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COMMENTARY

Managed Alcohol Programs: An Innovative and Evidence-Based Solution for Adults with Severe Alcohol Use Disorder Who Are Experiencing Homelessness

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Communities across the country seek compassionate, effective solutions to help the growing number of their residents without stable housing who live in encampments and outside, often rotating through a variety of institutions including hospitals, jails, and shelters. Substance use often exacerbates and is a response to homelessness. Alcohol use disorders (AUDs) are particularly common, affecting 30%–50% of people experiencing homelessness. Due to the inherent instability of their living situation, people with severe AUD and unstable housing often engage in dangerous drinking patterns such as high-intensity binge drinking and consumption of non-beverage alcohol. They also have few options other than to drink in public settings, which can lead to frequent interactions with police and emergency services. Often, the treatment and shelter options offered require abstinence from alcohol; yet, for many people with AUD, abstinence is not an attainable or desired goal. Managed alcohol programs (MAPs) are innovative, evidence-based solutions for helping people with severe AUD experiencing homelessness. These programs often include resources to meet basic needs such as shelter, meals, and primary care with alcohol administration throughout the day. These programs aim to address both the harms of high-risk drinking patterns and the harms of unstable housing. Despite evidence from Canada that MAPs improve patient outcomes and are cost-effective, these innovative programs

have not been widely adopted in the United States. In this paper, the authors review the rationale, logistics, and current evidence for MAPs. They propose that policy makers and leaders of health care organizations and public health agencies consider implementing MAPs as part of an approach to alcohol harm reduction and a potential solution to the dual challenge of AUD and homelessness, supported by further research and evaluation.

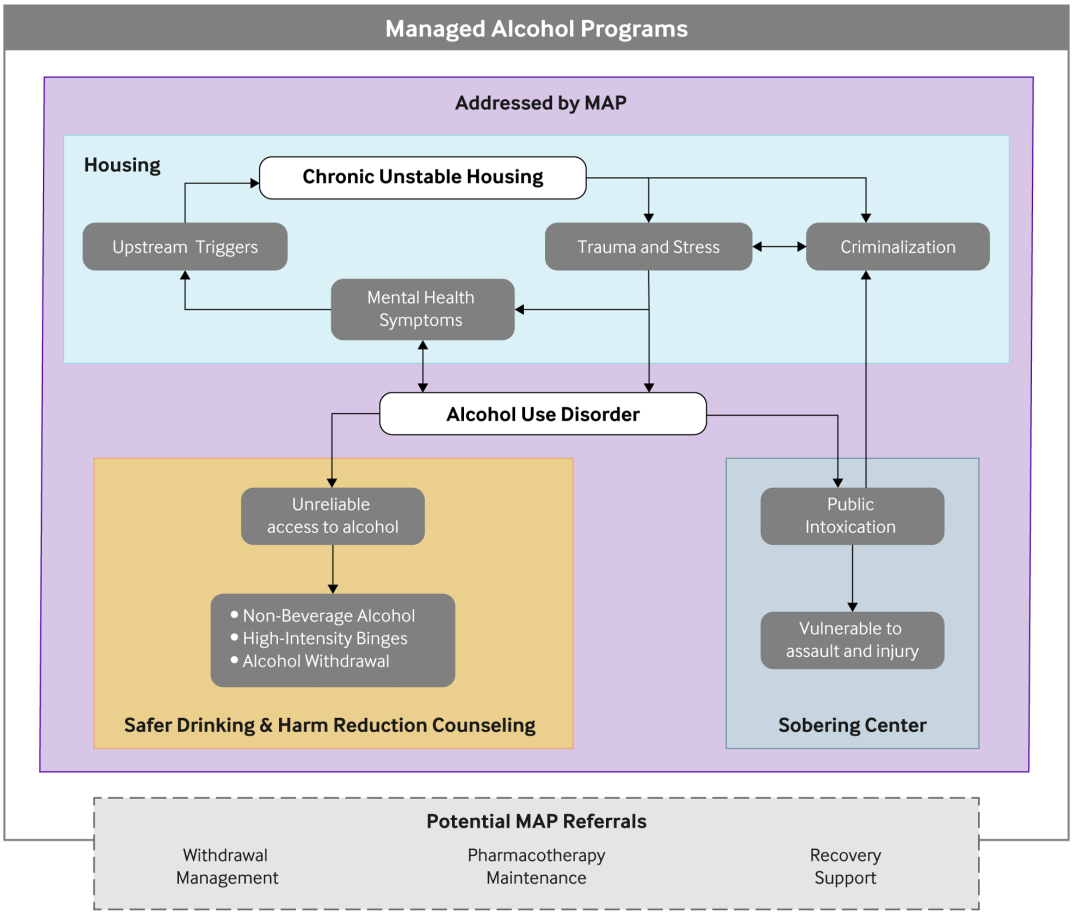
People experiencing homelessness are a highly marginalized group with severely reduced life expectancy,[1,2] compromised still further by the Covid-19 pandemic.[3] The majority of people experiencing chronic homelessness live outside, due to a lack of housing or shelter options that meet their needs (such as safety, autonomy, access to substances).[4-6] Communities across the United States struggle to find effective models of care and housing for this population. Unfortunately, many communities often resort to criminalization of homelessness, an approach that is inhumane and ineffective[7] and results in high-cost, low-yield utilization of the criminal justice and emergency medical systems.[8] Innovative models — such as managed alcohol programs (MAPs) — are urgently needed to address the needs of these individuals.

Substance use disorders (SUDs) are prevalent in people experiencing homelessness[9] and have a complex cyclical interaction with homelessness: The presence of an SUD increases the risk of homelessness, and homelessness exacerbates SUDs (Figure 1).[10]

FIGURE 1

The Inter-Related Cycle of Homelessness and Alcohol Use Disorder (AUD) and Potential Interventions

This figure shows how Managed Alcohol Programs (the all-inclusive grey box) aim to address the negative consequences of unstable housing and alcohol use disorder (AUD) and, importantly, break the cycle of these two inter-related conditions. The cycle includes the black boxes that represent the negative sequelae associated with the two primary conditions, depicted in the white boxes, chronic unstable housing and AUD. Traditional interventions (as represented by the colored boxes) can effectively address one part of the cycle (such as housing). However, without addressing the other contributing factors, the cycle often continues. The MAP approach is to provide reliable housing and alcohol, addressing the cycle as a whole and providing an alternative. MAPs are part of the spectrum of substance use services and programs may refer participants to other AUD interventions such as withdrawal management, pharmacology and recovery support if they are interested.



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The prevalence of alcohol use disorder (AUD) in people experiencing homelessness is estimated at 38%, and is likely higher among those who chronically experience homelessness.[11,12] People experiencing homelessness will describe multiple reasons for consuming alcohol, including coping with the stress and the isolation of homelessness, the pervasiveness of alcohol in their communities, and avoiding withdrawal.[13] The harms of AUD are intensified by homelessness — lack of money to purchase a reliable supply of alcohol is often a driver of non-beverage alcohol

consumption and high-intensity binge-drinking.[14] Furthermore, lack of housing itself contributes to high rates of public intoxication and alcohol-related injuries.[15-17] A spectrum of services that includes alcohol harm reduction is required to decrease the variety of harms that affect this population.

Here, we consider the limitations of the traditional abstinence-based approach and the role of harm reduction interventions.

Harm Reduction Approach

Traditional treatment options for SUDs require and assume abstinence as a patient's goal. However, many people do not seek or cannot attain abstinence — indeed, most people experiencing homelessness with AUD do not cite abstinence as their goal[18] and point to the need and value of harm reduction options.[19,20] A growing body of research has demonstrated that practical measures other than sustained abstinence can reduce the acute and chronic complications of ongoing substance use and increase functionality and well-being. Indeed, national organizations, such as the National Institute on Alcohol Abuse and Alcoholism (NIAAA), have recently removed abstinence as a necessary component of recovery.[21] A range of harm reduction approaches gained attention during the HIV/AIDs crisis[22] and are now accepted as a key way to address the overdose crisis, with a push for public health measures that reduce overdose deaths in people who use drugs.[23]

> *"National organizations, such as the National Institute on Alcohol Abuse and Alcoholism, have recently removed abstinence as a necessary component of recovery."*

A spectrum of effective harm reduction interventions can also be used for patients with AUD and unstable housing (Figure 1). The simplest intervention is education about safer drinking strategies[24]; more intensive harm reduction counseling paired with standard-of-care pharmacotherapy reduces alcohol consumption and alcohol-related harms.[25] *Wet shelters* (those that allow alcohol consumption) and *sobering centers*, which provide community-based care for adults experiencing public intoxication as an alternative to jail or the emergency department,[26] provide alternatives to criminalization, and improve housing attainment.[27-29] *Housing first* models do not require abstinence for housing and this model has shown promising outcomes.[8] Housing first incorporates harm reduction as a principle and such programs tolerate but do not manage substance use.[30,31] Yet, substance use continues to be a factor behind exits from housing first, resulting in a return to homelessness.[32,33] Managed alcohol programs (MAPs) aim to reduce harms of both homelessness and AUD by providing both shelter and alcohol.

Managed Alcohol Programs

Typically, MAPs provide regular doses of alcohol throughout the day in a residential setting with other social and clinical supports available.[34] MAPs were originally designed and implemented in

Canada and have gained international interest during the Covid-19 pandemic in response to both the need for alternatives to help people safely isolate and for shifts in withdrawal management services.[35] The number of MAPs increased in Canada during the first 2 years of the Covid-19 pandemic response, to 38 in 2022 from 26 in 2019.[36] To our knowledge, in the United States, MAPs now exist in the San Francisco Bay Area and Alaska. Internationally, there are MAPs in Ireland and Scotland and plans to initiate MAPs in Australia.[37] In this paper, we draw upon our experiences with the rollout and evaluation of MAPs in Canada and California in the United States. We will describe the rationale and genesis of MAPs, summarize existing outcome data, describe some operational considerations, and advocate for broader adaptation and study of MAPs across the United States.

The Canadian MAP Experience

Origin

One of the first MAPs was formed in the 1990s in Toronto when three men died of exposure after being denied access to the city's shelter programs due to alcohol use.[38,39] The resulting intervention started with storing clients' alcohol, progressing to providing alcohol with meals to prevent withdrawal and encourage nutrition, ultimately developing to a MAP that provides regular doses of alcohol throughout the day.[34] There are now more than 38 MAPs throughout Canada, each with varied structures designed to meet the needs of the specific community served and in a variety of settings.[40]

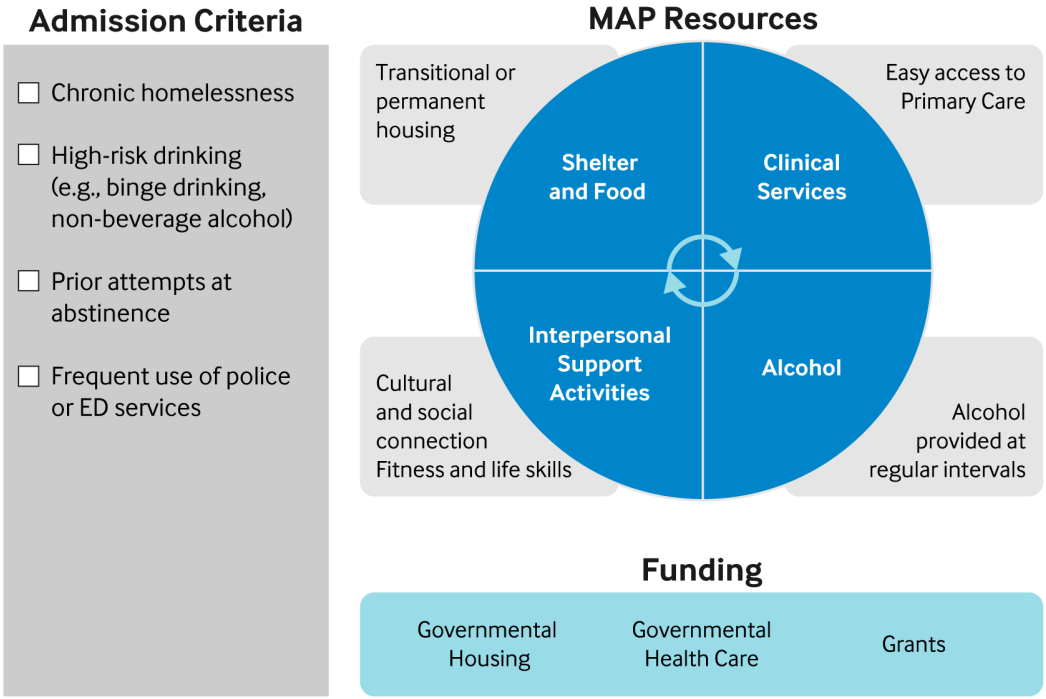
Implementation

Key dimensions of a MAP include defining program goals and eligibility, providing food and accommodation, alcohol procurement and administration, funding, primary care service, and social and cultural connections.[34] To be successful, a MAP requires attention to at least three major operational components: (1) implementation of fair and defensible admission criteria; (2) negotiation of sufficient and sustainable funding; and (3) provision of necessary resources to ensure that participants consider the MAP their home base for their basic physical needs, alcohol, clinical services, and interpersonal support activities (Figure 2).[34]

FIGURE 2

Three Key Dimensions of Successful Managed Alcohol Programs

Managed Alcohol Programs (MAPs) need to incorporate three components related to admission criteria, funding, and MAP resources. They must identify participants for whom the benefits of the program outweigh the risks of access to alcohol with admission criteria. MAPs must secure sustainable funding, which in Canada often is from a combination of governmental housing and health care funds as well as grants. Finally, MAPs must provide resources that will meet the comprehensive needs of their clients; this includes alcohol, but also often includes shelter and food, social and cultural activities, assistance in connecting to available benefits, and clinical services.



Source: The authors, informed by Pauly B, Brown M, Chow C, Wettlaufer A, Zhao J, Stockwell T. Managed Alcohol Programs (MAPSs): History, Evidence, and Evolution in a Global Pandemic. Presented at: Scottish Health Action on Alcohol Problems (SHAAP) MAP Knowledge Exchange Webinar. February 23, 2022 and Pauly B, Graham B, Vallance K, Brown M, Stockwell T. Scale Up of Managed Alcohol Programs. 2020 Jun. CISUR Bulletin #20, Victoria, BC: University of Victoria.

> *"Key dimensions of a MAP include defining program goals and eligibility, providing food and accommodation, alcohol procurement and administration, funding, primary care service, and social and cultural connections."*

Outcomes

Although established in the 1990s, MAPs in Canada operated under the radar for many years and published evaluations were limited.[34]However, since 2014, the Canadian Managed Alcohol Program Study (CMAPS) has evaluated outcomes of more than 360 MAP participants and matched controls. The primary goals of MAPs are improved housing stability, reduction in alcohol-related harms, and decreased utilization of police and emergency medical services. Within these programmatic goals, individual client goals may be to stabilize, reduce, or cease alcohol intake. Given the extensive impacts of alcohol use on long-term health,[41-43] efforts with or without abstinence have the potential to reduce harms.

Alcohol Consumption and Service Utilization

Initially, several small-scale pilot studies at single sites showed that MAP clients had fewer ED visits when enrolled[44] and, compared to matched controls, had fewer detoxification admissions and police encounters leading to custody time, as well as reduced consumption of non-beverage alcohol.[41,42] One of the MAP staff described the collaboration with community stakeholders, such as police departments, and the resulting change in officer reactions to their clients: "[The police] might pick up one of our residents that's intoxicated and they'll call us and ask if they are still in the program and they'll happily bring them to us [rather than to jail]."[45]

More recently, the multisite CMAPS research program has confirmed these promising findings on a larger scale. While MAP participants follow a variety of trajectories upon enrollment in a MAP, many leave the MAP after a period of time and reenroll later on; in one study, followed from 2006–2017, participants averaged 5 different MAP enrollments.[46] Some participants do stay enrolled for longer periods; of MAP participants who stayed in the MAP more than 2 months, the average length of enrollment was 27 months.[47] Compared to matched controls, these long-term MAP participants (who have been enrolled for >2 months) consumed less non-beverage alcohol and were less likely to use illicit drugs (odds ratio (OR) 0.50, p=0.02) or steal (OR 0.50, p=0.04) when they couldn't afford alcohol.[48] While MAP participants reported drinking similar monthly quantities of alcohol compared to controls, the drinking pattern shifted from binge drinking to more consistent intake with more drinking days but fewer drinks per day.[49] Despite being provided with regular doses of alcohol, followed from 2006–2017, MAP participants had similar rates of mortality and ED visits to controls and significantly fewer hospital bed days (12.8 days compared to 20 days, p<0.01). Compared to times they were not enrolled in a MAP, participants' risk of mortality decreased by 60% when they were enrolled.[46]

Quality of Life and Reducing Harm

Given the aim of MAPs to improve quality of life and reduce harm, client-reported outcomes are crucial for evaluation of MAP effectiveness. Both new and long-term MAP participants reported fewer alcohol-related harms (measured in domains such as relationships, police/courts, withdrawal, and health) than matched controls.[47,49] In initial pilot studies, MAP participants compared to controls were more likely to retain their housing and report improved quality of life and safety.[45] MAP participants rated the safety, spaciousness, privacy, and overall quality of their

MAP experience higher than matched controls staying at the nearby shelter, and MAP participants retained their housing longer.[45] In qualitative studies, MAP clients outlined their experience prior to MAP enrollment of constantly revolving through health care settings, the carceral system, shelters, community, and the street.[50] Many respondents described the MAP program as a safer, more permanent world with little of the judgment and stigma they experienced in other settings (jails, hospitals, and shelters), and ample opportunities for connection through an environment of caring, respect, and trust.

> *"The primary goals of MAPs are improved housing stability, reduction in alcohol-related harms, and decreased utilization of police and emergency medical services. Within these programmatic goals, individual client goals may be to stabilize, reduce, or cease alcohol intake."*

Cost Effectiveness

MAPs have been shown to reduce societal costs by decreasing the utilization of costly social, health, and legal services, and colocating many of the services required by people experiencing homelessness with AUD. One Canadian study evaluated the societal cost (including costs of detoxification, inpatient admissions, ED visits, carceral system encounters, and shelter/housing) for MAP participants and found a savings of $1.21 per dollar invested compared to matched controls, or an annual savings of $35,590 per person enrolled in MAP.[51]

Covid-19 Pandemic as a Catalyst for AUD Harm Reduction

Covid-19 has presented unprecedented challenges for people experiencing homelessness and increased the demand for effective alternatives to congregate shelters. This demand catalyzed many innovations in treatment of SUDs for people experiencing homelessness, including a growing appreciation for the role of harm reduction for AUD.[52-55] Internationally, interest in MAPs grew; the number of MAPs increased across Canada (to 38 in 2022 from 26 in 2019), and other countries laid the groundwork for their implementation.[35] Indeed, the British Columbia Centre for Substance Use and the Canadian Institute for Substance Use Research developed an operational guide to support this growing interest.[56] Here we will describe a MAP that opened in the United States in the San Francisco Bay Area, California, in May 2020.

San Francisco's MAP

Building on Sobering Center Origins

Early in the Covid-19 response, isolation and quarantine (I&Q) hotels were quickly established throughout California[57] to provide safe places for people experiencing homelessness to quarantine for typically 10 to 14 days. As occurred in Canada,[55] some of these sites soon began to administer

alcohol to their participants when it became clear this was an effective way to promote quarantine adherence.[52,58]

San Francisco's MAP was built upon existing AUD harm reduction infrastructure. San Francisco has operated a sobering center since 2003, offering short-term (4- to 16-hour) care for adults with acute alcohol intoxication as an alternative to emergency or criminal justice settings. Half of the encounters originate from a small group of individuals, who are often older adults experiencing homelessness — a population that has traditionally benefited from MAPs.[26]

The San Francisco MAP was started in May 2020 after the admission of a Covid-19–positive individual to the sobering center resulted in 23 clients becoming exposed to Covid-19. To continue serving this population while facilitating infection control practices, sobering center staff, operations, and beds were moved to an I&Q hotel, with a colocated I&Q program to care for exposed individuals. While the initial funding for the I&Q site was from the Federal Emergency Management Agency (FEMA), the sobering center staff remained consistent, with funding and support from the city's department of public health, its fire department, and the University of California, San Francisco.

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Aiming to facilitate shelter-in-place recommendations for their clients — and in conjunction with community paramedics and addiction medicine fellows — the sobering center expanded its services to provide alcohol and individual hotel rooms for the 11 exposed clients who agreed to stay in I&Q; 12 chose to not stay in I&Q. After the recommended isolation period was completed, the 11 exposed individuals were offered the opportunity to remain in their rooms and continue to participate in MAP. In addition to remaining sheltered indoors and receiving onsite services, these 11 exposed individuals who chose to stay in the sobering center MAP had a reduction in emergency medicine service (EMS) utilization compared to time prior to enrollment. For example, one client who had used EMS services 105 times in the 6 months prior to enrollment used EMS services 4 times in the 10 months during which they were enrolled in the MAP.[59] Given the limited but promising outcomes in the initial implementation period, the sobering MAP was continued as a shelter-in-place facility for those with frequent use of EMS and sobering services, not limited just to clients exposed to Covid-19.

Elements of the San Francisco MAP Model of Care

In the transition from the Covid-19–related sobering MAP, the San Francisco MAP (SF MAP) expanded to include any people experiencing homelessness or at risk of losing their permanent supportive housing because of their alcohol use disorder. This expansion is funded primarily

through local funds, specifically Proposition C, a ballot measure approved in 2018 that funds services for San Franciscans experiencing homelessness. Under the SF MAP model of care, clients are provided individual rooms, three meals a day, laundry service, and on-site access to behavioral health services, substance use disorder treatment, and harm reduction resources.

The SF MAP's protocol for alcohol dosing initiation and titration is facilitated by the registered nursing (RN) staff, which is available 24 hours a day. On admission, clients receive withdrawal and intoxication assessments every 2 hours with subsequent adjustments in alcohol dosing. With this baseline, the client and nurse practitioner (NP) or medical director develop an ongoing scheduled dosing plan, aiming to prevent withdrawal and maintain client comfort while avoiding intoxication that would impair safety or functional status. Once the alcohol schedule is established, clients receive a set amount of alcohol (beer or vodka) every 4–8 hours between 6 a.m. and 10 p.m., administered by nurses, with the option of one as-needed dose per day.

The RNs are staffed 24 hours a day and provide alcohol, dispense medications, perform basic wound care, coordinate care with community partners, and build rapport with clients on their health and goals. A full-time case manager assists clients with connecting to financial benefits, identification documentation, and other services. An NP prescribes medications for addiction treatment and provides urgent and primary care twice per week, while a health worker (who does not have clinical training or licensing) coordinates activities for clients and serves as an escort to appointments and outings. When at full capacity, the SF MAP plans to have 1 RN and 1 health worker per 10 clients. There is currently no maximum length of stay, with some individuals participating now for 2 years.

> *"Under the SF MAP model of care, clients are provided individual rooms, three meals a day, laundry service, and on-site access to behavioral health services, substance use disorder treatment, and harm reduction resources."*

Successes and Operational Challenges

The SF MAP is quite new, having launched in May 2020, and empiric outcome data are being collected. At least two notable early successes have been realized, however. First, by eliminating the need for individuals "to find their next drink" (an often-chaotic experience), clients experience increased stabilization with fewer intoxication-related harms such as acute injuries and encounters with EMS or law enforcement. Second, although robust data is not yet available, anecdotally, this stabilization has allowed clients to connect to both family as well as services such as case management, health care, and financial benefits; previously, such relationships were largely untenable. These improvements mirror those observed in the Canadian MAPs.

The biggest operational challenge facing the MAP is staffing, related both to the national shortage of health care workers and the long hiring and onboarding process of the department of public

health, which has resulted in a closed campus that requires an escort for clients who wish to leave and return and limited formal activities, deterring some potential clients.

Future

The San Francisco program, now referred to as *SF MAP*, received funding to expand to a 20-bed facility (current capacity is 12), 10 of which will be designated for Latinx and Central American Indigenous clients, who traditionally encounter more barriers to accessing resources. The expansion is ongoing and expected to reach full capacity in fall 2023. Initially, in addition to alcohol use and housing status, clients were exclusively identified by sobering center staff and community paramedicine partners based on patterns of high EMS service utilization. As of late 2021, SF MAP accepts community referrals and is expanding admission criteria to include people experiencing homelessness for whom AUD is interfering with their ability to connect with important services, regardless of their EMS service utilization. The city is attempting to acquire a standalone facility for the SF MAP with space for community activities and plans to increase staffing with behavioral and clinical providers and a second case manager.

Common Challenges and Lessons Learned

With experience in implementing and evaluating MAPs and observing their international expansion and adaptation to a variety of settings in the Covid-19 pandemic, we have encountered three recurrent challenges and learned valuable lessons that guide our recommendations for future implementation in other communities.

Common Challenges

It is not unusual for MAP supporters to face obstacles in (1) ensuring that community stakeholders understand and support the model and its goals; (2) establishing equitable and appropriate admission criteria that select for people who will most benefit from managed alcohol; and (3) identifying and securing sustainable funding.

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>
> Stakeholder Support

People experiencing both homelessness and severe AUD — and those who care for them — are most concerned about the ongoing harms associated with those conditions, and the failure of traditional solutions to successfully meet the often-complex needs of the clients. MAPs provide a way out of this cycle.[50] However, deviation from conventional abstinence-based models can be controversial. Many clinicians, public health officials, and other community members share a common concern about MAPs: that the intervention may do more harm than good. Specifically, there are concerns

that the managed alcohol program model may be causing or exacerbating physical disease associated with severe alcohol consumption, such as liver disease and pancreatitis, or by "enabling addiction." Heavy alcohol consumption is indeed dangerous; MAP participants — if and when they are ready — should have opportunities for breaks and short-term abstinence.

MAPs should provide bridges to abstinence-based care if participant goals change. For those who do not wish to attempt abstinence or cannot sustain it, MAPs can support participants in safer drinking education and strategies to reduce their alcohol harms and consumption while enrolled. Cannabis substitution is being explored as an alternative.[60] In this way, MAPs can further reduce the severe morbidity and mortality that result from co-occurring heavy alcohol consumption and homelessness while not mandating abstinence. The evidence for MAPs outlined above demonstrates that a specific population of people experiencing homelessness with severe AUD may experience fewer alcohol-associated harms, an improved quality of life, and successful connection to community resources, and they may stabilize their drinking to less harmful consumption patterns. Identifying shared stakeholder goals of a MAP — which does not view abstinence as the primary objective — is thus critical; these goals may be considered at the individual, program, and community level.

Appropriate and Equitable Admission Criteria

MAP admission criteria aim to select patients for whom the current pattern of alcohol consumption and related harms outweigh the potential risks of supervised consumption. The primary goal is to prevent and reduce alcohol-related harms, both individually and socially. Commonly used admission criteria include individuals with histories of repeated attempts at traditional abstinence-based services, high-risk drinking patterns, unsheltered homelessness, and utilization of crisis services including jail and the ED.[34] An additional consideration is ensuring equitable access to MAPs, reaching participants who are traditionally difficult to engage or for whom culturally appropriate resources are unavailable. For example, 50% of the availability for the expanding SF Bay Area MAP is set aside for Latinx or Central American Indigenous individuals; state-funded substance use treatment or housing resources have historically been challenging for these communities to access.

Sustainable Funding

Funding is essential to program success yet is one of the more significant challenges faced by communities developing and operating MAPs. MAPs impact multiple sectors including primary health and emergency services, housing access, criminal justice, public health, and the community; thus, a variety of funding sources may be appropriate. As noted in the Canadian experience, funding is typically secured from multiple parties including local, regional, and provincial government sources, health systems, community resources, and the clients themselves.[34,37] Within the United States, more stable sources of funding may include governmental support; for example, the San Francisco Department of Public Health provides direct funding in part due to the reduction in the use of EMS services by MAP clients. Moreover, considering that MAPs can build upon existing shelter or housing infrastructure and might add only the cost of alcohol but offer improved outcomes, a MAP intervention may be considered a cost-avoidant model of care, providing high-value, low-cost services as an alternative to the more costly options including incarceration, emergency services, and hospitalization. Increasingly, the federal government is recognizing

that "housing is health care,"[61] and MAPs are an excellent example of an intervention that spans housing and health; the cost savings of MAPs therefore likely span multiple governmental agencies including departments of public health and housing.

> *"MAPs impact multiple sectors including primary health and emergency services, housing access, criminal justice, public health, and the community; thus, a variety of funding sources may be appropriate."*

Lessons Learned

We offer three key lessons learned about MAP initiation and maintenance: (1) MAPs are customizable based on community needs and resources; (2) program evaluation through the identification and tracking of standardized outcome measures, some of which will be distinct from traditional homeless-related and alcohol treatment models, offers substantial assessment potential; and (3) participant stabilization may take time.

MAP Customization

With the basic premise of providing a reliable source of alcohol to people experiencing severe AUD and homelessness in a nonjudgmental and person-centered manner, MAPs may be adapted to a variety of populations, settings, and communities. The needs of the population(s) to be served and the resources available ought to dictate the model of care and services provided. Client characteristics that could inform a MAP structure include cultural or ethnic background, functional status and age, and comfort with communal living. For example, in Canada, particular considerations and Indigenous approaches to MAP are provided to offer culturally safe and supportive alcohol harm reduction programs.

Additionally, MAPs can augment or add to services already existing in a community and can function in a variety of settings. For instance, some MAPs operate out of previously existing shelter or supportive housing infrastructure, and some MAPs have been incorporated into hospital units to help people with AUD stay in the hospital to receive care.[62] As these needs change, the MAP ideally has the flexibility to modify its own services in response to outcomes data, feedback from clients and staff, and feedback from other stakeholders such as emergency services or police personnel. A noted best practice is to staff individuals who share lived experience of the populations to be served (e.g., history of incarceration, poverty, homelessness, AUD) and similar cultural identities (e.g., Indigenous culture, racial and ethnic makeup, gender and sexual minorities, generational considerations). Though many programs offer specific positions for "peers" (e.g., peer support specialist), staff who share lived experience and expertise should likewise be in direct care, management, and leadership roles.

Program Evaluation

Standardized data points and methods of analysis are critical to quality improvement and determining program success, and guidance aimed at programmatic and evaluation considerations

are emerging regularly.[34,37,63] Similar to many homeless- and substance use–related interventions, goals for MAP success may include changes in alcohol consumption patterns, reduction in utilization of emergency services, fewer criminal justice contacts, tracking relevant physical or mental health measures, establishing housing stabilization, improving social or cultural connections, and improving quality of life. However, consider that many traditional goals for substance use treatment, such as cessation of alcohol consumption or transitions to treatment programs, may not be the primary objectives of a MAP environment. This is in line with both the National Institutes of Alcoholism and Alcohol Abuse (NIAAA) and Substance Abuse and Mental Health Services Administration (SAMHSA), of which cessation of alcohol consumption is no longer a criteria for recovery.[64,65] This does not mean these goals are inappropriate; rather, the focus of MAPs is on harm reduction and overall stabilization.

When developing a MAP, involve all potential stakeholders in determining outcomes and goals for the program; potential users of the MAP are important stakeholders and should be included in these efforts. For the most beneficial evaluation and analysis, make all efforts to obtain related data points for the time prior to and at MAP enrollment, throughout the MAP experience, and after MAP departure as appropriate. MAPs can partner with local or national research groups for assistance in data analysis and dissemination; for most success, initiate these partnerships prior to MAP initiation to ensure the quality improvement and evaluation plan is achievable.

> *"Increasingly, the federal government is recognizing that 'housing is health care, and MAPs are an excellent example of an intervention that spans housing and health; the cost savings of MAPs therefore likely span multiple governmental agencies including departments of public health and housing."*

Stabilization Time Frame

While each MAP participant will have a different experience, for many, entering a MAP is a dramatic and challenging shift. Emerging from an often isolating, chaotic, yet familiar *survival mode* experience, participants are offered a more secure and durable setting with judgment-free personalized care, acceptance, and targeted services. Though the MAP option may appear superior from an outside perspective, for many clients, this transition is neither straightforward nor immediate; rather, many clients require time to adjust to a MAP environment. The ability to trust in others and themselves is a major hurdle for many, who have often experienced immense trauma, isolation, and disconnection. Many clients will enter a MAP for a period and then return to living outside (an environment that is often very familiar after years or decades) before reentering the MAP. Despite this, as demonstrated by the research on Canadian MAPs outlined above, MAPs have successes and stabilization effects — such as reduced non-beverage alcohol consumption, improved connection to health care, or reduction in injury when people are*on* rather than*off* MAP, but long-term harms require more attention. Anticipating a longer-term time frame and the challenges in providing care to a disenfranchised population can help set stakeholder and participant expectations for MAP success.

Looking Ahead

Ideal care for any chronic condition with a heterogeneous pathophysiology, severity, and clinical presentation includes guiding patients about a variety of evidence-based interventions to address the underlying disease as well as prevent complications and promote functionality. Traditional options for people experiencing homelessness with severe AUD often require abstinence or a consumption-focused treatment plan that does not typically address the interrelated structural and social vulnerabilities of poverty and homelessness. Managed alcohol programs provide an innovative evidence-based and cost-effective alternative intervention, decreasing harms and increasing stabilization for a population that historically has not been successfully served within our current systems of care. We urge communities with members who experience homelessness and AUD to consider implementing this innovative and effective solution for those who require alternatives to abstinence-based treatments, and we advocate for funding, research, and support from local public health departments, academic institutions, health systems, and housing authorities.

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