MANAGED ALCOHOL PROGRAMS AS PUBLIC HEALTH INTERVENTIONS: HARM REDUCTION AND INFECTIOUS DISEASE SCREENING IN A LOW-THRESHOLD HOMELESSNESS SHELTER

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Background:
People experiencing homelessness with severe alcohol dependence experience a disproportionate burden of infectious diseases and low engagement with conventional health services. Abstinence-based accommodation models frequently exclude individuals with ongoing substance use. We implemented a low-threshold harm reduction accommodation model integrating supervised consumption with universal infectious disease screening and structured linkage to care.

Description of model of care/intervention:
The program operates within a homelessness shelter where residents bring their own alcohol and consume it on-site in a supervised and structured environment monitored by trained staff. A non-alcoholic beverage is offered at each drinking episode to promote hydration and mitigate alcohol-related harm. The facility also includes supervised rooms for smoked and injected drug use, providing sterile and aseptic equipment for illicit substances within a harm reduction framework. Universal screening for hepatitis C virus (HCV), hepatitis B virus (HBV), human immunodeficiency virus (HIV), and syphilis is conducted at entry. Routine biannual screening ensures re-testing of residents not screened within the previous six months. On-site nursing care, medical and psychiatric follow-up, and medication management are integrated into daily practice.

Effectiveness:
Between 2021 and 2025, the program supported 899 individuals (158 in 2021; 406 in 2022; 240 in 2023; 342 in 2024; 267 in 2025). Entry screening coverage reached 100%, with systematic six-month re-screening. Among residents with confirmed active HCV infection (RNA positive), 100% initiated and completed antiviral treatment. Overall, 78% of scheduled health referrals were attended.

Conclusion and next steps:
Embedding universal infectious disease screening within a comprehensive harm reduction shelter creates a structured public health entry point for highly marginalized populations. This model demonstrates sustained screening coverage, full treatment completion for confirmed HCV cases, and strong engagement with healthcare services, supporting replication in similar urban settings.

Disclosure of Interest Statement:
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