

Sherry aid



cutting edge

Problem heroin users have needle exchange and maintenance prescribing, yet there is no harm reduction equivalent in the UK for chronic alcohol users. Mike Ashton on a residential unit in Canada which uses doses of wine and sherry to bring people back from the brink.

THOUGH England, unlike the rest of the UK, has opted to keep alcohol and drugs in separate policy boxes, there are clear and substantial overlaps in treatment and prevention. This is not the case with harm reduction. True, wet day centres (see last Cutting Edge) and drug consumption rooms share some of the same problems and dilemmas – such as ensuring safety, nudging towards treatment without deterring, overcoming community resistance, maintaining order and avoiding public nuisance – but there has been no alcohol equivalents of the two major drug harm reduction modalities: needle exchange and maintenance prescribing.

In one small way, that is no longer the case. At a shelter for the homeless in Ottawa in Canada, a 15-bed unit has been set aside for a selected group of severely alcoholic residents who have failed or been rejected by abstinence-based programmes and are causing harm to themselves and to the local community. Every day the residents have free alcohol available from seven in the morning until 10 at night. Doses are limited to 140ml of wine or 90ml of sherry hourly but are otherwise provided on demand.


Known as the Managed Alcohol Program (MAP), this is alcohol maintenance in all but name. And there's more. Housing, meals, and medical care are supplied by the host shelter, while staff employed for the new programme adopt a proactive case management role, helping residents

manage daily living tasks, arranging welfare payments and ensuring they take medication prescribed for physical or mental ailments.

HARDCORE

How 17 of these residents fared was monitored by researchers from the University of Ottawa and detailed in a report, Shelter-based managed alcohol administration to chronically homeless people addicted to alcohol, published in the Canadian Medical Association Journal earlier this year. The service they studied may seem unnecessary and even bizarre, until you realise that these residents each had behind them at least 21 years of alcoholic drinking. Most had descended to non-beverage, alcohol-containing products like mouthwash, aftershave, medical 'rubbing' alcohol and highly salted cooking wine. With the aid of these toxic products, they were averaging 80 UK units of alcohol a day. Not surprisingly, all but two had at least one chronic medical or psychiatric illness. Bad enough for themselves, they were also a burden on local services, each on average accessing emergency treatment and being reported by the police about once a month and necessitating ambulance call outs once every two months.

They were the alcohol equivalents of addicts who have resorted to groin injecting and other such dangerous practices using concoctions neither meant for nor properly prepared for



injection, with half a lifetime of dependent consumption behind them resulting in physical and mental deterioration and with no signs of stopping. In other words, prime candidates for intensively supported injectable prescribing regimes.

PROGRESS

With MAP, the answer was to substitute their usual fix with controlled doses of non-spirit, commercially produced alcoholic beverages while providing the support to keep them in the programme for at least five months. Among the 11 who could be re-interviewed to check their drinking, their alcohol consumption had plummeted to 14 units a day, while staff reported that hygiene and nutrition had improved. A few even accepted detoxification and found housing. Doubtlessly relieved, health workers saw emergency visits cut by a third while hospital admissions were virtually eliminated and police reports halved.

It wasn't all rosy. Three died during the two years of the study before they could be re-interviewed. Ambulance call outs – possibly due to closer supervision – fell only slightly, drinking usually remained highly excessive and, in the short term, the intervention was expensive – costing more than the estimated savings in police time and health care. And with no control group, it is impossible to eliminate the possibility that the

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positive changes would have happened anyway. But more likely, accumulating damage from continued uncontrolled drinking would have taken more lives.

REGIME

The Ottawa initiative is not the only one in Canada. In Toronto a shelter has been running a similar programme for several years. In Vancouver, host to North America's only legal drug injecting facility, the city's drug policy coordinator has recently mooted the idea, citing the Ottawa research – although colleagues in the police and health services are sceptical. Indeed, it seems likely that only a minority of hardened street drinkers would accept and benefit from such a constricting regime. Yet this too is true of heroin addicts who have not swarmed to heroin prescribing programmes which require them to attend for supervised injecting two or three times a day. But for those who do go, the benefits are substantial and, for many, seemingly unachievable by less radical interventions. ●

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