would work... I don't think I'd be able to deal with that. I think if I had a glass I'd be probably wanting a bottle. (Potential beneficiary participant 2, Third Sector Homeless Service A)

Participants were also concerned about whether clients would drink outside of the MAP, which is an acknowledged issue in the Canadian MAPs. Participants worried that some people would drink too much:

If you let someone out without watching them, you know, maybe eight out of ten are going to go and have a wee sneaky one... Or maybe take drugs, whatever they are doing, and then come back and the staff might not notice it, because they might be 'oh he just looks normal to me, there you go there is your drink' and then the next minute he's away with it. (Potential Beneficiary participant 7, Third Sector Homeless Service B)

There were noted challenges regarding where people would get money to buy alcohol for the MAP if it was not provided as part of the service.

For participants, the distribution and consumption of alcohol, while a key component of MAPs, was complex. Again, alcohol provision would need to be individualized to clients' needs, in terms of frequency, quantity, and alcohol type. Clear agreements regarding alcohol consumption would be required, as they are in established MAPs.

Holistic care and a focus on well-being

Participants talked about the importance of MAPs providing more than just alcohol. There was recognition of the need to take a holistic approach, with consideration of a range of elements of a person's life, such as physical and mental health, housing status, financial situation, any requirements for skills development, and the need for wider meaningful and social activity and connections. In terms of healthcare, some participants expressed the view that a nurse and/or a GP should be on-site to deal with physical health problems which they thought could be considerable and should include monitoring the effects of alcohol. Alternatively, others saw the value of clients attending mainstream health services to encourage independence:

... for a period of time, maybe initially, the GP comes onsite just to monitor people and see how they are going, but after a period of time they maybe need to start accessing the local community and be part of that local community because that reconnecting and feeling a part of their local community, is visiting their local GP

centre, and building on that. (Staff participant 14, Third Sector Homeless Service A)

All participants viewed the provision of social activities within MAPs as important: a way of reducing boredom and social isolation, building self-esteem, and developing relationships:

Giving people an opportunity to learn a bit about themselves, what they like, what they don't like... through their experiences of addiction... maybe have not either had the opportunity to develop those interests or have lost them. (Staff participant 19, Third Sector Homeless Service B)

Lots of people are just drinking on their own, day in, day out, every day not seeing anybody. They are losing all their social skills, they are really anxious, so you would introduce them to being around people. (Strategic participant 12, NHS)

There was also a view 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. One staff member highlighted the value of clients cooking for themselves to retain/create new skills:

Why not encourage them to be making their own dinners? The way my building is set up is we provide meals but I think what you want to be doing is you want to be skilling people up, not deskilling people, so I would be keen on getting people to do as much for themselves. (Staff participant 14, Third Sector Homeless Service A)

Potential beneficiary participants talked about the challenges they experienced with food and nutrition, and the lack of priority placed on eating when they were drinking:

When I was an alcoholic... the drink stopped giving you an appetite. But since I've been recovering in here I am eating good food. I'm getting my vitamin tablets, I am getting healthy food and starting to have fruit and veg, some salads... I feel a lot better... I'm looking a wee bit healthier and through time hopefully I will look better and better and better. (Potential beneficiary participant 2, Third Sector Homeless Service A)

Cooking and eating together was a way of reducing boredom, connecting with others, and feeling valued as a community member. A wide range of health-promoting and well-being-focused activities were therefore viewed as required as part of a successful MAP.

Types of settings and service models

In the vignettes, participants were asked about the potential settings for MAPs, including residential settings and day centre/drop-in services, and to talk about which settings/service models they believed were best to meet client needs. As discussed above, almost every participant across the three groups expressed the view that different service models would need to suit the needs of different individuals. There were pros and cons considered to be associated with different models, with no 'ideal type.'

Several participants from each category group supported the idea of 'wrap-around' care and viewed a residential centre as a more nurturing environment. There was general agreement among participants that a residential model would provide the most comprehensive level of support by allowing a 24 h staff presence for monitoring, support, and

structure, which was deemed necessary for many of those experiencing severe alcohol problems and homelessness:

I always think, with residential, you are taking away some of the complications I suppose of kind of day-to-day life, you know, it's like a safety haven. (Staff participant 6, Third Sector Homeless Service A)

However, there were concerns that a residential model may be restrictive and lead to an overly institutional atmosphere. Some participants were concerned that clients would over-rely on a single location and viewed a day centre as providing enhanced opportunities for community interaction.

Day/drop-in centres were considered to be good models to develop in Scotland because many participants viewed them as particularly low threshold, and a good way to prevent institutionalization. For instance, alcohol serving times could be more flexible allowing clients to leave the building for longer periods:

They are not locked in and they are not dictated to... they are not isolated from the community either... they are not so socially isolated from their normal friends and family. (Strategic participant 13, NHS)

Several staff/strategic participants envisaged the day centre as a good transition from the streets to residential settings, particularly for those perceived as leading chaotic lifestyles who would not be ready/able to engage in the potential restrictions of a residential setting. Instead, individuals could use the day centre to initially engage, to 'see how it goes, get an idea of what it might be like' (Potential beneficiary participant 2, Third Sector Homeless Service A), with residential settings as a next step:

... even if it did get to a point where we were, you know, it wasn't right for the person... you've had an opportunity for that person to build up maybe support networks, build up relationships and connections with people. (Staff participant 19, Third Sector Homeless Service B)

Some participants were keen on a residential MAP model because they saw them as having the potential to solve the housing situation experienced, as well as the alcohol problem:

... doesn't really take them off the streets at night, that would be my concern. I don't like that, that's not dealing with homelessness. (Strategic participant 1, Government)

Regarding wider potential settings for a MAP, participants suggested hospitals, prisons, and other residential settings, such as within a person's own home or within a Housing First service. According to some participants, such settings could have a MAP embedded within them so that individuals could manage their alcohol without fear of detoxification:

The hospital settings where people are coming in for... the moment they come in they will be detoxed, they will be treated... and then sent on their way. So, in some situations, it may be more appropriate to give people alcohol depending on the treatment they are getting, rather than detoxing them. Same with short term sentences in prisons. The decision to detox is effectively based on whether the court sends them to prison or not. So a MAP in prison for people on short term sentences might be quite sensible. (Strategic participant 4, Government)

These alternative settings were seen as providing support to those who might go into alcohol withdrawal in emergency situations: a MAP would ensure people do not experience withdrawal symptoms and enable them to access support services. However, such settings were described as controversial due to the potential ethical issues of providing alcohol within them.

Participants also discussed particular sub-group needs, particularly women and those identifying as lesbian, gay, bisexual, transgender, queer, and related communities (LGBTQ+). Of the eight homelessness services involved in the study, one was a women-only setting and the remaining had mostly male clients, something reflected in the gender of the case note data and potential beneficiary participants. A substantial reason for women-only substance use services is male violence. In some cases, individual choice was advocated, however it was broadly agreed that there should be the option of women-only services:

Women come in here and they like the fact that it's women only because women can be a bit more intimidated. It might not feel like a safe place because again most women are abused by men... they have different needs. I think they have got different supports. At different times they focus on their own recovery and the distraction is there always. (Staff participant 14, Third Sector Homeless Service A)

There was a view that MAPs should be 'inclusive to anyone who needs them, regardless of how they self-identify' (Strategic participant 3, Government).

Overall, participants did not have a clear preference for residential or drop-in settings and discussed the merits and shortcomings of both. They also highlighted the potential of MAPs in other settings like hospitals and prisons. It was clear that the options available would need to be tailored to the local setting and the needs of those who would be accessing the MAP. Participants also noted that MAPs would have to take into account the different needs of those accessing them, particularly women and those identifying as LGBTQ+, due to potential safety concerns.

Staffing

There was considerable discussion regarding the complexities of providing MAPs, and the need for such services to be staffed by well-trained people, for example in counselling techniques, such as motivational interviewing, trauma-informed care, and managing challenging behaviour. Participants described the need to work with people to manage their alcohol use in a compassionate and non-judgemental way:

It's about taking away any judgment, do you know what I mean? Letting them kind of lead what is right for them as an individual. And the staff in the centre kind of understanding and agreeing that so that the individual doesn't feel like they are judged and criticised. They are more likely to engage if they feel that someone has listened to them. (Strategic participant 1, Government)

Concerns around staffing mostly oriented around challenges managing an individual's alcohol consumption, and potential risks if the staff member refused to provide alcohol

to someone, or staff being perceived as overly controlling by clients. While participants did not explicitly mention violence towards staff or other clients, it was implied by participants' discussions of risks and repercussions. There were also concerns about providing alcohol to people who already had alcohol-related health problems:

It would be hard being a worker just handing over the alcohol and not seeing, I suppose, the benefits of it, because if you are drinking a lot of alcohol over a sustained amount of time you are going to kill yourself and your body is going to shut down... if you done that job for four years and you kept on handing the same person the same alcohol and you can see them deteriorate, it can't be good for the worker, never mind the person who is drinking the alcohol (Staff participant 14, Third Sector Homeless Service B)

It is apparent that training of staff around the benefits of MAPs and the provision of alcohol would be needed. Several staff and strategic participants discussed the subjectivity of staff in determining levels of intoxication and the provision of alcohol and queried how staff would or should manage these incidences. Power dynamics were also discussed highlighting the need for collaborative agreements between staff and clients around their alcohol use and behaviour.

The contribution of those with lived and/or living experience in the provision of MAPs (as staff members) was viewed as vital by participants at all levels because it was something that could provide hope, a greater understanding of the problems and needs of those with AUDs, and better overall engagement with the program:

Lived experience in my opinion is the key, the key to people knowing that it's doable I suppose... because we can read a book and tell them how they are going to feel but we haven't actually felt it. (Staff participant 14, Third Sector Homeless Service A)

For potential beneficiaries, the involvement of those with lived/living experience could also facilitate friendships and there was a sense of looking out for each other.

Participants were clear that MAPs needed to be suitably staffed by those who were well-trained, both in terms of the skills necessary for working with the client group and also in the provision of alcohol and the associated challenges. The involvement of those with lived/living experience within MAPs was also deemed to be important.

Autonomy and rules

When participants considered each of the three hypothetical MAPs in the vignettes (see [Appendix 2](#)), they discussed the need for a balance between service rules and individual autonomy for those accessing MAPs. In one of the vignettes, alcohol was provided every 90 min and those accessing the MAP would have to stay on-site an hour beforehand, as is the case in some MAPs in Canada (Pauly et al., 2016). Participants were concerned about the rigidity of this approach and felt that flexibility in rules and structure was required. As one strategic participant (1, Government) noted, for some people experiencing homelessness and severe problem alcohol use: 'they find all these rigid rules really hard to stick by.'

[In vignette 1] it seemed like basically you were giving up all of your power and the alcohol, like you contributed to buying, was then being doled out to you. So it's hard to imagine how helpful that would be for a lot of people who might not like to be treated that way. (Strategic participant 5, NHS)

If you take away the rules to some extent and ask them what would suit them? I think that would be the best way, so it's not pre-defined morning, lunchtime, teatime, do you know what I mean? (Strategic participant 1, Government)

On the other hand, other participants believed that some clients would need this intense level of support and structure to help them, particularly at the beginning:

It sounds as if it's got a good structure, so that could be a good thing, having that structure in place. Although I think a lot of people would probably struggle with the structure to start off with. I know I would probably struggle with the structure but it's like everything, you need to give it a go and you'd probably get into the swing of things and you'd start to be involved more. (Potential beneficiary participant 2, Third Sector Homeless Service A)

Relatedly, participants also talked about considering people's need for autonomy in terms of their money, particularly around alcohol purchasing. Potential beneficiary/client participants discussed the benefits of MAPs being involved in supporting people's budgeting and working with them to identify how much money could be spent on alcohol. They described experiences of services where money is managed by staff, to support budgeting:

... when you are on a massive sesh (drinking session), you just lose track, like how much money is in your wallet. I have to check my bank statement, so that sounds like a pretty good idea, definitely. (Potential beneficiary participant 5, Third Sector Homeless Service B)

Staff and strategic participants, on the other hand, had concerns about MAPs being involved in taking people's money to purchase their alcohol, as they perceived doing so as being too controlling:

I wasn't sure about taking money off people, because I suppose well, if they drink too much and we withhold alcohol then it's still that person's money, I am not sure about that. (Staff participant 19, Third Sector Homeless Service B)

Participants highlighted the need to support those accessing MAPs, in terms of encouraging autonomy, providing opportunities for people to make their own decisions, build self-efficacy and self-esteem, and the importance of ensuring that those accessing MAPs were in control of their support:

It's giving them power, different choices. It's exploring the control, being told you have to go in somewhere but you are not getting your alcohol ever again or we are controlling your money or things because you are vulnerable adults. The first thing they are going to think is get angry and run away, horrible people kind of thing. (Staff participant 10, Third Sector Homeless Service A)

You turn up with your alcohol and say yesterday I just drunk it myself and today I am going to give it to you, can you give this to me at X, Y, and Z, it's a wee bit less than I did yesterday I really need to do something about it... that's full of control. (Staff participant 9, Third Sector Homeless Service B)

Having clear rules within a context of autonomy was deemed important by many participants across all groups. Striking a balance between rules within MAPs, particularly

around alcohol consumption, as well as providing a compassionate service, would be needed. Having clear guidance regarding clients' money and payment for alcohol would also be essential. Related to the notion of holistic care, opportunities would need to be provided to help clients develop self-esteem and make their own decisions.

Discussion

This is the first Scottish study to examine stakeholder views on how to take forward implementation of MAPs to address the complex needs of people with co-occurring AUDs and homelessness. We have described six considerations to inform the implementation of MAPs in Scotland: the importance of individualized care; provision of alcohol; holistic care and a focus on well-being; types of settings and service models; staffing; and autonomy and rules. While we have outlined these novel findings about Scotland where we are not aware of any other studies in this specific field, these six considerations are broadly coherent with wider literature on MAPs and safer environments, from Australia, Canada, and Ireland, to which we now turn to place our findings in context. Implications for policy and practice are threaded through this discussion rather than being separately highlighted, given the centrality of these to our initial study goals.

Duff's (2007, 2009, 2010, 2011) theory of 'enabling environments' and 'enabling resources' is relevant to our study findings due to the potential of MAPs to create 'safe havens' for those who experience the interrelated challenges of homelessness and alcohol dependency. Duff's (2010) enabling environment theory builds on Rhodes' (2002) risk environments framework. Duff argues that Rhodes' framework overemphasises the role of the risk environment in identifying drug use-related harm without fully considering 'enabling' environments. For Duff (2009), enabling and risk environments should be considered together because contextual spaces often include pre-existing and co-occurring elements of both risk and enablement in a fluid way. Duff describes contextual spaces as fluid, complex, and always in interaction with each other: these are the spaces and places that care and support take place *within* but also include staffing and relational issues like trust. Duff (2010) suggests that enabling environments can only be understood in terms of the enabling resources (social, material, or affective) that operate within a contextual space. This can be a direct result of the design and implementation of specific harm reduction interventions, as well as unintended resources (created or discovered by people in community spaces) which could indirectly facilitate the success of an intervention (Duff, 2009). This analysis can provide insight into the way that risk and enabling environments can interact in the same space to create different outcomes for different people in different contexts. While this theory was initially developed about drug-related harm, it has also been used to understand the enabling environments of MAPs (Evans et al., 2015; Pauly et al., 2019).

Duff (2007) emphasises that enabling environments are created through process and interaction as much as through

'outside' structural forces and that, in turn, these processes and interactions shape the boundaries of the space. For Duff (2007), space is a means of making sense of the world, as well as a measurable dimension. In this study, we have elucidated the manner in which newly developed MAPs in Scotland could organize their material and empirical dimensions, as well as addressing Duff's focus on how actors might make space 'meaningful' or 'inhabitable,' by emphasizing the need for individualized, holistic care. Developing social and supportive relationships via enabling environments such as MAPs draws on communicative and expressive competencies, emotionality and empathy, listening, and interactional skills. It is perhaps no coincidence that within our study a prominent theme was that of holistic care, and particularly that provided within a residential MAP. These are arguably settings through which social relationships and social cohesion are most rapidly facilitated. Yet, as Duff (2011) points out, staff and environment 'qualities' which facilitate the therapeutic benefits of enabling places are not innate: they must be developed and nurtured.

The emphasis from many of our participants on individualized care recognises that not everyone has access to the same resources. Even within the same space, Duff (2011) points out that the therapeutic effects of an enabling environment may wax and wane over time, mediated by such factors as gender, class, ethnicity, and the social capital required to access therapeutic benefits. Indeed, what may be an enabling factor for one person may be indifferent, or even detrimental, to another: what represents safety to one person might be constraining and controlling to another. Consequently, developing a range of potential MAP models and settings addresses the need for heterogeneous provision. In addition, in using Duff's theory of enabling resources, those working in this field should be cognizant of his assertion that no one resource is innately enabling: all resources, even those such as hope, connectedness, money, and trust, rely on their utility in a particular context (Duff, 2010).

As we described in our linked paper from this study (Carver et al., 2021), MAPs need to take into account other factors, such as polysubstance use, clients' physical and mental health needs, and the lack of appropriate services currently available for those with AUDs who are experiencing homelessness. Participants believed that MAPs could be offered in settings such as hospitals and prisons where people might go into alcohol withdrawal in emergency situations. However, the provision of a MAP in such settings was described as controversial due to what were considered to be ethical challenges of providing alcohol within the context of negative public and professional attitudes. This was a finding in a study by Pauly et al. (2019, para. 61), where the provision of MAPs outside of an alcohol harm reduction environment was not widely accepted or understood: *'Thus, an important aspect of implementation is alcohol harm reduction education for other organizations.'*

The theme of social connectedness and activities to address loneliness and isolation, as well as boredom, led to participants suggesting the need to provide social activities to build self-esteem and develop relationships. This is something that the Depaul Dublin MAP incorporates into their

model of care (Depaul Ireland, 2010) and, again, chimes with Duff's (2009) enabling environments theory which highlights the importance of everyday interactions and displays of care within harm reduction services. Places and spaces for care and reciprocity can enable healing from past life experiences through the 'enabling resources' that create safety, flexibility, and supportive relationships. Improved life circumstances, self-acceptance, and positive identities may then flourish within such 'cultures of care' (Duncan et al., 2019). Participants highlighted the importance of alcohol provision just being one of many threads of service that needed to be offered to reduce harm and promote health and well-being.

MAPs require individualized care pathways (into, through, and back out of MAPs) with a range of options required to meet the complex needs of clients with co-occurring AUDs and homelessness. Journeys into and out of MAPs need to be carefully considered. They should be seen as a long-term intervention, as a place of safety and connection, and as homes (Pauly et al., 2016). When considering the wider needs of the population, and their possible difficulties with trust and relationships, long-term approaches are indicated. This has been highlighted by Depaul Ireland (2010) where they discuss the importance of MAPs promoting a culture of caring. Holmes (2019) emphasised the complexity of the needs of this client group in her work consulting stakeholders about MAPs in Northern Territory, Australia. She concludes that having 'step-up' and 'step-down' pathways can enable different exit pathways for individuals, while also providing long-term home environments for as long as needed/wanted. Holmes (2019) also acknowledges the poor health that many clients may face when coming into a MAP which might mean palliative care, either on entry or at a later stage, is required. The importance of including ongoing care options, such as to hospital or a family environment, in service designs is one way to build in flexibility and exit pathways.

MAPs should also provide a range of support and activities to increase well-being. Research from Canada highlights the importance of providing holistic care, through food, social activities, and health and social care (Pauly et al., 2016, 2018, 2019). In our study, potential beneficiary/client participants talked about the challenges they experienced with food and nutrition, and the lack of priority placed on eating when they were drinking alcohol. This has also been highlighted by Depaul Ireland (2010), alongside the importance of holistic and person-centred provision. Our findings closely connect with the stakeholder perspectives described by Holmes (2019) which underscore the need for holistic models to be developed, with access to primary care and counselling services, social, cultural, and recreational activities to support (re)engagement with family and community and build life skills, and provision of meals, alongside safe and suitable MAP housing.

Alcohol provision was discussed in depth by all participants as a complex area. There was a view that provision of alcohol needed to be tailored to the individual, in terms of frequency, quantity, and type, with agreements established on entry to the MAP, as Mattison et al. (2019) have also observed. Balancing clear rules with client autonomy was a central theme suggesting the need for flexibility within the

rules and structure of MAPs, something that has also been noted in Canadian research (Stockwell et al., 2013). Given the importance of meaningful involvement of people with lived and living experience, this is an area where such expertise could be used very effectively to ensure collaboration around the development of such rules. Concerns about clients drinking outside of the MAP is an acknowledged issue within the Canadian MAPs (Pauly et al., 2018, 2019). Research suggests that MAPs that have effective policies for outside drinking are associated with lower rates of alcohol use and related harm (Stockwell et al., 2021) demonstrating the need for clear protocols around alcohol use. Overall, encouraging autonomy, self-esteem, decision-making, and a sense of control, can be mechanisms to help people self-manage their alcohol use and rely less on staff input and rules.

Different models of MAPs exist in Canada and Ireland and our study participants reflected on the need for diversity in models and settings in Scotland. The advantages and disadvantages of residential and drop-in models (the most common MAP models) were described, highlighting the need for local contexts, current service provision, and client group needs to be taken into account. While little research exists internationally on the issue of different models of care for MAPs, Ezard et al. (2018) surveyed 51 people who were experiencing homelessness and alcohol dependence and enquired about participant preference in this regard, with 76% supporting a residential model. One of the reasons why our participants were keen on MAPs being delivered within residential settings was because they perceived them as having more potential to successfully resolve the poor housing situations that individuals were experiencing, as well as their alcohol problems. Pauly et al.'s (2013) framework explicating the role of harm reduction approaches in addressing homelessness is highly relevant to this point. They stress that the harms of substance use, including stigma, overdoses, and death, are exacerbated by homelessness and, concurrently, that effectively addressing concerns related to substance use should be integral to a systems-level response to ending homelessness. Their framework draws on Rhodes' (2002) risk environment concept to highlight the role played by safe environments in mitigating harms relating to structural determinants, such as housing policies and the political economy:

'Proposed interventions to create safer environments would encompass policy level changes to increase the supply of housing and ensure sufficient incomes and removal of barriers to implementation of harm reduction programmes and policies (285).'

Four key dimensions and areas for action are identified in their framework: (1) developing policies of social inclusion; (2) ensuring an adequate supply of housing; (3) providing on-demand harm reduction services; and (4) systemic and organizational infrastructure (Pauly et al., 2013). Provision of MAPs via residential models of care and support for people experiencing homelessness and alcohol dependency closely aligns with this framework by addressing all four of these dimensions. They also address the pervasive stigma that still exists for this group by providing relevant and quality services tailored to need.

Non-residential MAP models are also possible but it is likely that greater awareness and education of alcohol harm reduction and MAPs would be needed first, as highlighted by Pauly et al. (2019). Recently work has been published on a non-residential MAP run by people with lived and living experience (peers) in Vancouver, British Columbia which illustrates a positive impact on participants' lives, including a move away from non-beverage alcohol use, improved self-management of levels of alcohol consumption, and developing stronger community engagement (Pauly et al., 2021). In terms of targeting specific needs, the needs of women and those who identify as LGBTQ+ should be taken into consideration when developing such provisions in Scotland to ensure services are appropriate and sensitive. Nielsen et al. (2018) underscore the importance of ensuring MAPs are tailored to the local context which in Scotland could include attention to specific demographic characteristics, drug as well as alcohol use, a range of settings and locations, and the central involvement of peers.

MAPs require highly trained, compassionate, and non-judgemental staff, aspects that are often highlighted by those experiencing homelessness as important features of services (Carver et al., 2020). Access to supervision and reflective practice would also be important to maintain staff well-being when working in challenging environments like MAPs (Scanlon & Adlam, 2012). This was a feature of Holmes' (2019) stakeholder analysis on MAPs, where staff values, such as being supportive of people's goals and rights and being kind, compassionate, and caring, were featured. In our study, participants pointed to the importance of involving people with lived/living experience, to provide hope, increase engagement, and a greater understanding of people's lives (Miler et al., 2020). This also connects with Pauly et al.'s (2013) framework where social inclusion policies are listed first of the four dimensions. Meaningful involvement of people with lived and living experience facilitates voice in the development of policies and programs, addresses power differentials, and can facilitate the promotion of self-esteem and individual control (Pauly et al., 2013).

Strengths and limitations of the study

This is the first Scottish study to examine a range of views regarding the implementation of MAPs. By including strategic level, staff, and potential beneficiaries/client participants, we have been able to illustrate diverse vantage points. For example, potential beneficiaries talked about the importance of choice in drinks, frequency of alcohol provision, the benefits of different setting types, and the availability of social activities. Strategic and staff participants discussed practical aspects of developing MAP provisions, such as staffing, individualized care, and autonomy and rules. Together these data have provided detailed insight into six key considerations for future implementation of MAPs in Scotland, with potential relevance to other countries within the UK and beyond. Field notes and reflexivity ensured that any potential researcher bias was mitigated during the research process. Purposive sampling was used to try to reduce bias (Morse,

2006) and ensure a range of viewpoints were considered. However, our participants may reflect a particular sub-set of clients in that they were willing and able to participate in a research interview. Some individuals who were initially interested in being involved were subsequently unable to participate due to their levels of capacity and intoxication, and only those who were able to speak/understand English were included, so some diverging views may have been missed. Additionally, we were only able to interview one female potential beneficiary, despite trying to recruit from one women-only service; and no participants identified as LGBTQ+. Understanding the views of women and those identifying as LGBTQ+ will be essential going forward into piloting these services and should therefore be prioritized in future research.

Conclusions

This study has examined the factors that should be addressed when implementing MAPs in Scotland for them to best meet the needs of those who would be eligible. Drawing on the views of a diverse range of stakeholders, including those who would be eligible for MAPs, we highlight six considerations to inform the implementation of this novel approach: the importance of individualized care; provision of alcohol; holistic care, and a focus on well-being; types of settings and service models; staffing; and autonomy and rules. Study findings connect closely to the existing literature on safer environments and MAPs across Australia, Canada, and Ireland. Future research on MAPs in a Scottish setting should move to feasibility testing and piloting using different models/sites given there is no particular ideal type: there are benefits to both residential and non-residential models that could be effectively explored through such piloting. Using different service models and contexts would enable a continuum of options for those impacted by AUDs and homelessness. Finally, it is important that those with lived/living experience are closely involved in the design and implementation of these services, and their evaluation.

Acknowledgements

The authors wish to thank all of the participants for their time, and service managers and other staff from the services for facilitating the interviews and welcoming the researcher (TB) on their premises.

Disclosure statement

The authors have no conflicts of interest to declare.

Author contributions

TP and HC conceived this study. TP, HC, CM, and BP collaboratively contributed to the design of this study. HC and TB were involved in participant recruitment. HC and TB performed all data collection. HC and TB performed data coding and analysis, with input from TP, CM, and BP. TP and HC wrote the first draft of this manuscript. All authors contributed to the interpretation of the findings and the final version of this manuscript. The authors read and approved the final manuscript.

Funding

This research was funded by Chief Scientist Office Scotland under Grant CGA/19/14.

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Data availability statement

Due to the nature of this research, participants of this study did not agree for their data to be shared publicly, so supporting data is not available.

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Appendix 1. Interview schedules

Strategic informants

1. What is your role/day-to-day job?
2. What are your experiences of commissioning/leading/providing/reviewing services for people with problem alcohol use?
3. What do you think is the scale and nature of severe alcohol use/problems in Scotland?
4. What particular problems do you think people who are homeless experience with their alcohol use/dependence?
5. How well do you think services you manage/commission/try to influence currently support people with more severe alcohol problems including dependency?
6. What are your experiences regarding access to structured treatment to address alcohol problems for your clients?
7. What are your thoughts on the best approaches to minimising risks/harms for this group of people?
8. What are your thoughts on the proposed intervention this study is about – Managed Alcohol Programs (MAPs)?
9. How would you feel about MAPs being delivered locally or nationally?
10. What are your thoughts on the different approaches to MAP – residential, drop in and co-op model?
11. We know that from the Canadian work on MAPs, one of the reasons people leave is due to control – people find that staff controlling their alcohol intake can be problematic. An alternative option is that people in the MAP choose their own timings for drinking the alcohol, but they will still have a set amount they can drink each day. What are your thoughts about staff vs. own dosing of alcohol?
12. Any other comments or questions regarding MAPs?
13. Anything else you would like to raise that you have not had the chance to that is relevant?

Staff participants

1. What is your role/day-to-day job?
2. What are your experiences of working with/supporting people with problem alcohol use currently in your service?
3. What do you think is the scale and nature of severe alcohol use/problems in your local service area more generally? Compared to Scotland as a whole?
4. How many people do you think are currently in your service (or have used your service in the last 6 months) with (1) problem alcohol use (negative impacts on health and social circumstances in addition to homelessness) (2) severe alcohol disorder/dependence as recorded on a screening tool like AUDIT? What is the wider social and health profile of these clients/residents? Gender/age – any particular ethnic group who are at higher risk?
5. What particular problems do clients/residents experience with their alcohol use/dependence?
6. How well do you think your service currently supports people with more severe alcohol problems including dependency?
7. What are your experiences regarding access to structured treatment to address alcohol problems for your clients?
8. What are your thoughts on the best approaches to minimising risks/harms for this group of people?
9. What are your thoughts on the proposed intervention this study is about – Managed Alcohol Programmes?
10. What are your thoughts on the different approaches to MAP – residential, drop in and co-op model?
11. We know that from the Canadian work on MAPs, one of the reasons people leave is due to control – people find that staff controlling their alcohol intake can be problematic. An alternative

option is that people in the MAP choose their own timings for drinking the alcohol, but they will still have a set amount they can drink each day. What are your thoughts about staff vs. own dosing of alcohol?

12. Any other comments or questions regarding alcohol management in your service or MAPs?
13. Anything else you would like to raise that you have not had the chance to that is relevant?

Potential beneficiaries

1. How long have you lived here/been using this service?
2. This is a study about how to provide good support to individuals with problem alcohol use. Do you consider yourself to have problems with alcohol? Would you mind telling me more about any problems you have in different areas of your life? Are any of these created by drinking too much or made worse by drinking?
3. If you are comfortable doing so, please can you tell me a bit more about your drinking? How much? How often? What times of the day? Do you drink any non-beverage alcohol (like mouthwash, methylated spirits, rubbing alcohol, hand sanitiser)? Do you drink on your own or with others? In the service or outside of the service you are currently in, or both?
4. Have you ever tried to access alcohol treatment (including rehabilitation/detoxification)? If yes, how many times? How did you find that treatment? Please tell me about the things that worked or did not work for you if you are comfortable doing so.

Appendix 2. Vignettes

Vignette 1 – St Peter's Centre

St Peter's is a residential centre which is part-funded and managed by a charity. Additional funds are received via clients' Housing Benefit. The centre is only open to people over 30 years of age but is open to both men and women. There are 20 beds available at the centre, and they are exclusively for people on a Managed Alcohol Program. The staff at the centre help clients to budget and manage their money, and they take a percentage of the client's money in return for providing daily drinks.

Clients are given a drink of red or white wine every 90 min between 7.30 in the morning and 10.30 at night. The amount of wine clients receive is agreed upon in advance between clients and their case staff but is generally around 150 ml per drink. Clients may prefer to have a larger drink first thing in the morning at the expense of less wine in a few of their drinks later in the day, and this is considered acceptable. Staff reserve the right to withhold drinks if clients appear to have drunk more than their allocated amount. Residents are required not to drink outside of the programme or they will have the number of drinks reduced.

The centre serves three meals daily, which are prepared and cleared by staff and clients on a rota. Clients are encouraged to take part in community activities, such as art and music therapy, and they are supported by former client volunteers who have moved on to live more independently. A practice nurse visits a few afternoons a week to give advice and to monitor liver function, and a GP comes to the centre one morning per week.

Vignette 2 – The Gale Centre

The Gale Centre is a day centre for people who are homeless, including those in temporary accommodation. The centre is used by around 25 people each day, and about 80% are men. The average age of clients is 44 years. The staff at the centre advise clients on the financial and housing help that they can get, as well as running a part-time health clinic with a practice nurse. Clients can also use showers and laundry.

Not all clients at the Gale Centre are part of the Managed Alcohol Program (MAP). There are regular sessions about the MAP and educational opportunities to learn about strategies for safer drinking and staying healthy. Those who want to join buy their own alcohol. Clients give their alcohol to the centre staff when they arrive, and one-third of rations of the

drink are given at mid-morning, again at lunchtime, and then at the mid-afternoon session where there is usually a social activity. Clients do not have to remain at the centre all day, but they are welcome to stay for activities, free tea and coffee, and cheap lunches. Clients have to be on-site for an hour before being given their drink ration. This is so that staff can monitor them, and make sure that they haven't had too much to drink during their time spent elsewhere. If a client seems too drunk then their ration will be declined and given back at the end of the day.

Some clients who can stay in St Peter's choose not to go, and use the MAP at the Gale Centre instead. These clients may be worried that the rules will be too rigid, that they won't be able to stay with friends, partners, and family members, and that they will be confined to the building by the schedule of the drinks.

Vignette 3 – Dunn Street Centre

Dunn Street Centre is a drop-in centre that is open daily. In some ways it's the same as other drop-in centres in town - the staff at the

centre advise clients on the financial and housing help that they can get, as well as running a part-time health clinic with a practice nurse. Clients can also use showers and laundry. It is different because some of the people who use Dunn Street have learned to make their own wine in the centre's 'Master Brewer' program, and together they run a co-op that supplies the drinks for the centre's managed alcohol program. This gives them confidence because they have learned a new skill, and helps them to build friendships with each other as they need to work together to make decisions. It also keeps down the costs as the people who use it drink the wine that is made there.

People pay a fee to be members of the managed alcohol program, and this pays for the wine-making costs. They can then drink homemade wine. At the moment, about 25 people are in the scheme. There is also an Alcohol Exchange system, where members can trade in their non-beverage alcohol (like mouth wash or hand sanitiser) for drinks supplied by the Brew Co-op. The wine made by the co-op is stronger than wine that can be bought in shops, and the co-op now makes 200 litres per week.