Managed Alcohol Program Jurisdictional Review: Part 1

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for

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Contents

Introduction

Chronic alcohol use can lead to a wide array of physical and social harms. The most widely accepted treatment for harmful alcohol use is abstinence-based programs. These programs have become well established across the globe.[1] Despite their success for some individuals there are gaps in supports for folks for whom abstinence is not feasible or desired. To address these gaps Managed Alcohol Programs (MAPs) have been utilized in Canada as a harm reduction approach for alcohol use.

Marguerite's Place (MP), a program of the St. John's Status of Women Council (SJSWC) piloted a MAP with one resident in 2019. From this pilot the SJSWC identified the need of a MAP to serve the larger community. In May of 2021, the St. John's Status of Women Council (SJSWC) was successful in obtaining funding for a MAP from the Substance Use and Addictions Program (SUAP) through Health Canada.

The purpose of this review is to provide an evidence-based foundation for the development of the SJSWC MAP. This evidence includes a literature review, consultations with existing MAP's, and most essentially the voices of people with lived experience.

Methods

This review was conducted in three parts. The first was a literature review of peer reviewed academic journal articles. The second was interviews with individuals with lived experience. The third was consultations with existing MAPs.

Literature Review

A search of the literature was performed using Canadian Managed Alcohol Program Study (CMAPS) resources, The Cochrane Library, and Memorial University of Newfoundland and Labrador (MUNL) library. Search terms "managed alcohol program", "regulated substance use", and "alcohol harm reduction" were used. Bibliographies were cross referenced for additional literature.

Lived Expertise

Recruitment

Multiple methods of recruitment were used in an attempt to reach a diverse range of participants.

1. The MAP team identified a number of community organizations whose clients/participants were likely to include those with lived experience. The Harm Reduction Case Manager (HRCM) and/or the Harm Reduction Coordinator (HRC) connected with the community agencies to introduce them to the MAP project and recruit those with lived experience. Individuals who were interested in providing input were directed to contact the Harm Reduction Researcher (HRR or complete a brief survey to provide their contact information and preferred method of participation. When possible, clients/participants were met with directly but when this was not feasible, service providers were asked to share the information with their clients/participants. The list of organizations that the MAP team was successful in reaching is below.

Community Organizations identified:

- ACNL/Tommy Sexton Centre Shelter
- Choices for Youth
- Community Corrections (Probation)
- CSSD
- Drug Treatment Court
- End Homelessness St. John's
- First Light
- Housing and Homelessness Provincial Working Group
- Income Support- Social Work Department
- John Howard Society
- Lemarchant Medical Clinic
- NAVNET
- NLC
- NLCCW
- NLHC Emergency Shelter
- Planned Parenthood
- Quadrangle
- Stella's Circle Housing and Just Us
- SWAP
- The Gathering Place
- Thrive
- Uturn

2. Posters were distributed around St. John's. The posters directed people interested in providing feedback to contact the HRR or complete a brief survey to provide their contact information and

preferred method of participation. The MAP team identified locations where people with lived experience were likely to frequent

Locations identified:

- Pharmacies
- Convenience stores
- Liquor stores
- Community organizations
- George Street

3. Posters were also distributed digitally on the SJSWC social media, through the Thrive newsletter, and directly to over 50 community organizations, health care providers, and community groups.

Individuals who expressed interested in participating were contacted by the HRR to schedule an interview. For those who were not reached on the first try, contact was attempted twice more.

Inclusion Criteria

A broad inclusion criterion was utilized to capture a wide range of experiences. Participants had to have lived experience with harms related to alcohol use and/or other drugs. Lived experience for this review is defined as having the experience yourself or supporting others who have had that experience. Participants needed to be currently living or have lived in the St. John's metro area. Additionally, anyone who felt they had information that could inform harm reduction services in the community was encouraged to participate.

Data Collection

Accessibility and safety, both physical and emotional, were a priority for all interactions with persons with lived experience. Review protocols were informed by the guidelines for partnering with people with

lived experience from the Canadian Centre on Substance Use and Addiction.[2] Participants were given a choice of interview methods. The options available were in person, over the phone, by email, or facilitated through a participant identified community support. Participants were informed at multiple points that their participation was voluntary, they could choose to withdraw at any point without their future interaction with the MAP or their healthcare being impacted. Participants were provided with information about mental health resources available to them including a MAP staff, other than the HRR who was available for support during the interview. The interview cover sheet, questions, and support sheet were sent the day prior to the interview if the participant wished. See appendices A and B for interview cover sheet and questions. Protocols were developed for situations where participants were intoxicated or became emotionally distressed during the interview, however neither situation occurred.

During the in person and phone interviews the cover sheet was reviewed verbally, and consent was obtained for the interview to be recorded. The interviews were semi-structured. Participants were compensated with $20 in the format of their choice: cash, e-transfer, or gift card.

Measures

Interview questions were structured to gain an understanding of the participants experiences with alcohol and their recommendations for the MAP. Participants were also asked demographic questions.

Data Storage

Each participant was assigned a study number. Interview recordings were linked to participants only by this number. The recordings were transcribed, and any identifying information was removed. The transcripts are linked also linked to participants by study number. Participants contact information, interview recordings, and transcripts are kept using password protected files on the HRR's computer.

Existing MAP Consultations

Existing MAPs were identified primarily through the CMAPS database. Additional searches were done using search engines and knowledge within the MAP team.

MAPs were categorized as either residential, scattered site, or unknown.

- Residential meaning multiple MAP participants resided in single location where alcohol dispensing and additional support occurred.
- Scattered site meaning MAP participants reside at separate locations. Alcohol dispensing and additional support occurs on an outreach basis.
- Unknown was used when information about the MAP structure was unavailable.

Scattered sites are the focus of this review. The SJSWC does not currently have infrastructure available for a residential MAP model. Consultations with residential MAPs will occur in the second part of this review.

Thirty-one MAPs were identified in total. Twenty were residential, five scattered sites, and six were unknown. All scattered and unknown sites were contacted for this review. Multiple contact attempts were made.

Marguerite's Place, the site of the initial pilot was also recruited for consultation.

Results

Literature Review

Fourteen studies were obtained from the CMAPS resources. The Cochrane Library yielded one review. A search of the MUNL library yielded eight new results that were not previously found through CMAPS. Three studies were identified through backwards searching of bibliographies. These 26 publications were categorized into the following: characterization of MAPs, measuring the effectiveness of MAPs, MAPs in hospital settings, examining the place of MAPs in society, and miscellaneous.

Characterization of MAPs

Five articles were found that provide characterization of MAPs. The first is an operational guide for implementing a MAP from the University of Victoria(UVic).[3] It was created to enable organizations to rapidly implement MAPs in response to at risk population experiencing increasing harms due to the COVID19 pandemic. This comprehensive manual details the process of planning to implementing a MAP including organizational specific considerations and sample procedural documents. The second article is a MAP Toolkit from the University of Calgary.[4] It also details the implementation of a MAP but is slightly less detailed than UVic's operational guide. The third article is a Rapid Synthesis from McMaster University on the Features of MAP's.[5] It provides a literature review about MAPs efficacy and a summary of MAPs, as of February 2019, which is available on the CMAPS website. The fourth is a description of the operating principles of an Ottawa MAP.[6] The principals were: provide alcohol only to people who were not currently intoxicated, money management as a way to stabilize drinking, individual alcohol administration plans, create a path to recovery, and invest in peer leadership. The final article in this group is an overview of key dimensions of community MAPs in Canada.[7] Thirteen MAPs were included in the study. The authors found that MAPs share a common goal of reducing harms of alcohol use. For program eligibility the majority of sites used medical professionals to screen clients, and most were open to all genders. Many sites struggle with funding, having apply to multiple sources such as health authorities or housing funds and some sites require clients to cover part of the cost themselves. Alcohol dispensing varied between the sites from hourly pours to daily dispensing with many providing non-alcoholic alternatives when alcohol could not be provided. Most MAP sites in this study were residential model providing permanent or temporary shelter and food. Primary care was a common goal amongst site with most including health professionals as part of the program. The final dimension explored was social and cultural connections. The authors identified the importance of peer input and programming as well as additional activities to combat boredom. Five of the MAPs also included indigenous programming at their site.

Effectiveness of MAPs

Eleven studies were available that analyze the effectiveness of MAPS. Measures of effectiveness were not consistent between studies.

Eight studies looked at quantitative measures of health and harms. Stockwell et al. compared 59 MAP participants and 116 controls in a 12-month longitudinal study of six sites in Canada.[8] They measured amount of alcohol consumption, non-beverage alcohol (NBA) consumption, liver function tests, and alcohol related harms. Stockwell et al also published a study in 2018 examining the same sites however this was the baseline data for the later longitudinal study and therefore this study will be excluded due to duplication.[9] Vallance et al analyzed the effectiveness of a shelter based MAP in Thunder Bay, Ontario using a case-control cross sectional design.[10] There were 18 MAP participants and 20 controls compared using liver function tests, alcohol consumption, NBA consumption, and emergency service interactions. Podymow et al retrospectively studied 17 participants from a shelter-based MAP in Ottawa.[11] They measured alcohol consumption, liver function tests, and emergency service interactions. A study on coping mechanisms of MAP participants and controls by Erickson et al measured NBA consumption, emergency service interactions, and positive coping strategies.[12] A study by Chow et al. explored the effectiveness of MAPs in accurately capturing the amount of outside drinking by participants.[13] The final two studies that looked at quantitative measure so MAP efficacy were summaries of previously published data and were excluded for duplication.

The findings of studies analyzing liver function tests were mixed. Vallance et al found improvements in liver function for participants while they were enrolled in the MAP program while Podymow et al. found no changes in liver function.[10,11] Stockwell et al. found no change in liver function while participants were on a MAP program, but their liver status deteriorated after departure from the MAP.[8]

Alcohol consumption, including NBA was measured in four studies. The Podymow et al study did not distinguish between alcohol and NBA consumption but found that the amount of alcohol consumed by MAP participants decreased significantly after enrolling in the program.[11] Vallance et al found MAP

participants drank more frequently but a smaller total amount than controls.[10] NBA consumption was also significantly less than that of the controls. When compared with controls Stockwell et al found MAP participants drank more frequently and consumed the same total amount of alcohol and NBA.[8] Erickson et al found newer MAP participants were more likely than controls to consume NBA when beverage alcohol was not available.[12] Chow et al. found that MAP participants were drinking upwards of twice the amount of alcohol being administered by the program.[13] Outside drinking was not being accurately captured by the MAPs procedures due to significant under reporting.

Interactions and other social and legal harms were captured in three studies. Vallance et al compared MAP participants with controls and also with the participants own preadmission histories.[10] The study found compared with both groups, current MAP participants had significantly fewer interactions with police, hospital visits, and detox admissions. In the study by Stockwell, it was found that MAPs with effective policies to reduce outside drinking also reduced overall harms that included social, legal, and housing.[8] Erickson et al showed that compared to controls longer term MAP participants ($\geq$ 2 months) were less likely to consume illicit drugs, less likely to steal alcohol, and more likely to seek treatment.[12]

Three studies qualitatively explored the impacts of MAPs. A study by Evans et al describes the properties of an Ontario MAP which make it an enabling place that facilitates clients' recoveries.[14] Through interviews with eight male participants the following three properties were identified. Togetherness was created between participants, the space, and the staff. The participants also felt a sense of awareness of personal health concerns that was mediated by staff. Finally, there was self-management of alcohol consumption patterns. Pauly et al interviewed 11 MAP participants in Ontario looking at perceptions of housing and quality of life.[15] They found participants experienced more safety in the MAP compared to shelters, the streets, hospitals, and jails. Participants also identified experiencing the MAP as an emotionally safe refuge where they were treated with respect. The MAP was described as a house and a home where participants were able to learn independent living skills and where reconnecting with family was facilitated. Another study by Pauly et al explored the impacts of MAPs for people experiencing

homelessness and severe alcohol dependance.[16] Fifty-three MAP participants, four past participants, and 50 program staff from five MAP sites were interviewed. They found that pre-MAP participants experienced displacement and survival in an abstinence-based world while navigating multiple losses of people and culture. While in the program participants experienced the respect and care of a harm reduction approach. They also experienced physical and emotionally safety and the opportunity to reconnect with social supports and family.

MAPs in Hospital Settings

Four studies looked at MAPs in the context of a hospital setting. These studies are purposely separated by setting for this review because their results are not easily generalizable to a residential or scattered site setting. A comprehensive review of academic and grey literature related to hospital MAPs by Brooks et al. examined 42 studies.[17] They suggested hospital MAPs are feasible and may have positive impacts on the patients' health. The study also included a section on community MAPs, however the studies cited have already been included in this review. Parappilly et al. interviewed five patients about their experiences at a hospital-based MAP in Vancouver.[18] From the interviews five themes emerged: reasons for alcohol use, patients were appreciative of the program, withdrawal symptoms and psychological symptoms were managed, engagement in the program, and the want for more varieties of alcohol. Another study at the same hospital by van Heukelom et al explored the nurses' perceptions of the hospital's MAP.[19] Ninety-seven nurses participated, and the response indicated a positive reception to the MAP and the perceived benefits included reduced harms from alcohol and improved quality of life for the patients. The nurses also noted the need for more education on harm reduction practices. A study by Hill et al. described an ethical case study.[20] A MAP patient had medical complications due to their alcohol consumption and was removed from the MAP program to reduce further physical harm. During their hospital stay the patient left several times to consume alcohol. There was an ethical dilemma about whether the risks of the patient resuming MAP outweighed the risks of the patient seeking alcohol outside the program.

Examining MAPs Place in Society

Four feasibility studies were found for locations across the globe. Two from Canada looked at potential MAPs in Manitoba and Victoria BC.[21,22] The studies found support for MAPs in their target populations and described potential models for the program. Both studies emphasized the importance of centering indigenous cultures and practices in the models. Another feasibility study from Sydney, Australia examined target population perceptions and financial impact.[23] They found participants supported the implementation of a MAP and favored a residential model. The potential cost savings for the government were estimated to be between $300,000 to $900,000 per year for a 15-person residential MAP when compared to hospital or crisis-based accommodations. A study from San Francisco outlines the temporary MAPs that were created for COVID19 Isolation and Quarantine Centers and how more permanent MAPs are needed.[24]

Four articles examine MAPs place within the larger Harm Reduction (HR) movement and community programs. Two studies explored the intersections of alcohol use and Housing First (HF) models. Collins et al observed staff and participants in a housing project that allows alcohol and other substance use.[25] The results found that traditional abstinence based approaches were not desirable or effective for this population and the harm reduction approach of allowing substance use facilitated attaining and maintaining housing. A study by Schiff et al examined Canadian policy of MAP development.[26] They found MAPs share many of the core values of HF but not all. MAPs may provide support for populations for whom the HF models do not work well. Ivsins et al explore MAPs place within the HR movement.[27] They highlight conventional responses to harmful alcohol use are not adequate. They identify alcohol as a unique substance in the HR world as it is not illicit in most countries and how MAPs can play a crucial role in addressing high risk drinking. A group from Vancouver, Eastside Illicit Drinkers Group for Education (EIDGE), published a commentary criticizing the lack of uptake in MAPs despite the group's advocacy around the growing evidence about MAPs efficacy as a HR model.[28]

Miscellaneous

Two studies were found that did not fit into any of the other categories. The first was a Cochrane systematic review.[29] The authors were unable to include any studies in the review and therefore were unable to draw any conclusions. The second is a study by Pauly et al about the feasibility of substituting cannabis for alcohol in MAPs in six programs across Canada.[30] They found some participants were already substituting with cannabis themselves and most participants were willing to try substitution as part of the program.

Lived Experience Interviews

Demographics

There were seven participants total with a mean age of 31 (range 24-44). Two individuals identified as non-binary and the remaining five identified as women. None identified as being racialized or part of the Black Indigenous, People of Colour (BIPOC) community. Two identified as disabled. Three identified as part of the 2SLGBTQIA+ community. Two identified having experience in the sex trade. Four identified as having experienced poverty and the criminal justice system. Three identified having experienced housing instability.

		Number (total n=7)	Percent (%)
Gender	Nonbinary	2	29
	Women	5	41
BIPOC		0	0
Racialized		0	0
2SLGBTQIA		3	43
Sex Trade		2	29
Poverty		4	57
Victim of Violence		6	86
Criminal Justice		4	57
Housing Instability		3	43

Table 1: Demographics of Lived Experience Interview Participants

Experiences with Alcohol

Alcohol Use Characteristics

Participants identified harmful alcohol use across a wide range of groups of people.

> *"It's definitely surprised me the type of people that I've been sitting next to with hefty shit that are like lawyers, random college students with privilege…" participant, 1208.001*

Harmful use was not limited by factors such as gender, income, or family history, however these factors impacted how the use presented. Alcohol use amongst women was perceived to be more hidden than men with women's drinking happening largely at home as opposed to social settings such as bars men frequented. Hidden alcohol use was also identified among those with higher incomes and more social supports. The perception of stability from owning a home or holding down a job masked the harmful alcohol use from others.

> *"I find that anyone who is I guess labelled a functional alcoholic, their outreaches for help are usually denied because people don't see that they're struggling because all those other things they have going on in their lives." participant 1208.002*

Participants also spoke about family histories of alcohol use and how subsequent generations with continued with the pattern of harmful alcohol use or were hyper vigilant about monitoring their alcohol intake. Multiple participants also identified polysubstance use. For those who binge drank, stimulants were used to counter the depressant effects of the alcohol. For more chronic alcohol users, the substances tended to be depressants.

Harms of Alcohol Use

Participants described harms of physical, social, and emotional nature. Physical harms included withdrawal symptoms, accidents while intoxicated, NBA consumption, engaging in high-risk behavior to obtain alcohol, homelessness, and death.

"I've seen people drinking mouthwash. I've seen people go buy different things with alcohol in them to drink" participant, 1208.003

Social harms identified were criminalization, financial hardship, loss of educational or career paths, and breakdown of relationships with friends and family.

"It does create kind of a barrier between yourself and doing the things that you want to do in life and following those goals and career paths." Participant 1208.002

Emotional harms included living in a constant state of crisis, judgment from the medical community, and judgment from abstinence-based programs.

"When they go to AA if they're not 100% abiding by the rules. If you have a drink of course you're welcome back but you're not really one of us kind of vibe" participant, 1408.001

Local Context

Participants all identified a distinct drinking culture within Newfoundland. This culture celebrates alcohol consumption where drinking is expected at most social events and drinking is engrained in the Newfoundland identity.

"there's funerals that turn into drunk ragers cause that's just the way we do things. It's scary." participant 2209.01

Because of the pervasiveness of alcohol consumption it is rare to find a dry event or a individuals who do not drink. Participants identified an othering or judgment of folks who chose not to drink. This othering was even present in individuals own homes where other members of the household consumed alcohol.

"You're weird if you don't drink here. I don't drink here, and I am the odd one out." participant, 1208.001

Recommendations for the MAP

Based on the harms and experiences with alcohol described above all participants identified a need for more support for safer alcohol use in the community. Additionally, all participants perceived that MAP could meet the need of folks looking for safer alcohol use. One participant expressed having sought help for her alcohol use previously, came upon MAPs in her research but unfortunately there were none locally available at the time. Another participant, while in support of the MAP held reservations and identified this mistrust stemming from having grown up in an abstinence-based culture. A different participant felt trust in the program citing the principals and successes of current SJSWC programming.

Approach

How MAP staff approach the program was important to participants. Because this is a novel program in this area and the potential population is vulnerable, the need for building trust was emphasized. Participants suggested this trust could be built through non-judgmental support and working to build relationships with individuals in the program.

> *"Getting somebody that can earn that person's trust cause trust is a big issue when it comes to people with this disease." participant 0209.002*

Participants also identified the need for flexibility in the program itself and in staff expectations.

Programming

Participants provided input around the structure of programming. Being part of a MAP and changing ones drinking habits was identified as a major lifestyle change that can be accompanied with feelings of grief and loss. Additionally, participants may find themselves with more free time as they spend time procuring and consuming alcohol. To address this, change the program should have wrap around supports that extend beyond alcohol provision. These supports need to be individualized and low barrier. Accessibility was a consideration for many participants. This was physical accessibility such as transportation, financial accessibility, and cognitive accessibility.

"I've seen a little bit of lacking of activity and stuff around out city for cheap and free activities and its like okay people might not be capable of paying to go to a movie or something like that." participant, 1208.003

Another suggestion from multiple participants was for the incorporation of peer support.

Outreach

Participants identified wanting outreach to engage folks beyond the MAP. Two populations identified for this was the general public and the family and friends of people engaged in MAP. Outreach to the general population could offer education about HR, alcohol use, and MAPs.

"Whilst advertising the program include information or images related to dispelling the stigma and dehumanization that surrounds addiction" participant, 1108.001

For friends and family, it could be opportunities to engage with the program or learn more about MAPs.

"Maybe some help with family reconnections or family dynamics and stuff cause some addicts, god love em, and alcoholics the family is really hard on them." participant, 1208.003

"How can family or loved ones or friends support the individual while respecting their own boundaries and not enabling" participant, 1408.001

Scope of the Program

The scope of the program was brought up by several participants. Most felt that the smaller number of participants (four in the first phase and 12 in the second) was beneficial.

"Four people then twelve people is absolutely done correctly because if you go over twelve [participants, it's] pointless. The attention isn't there." participant, 1208.001

It would allow for sufficient resources to be given to each participant. There was also a need identified to expand MAPs across genders and the province.

"I understand that you serve women and non-binary, but it would be nice someday to see just because all of the alcoholics in my life are primarily men." participant, 1408.001

Existing MAP Consultations

Of the eleven scattered and unknown sites that were contacted, five responded. One was not actually a MAP site. Consultations were completed with the other four and Marguerites Place. Supplementary resources supplied by the sites are stored on the SJSWC Google Drive.

Phoenix Residential Society MAP

Structure

The Phoenix Residential Society located in Regina, Saskatchewan operates a housing first program, HOMES, of which the MAP is part of. The HOMES program employs intensive case managers (ICM), two of whom are dedicated to the MAP. The MAP has multiple outreach workers to staff 12-hour coverage seven days a week. There is no formal partnership with primary health care, instead HOMES team has a working relationship with the sole family physician in the city who provides harm reduction services. This physician prescribes the alcohol for the MAP participants and is their primary health care provider.

Funding and Evaluation

The MAP began in 2016 with the client purchasing their alcohol and HOMES proving staff support. The program was then funded through federal housing money distributed through a local hosing corporation. In 2020 this funding was cut, largely due to stigma, and alternate funding was secured through the provincial health authority, Saskatchewan Health Authority. Participants contribute $80 per month towards the program.

Participants provide consent for the MAP to access statistics on participants interactions with emergency health and police services. This data is collected for the two years prior to joining the MAP and following two years. Quality of life surveys are also administered to participants

Participants

During the intake process for the HOMES program, individuals who disclose having consumed NBA are referred to the MAP. Potential participants are assessed using the Severity of Alcohol Dependence Questionnaire (SADQ). The program currently has eight participants, one of whom is woman identified. Participants' goals for the program are identified through a care plan created with their ICM. The care plan is revisited on a weekly basis. Participants are required to give trusteeship of their finances to the HOMES program. Participants exit the MAP program in several ways. They can opt out of the MAP, they are no longer with the MAP when they graduate the larger HOMES program, and in rare cases participants are removed due to violence.

Alcohol Provision

Alcohol is delivered up to three times daily. During weekdays, a case manager and an outreach worker do the morning drop and two outreach workers cover the afternoon and evening drops. Outreach workers staff the weekend drops. A delivery circuit for the eight participants takes 3 hours and is 40km. The type of alcohol provided is drinkers choice and up to five drinks are provided at a time, as determined by their prescription. Morning and evening doses are often higher to account for the longer overnight period. When staff arrive at a participant's house, they have a conversation with the participant and asses for intoxication using a scale created by the MAP. After assessment, the participant is either provided with their dose or juice if they are deemed too intoxicated. Information about intoxication and withdrawal is shared with the ICM who consults with the physician. If the participant has accessed NBA, they are required to trade it for beverage alcohol.

Emergency Measures

The program has adapted their policies based on the COVID19 pandemic. When public health restrictions are high the staff limit their visits to participants doorways rather than entering their homes. They also created a bucket on a stick for distanced alcohol exchange. The staff donned full PPE (gowns, shields, masks) when close contact with a participant was needed. The program does not currently have any

formal policies for inclement weather. The team works on an ad hoc basis utilizing whichever staff can get to the office that day.

Healing with Hope Home

Structure

The Healing with Hope Home located in Sudbury, Ontario is a supportive housing MAP operated by the Canadian Mental Health Association. The program began as a daily MAP drop in but moved into a residential location in 2019 with capacity for 15 residents. The program is open to all genders but currently only has men identified residents. They currently have a fulsome team of healthcare and non-clinical staff. The health care staff include an addictions lead, nurse practitioners, registered nurses, and registered practical nurses, as well as family physicians and a psychiatrist on a consultation basis. Non-healthcare staff include a life skills worker, indigenous social worker, and various administrative staff.

Funding and Evaluation

The MAP is funded by the regional health authority, Local Health Integration Network, and residents. Residents are required to pay rent, utilities, and a set amount for food and alcohol.

Participants provide consent for the MAP to access statistics on participant's interactions with emergency health and police services. Service satisfaction surveys are administered to residents throughout their stay.

Participants

Residents can be referred by service providers or self-referred. After referral, candidates complete a lengthy screening process including but not limited to the SADQ, risk assessment, and history with alcohol, housing, and the legal system. Residents join the program on a one-week trial basis during which their current housing (hospital, shelter, etc.) is held. Additionally, residents are not allowed to be off site or have visitors for the first two weeks of their stay. Care plans are created by the resident and an interdisciplinary team and are reviewed once a month. Residents can also opt into an employment program in partnership with the local YMCA. Residents are allotted a small amount of personal money a

day that is contingent on completing staff assigned tasks such as making their bed or showering. The money can be spent offsite, and residents are searched upon return to the site. Staff also conduct random room searches. The primary goal of the program is to transition residents into permanent housing. This is facilitated by a transition worker and CMHA case managers. Residents may also be removed from the program dur to violence or failure to pay rent.

Alcohol Provision

Alcohol is dispensed hourly from 7:30am to 9:30pm daily. The first and last pours are 7oz and all others are 5oz. Dispensing is done primarily by nursing staff who check resident's vitals and can off an additional smaller pour if someone is in withdrawal. Residents must be in the building for observation 20 minutes prior to a pour. Dispensing staff assess intoxication using an internally created tool and either dispense the full amount, half amount, or deny the pour all together. It was noted there were inconsistencies between staff regarding withholding of doses, with some staff never withholding a full dose. White wine is the alcohol used because it is economical and easier to clean than red wine. Some flexibility is available for residents attending offsite appointments. If they are going to miss a pour the pour can be split between their last pour before they leave and the first pour when they return.

Emergency Measures

The program followed health measures for the COVID19 pandemic and is prepared for all inclement weather conditions.

Mobile Outreach Street Health MAP

Structure

The Mobile Outreach Street Health (MOSH) is program of the North End Community Health Centre in Halifax, Nova Scotia that provides healthcare to vulnerable populations. In response to the COVID19 pandemic the organization began a MAP in June 2020. The program operates a scattered site model and quasi residential model. The larger MOSH organization has multiple healthcare and non-

healthcare staff. The MAP specifically employs a part time coordinator, one part time social worker, one part time team lead, and two full-time outreach workers. The program operates eight hours a day seven days a week. The prescribing physicians are not employed directly by the organization but are available on a consultation basis.

Funding and Evaluation

The MAP began in 2020 with COVID19 funding and is now partially funded by North End Community Health Centre and Primary Health Care at Capital Health.

Participants partake is weekly surveys to measure key indicators such as ER visits, over intoxication, participant experience etc.

Participants

Participants can be referred by service providers or self-referred. After referral, candidates complete a lengthy screening process including but not limited to the SADQ, risk assessment, and history with alcohol, housing, and the legal system. The program currently has 14 participants in their scattered site model. They also provide alcohol to a supportive living site with ten residents in more of a safe supply model. Most of the participants are 40 years and older with a third being indigenous, and all but one are men identified. Participants' goals for the program are identified through a care plan created with the social worker however interacting with the social worker is not a mandatory part of the program. Trusteeship is being considered but it is not currently part of the program. Participants exit the MAP program in several ways. They can opt out of the MAP, when the risk of being on the MAP outweighs the risk of unsupervised drinking, when participants pass away, or in rare cases when violence occurs.

Alcohol Provision

Alcohol is delivered up to two times daily. Outreach workers are responsible for the deliveries seven days a week. A delivery circuit for the 15 participants takes about 4 hours and is delivered in a van owned by the organization. The type of alcohol provided is wine or beer because the program receives those items at

cost from the local breweries and the Nova Scotia Liquor Corporation. Participants are prescribed a combination of beer and wine by the doctor with the highest daily amount being one bottle 12% wine and seventeen 355mL cans of 6% beer. Morning and evening doses are often higher to account for the longer overnight period. When staff arrive at a participant's house, they assess the participant for intoxication, withdrawal, and general health. The doctor makes the final call whether to withhold someone's dose. Some participants must return their empty alcohol containers in order to receive their dose. The alcohol is packaged in reusable cloth bags.

Alcohol is delivered in bulk by the outreach workers to the supportive living site and is dispensed by the site staff.

Emergency Measures

The program has adapted their policies based on the COVID19 pandemic. When public health restrictions are high the staff limit their visits to 15 minutes maximum. The staff donned full PPE (gowns, shields, masks) when close contact with a participant was needed. The program does not currently have any formal policies for inclement weather. The team works on an ad hoc basis utilizing whichever staff can get to the office that day. They are working on creating policies and had ideas about participants picking up alcohol at a gas station or delivering a double dose if it was safe for the participant.

Indigenous Harm Reduction Team

Structure

The Indigenous Harm Reduction Team (IHRT) in Victoria runs a program that is more of a safe supply model rather than a MAP model. It began in response to needs of the community that were exacerbated by the COVID19 pandemic. On the last week of the month (the week before income support cheques) the program provides a daily alcohol allowance. The program employs eight folks to cover the three hour shifts for the seven days a month. Most of the individuals have experienced criminalization for substance use. Some employees are currently using, and others are sober. The employees are scheduled for four

shifts a month and are paid for all shifts regardless of whether they work the shift as part of the organization commitment to economic justice. There is a volunteer that purchases and organizes the supplies.

Funding and Evaluation

The program has received several COVID19 specific funds but does not currently have any stable funding. There is no formal evaluation. The program tracks the number of participants and anecdotally notes there has been a decrease in theft of alcohol from store in the community.

Participants

There is no intake process for the program, and it is open to anyone over the age of 19. Previously the IHRT provided indigenous specific programming such as healing circles and arts and crafts however this ceased when they lost their physical space in 2020. They hope to secure a new space and resume programming in the near future.

Alcohol Provision

The staff set up in a garage doorway. Participants present and are asked for their first name and last initial. They choose what type of alcohol they would like from a variety of beer, coolers, and seltzers. Participants are given a package with three drinks, a multivitamin, a B100 tablet, a candy, and two cigarettes. Participants are asked not to consume the alcohol on the block where the garage is located.

Emergency Measures

Because of the outdoor dispensing the program, COVID19 measures have been easy to adopt by adding hand sanitizer to the table and asking for social distancing in the line. Inclement weather is not usually a problem for the area.

Marguerite's Place MAP

Structure

MP is a supportive housing program of the SJSWC. In 2019 there was an individual living at MP who was experiencing harms due to her alcohol use. To address these harms the resident, the Housing Coordinator, and the resident's family physician decided to engage in a MAP. This began in June 2019 and lasted approximately a year. The Housing coordinator, physician, and resident collaborated on a care plan and housing staff provided the alcohol dosing.

Funding and Evaluation

This MAP did not have specific funding and led to the application for MAP specific funding. While there was no formal evaluation for this program, anecdotal knowledge from staff is available.

Participants

There was one participant in this program. Staff identified that the participant felt supported in the program and especially by the non-judgmental response to her alcohol use. The participant was not consistently engaging in the program and sometimes staff would not see her for days. There were also challenges with group programming as participants are expected to not be intoxicated to attend and the individual was often intoxicated. This created some stigma and othering. Staff identified that current residents are much more supportive of each other, engaging in community care and there would likely not be the same isolation if the program happened now. During her involvement with MAP the participant moved out of MP and into the community.

Alcohol Provision

Alcohol was provided hourly by housing staff. The participant presented to the housing office and was assessed for intoxication. If she was able to have a pour the staff would provide the dose and supervise her consumption. Staff found the participant liked to talk and connect during this time. If she was intoxicated and could not receive a dose, staff identified she would often become upset and agitated. The

doses were available hourly, and staff noted the rigid schedule did not work well with the participant's schedule. Additionally, staff found it hard to balance the supervised hourly pours with the programming needs of the rest of the participants.

Emergency Measures

The program adapted to the COVID19 pandemic by doing drop off deliveries of alcohol. Unfortunately, the participant was not often home, and her alcohol was stolen multiple times. The participant was living in MP during the winter she was on the program therefore inclement weather was not an issue.

Summary

From the limited literature available it seems that MAPs seem to be having a positive impact on individuals and communities and are a viable harm reduction approach to alcohol related harms. The operational manuals and toolkits provide a useful starting point for creating a MAP. While fairly general and meant for residential sites they do provide useful foundational knowledge. There does not appear to be a standard evaluation approach of a MAPs efficacy. The studies that used similar measures found MAPs seemed to reduce social, legal, and housing harms related to alcohol and participants reported a sense of safety and community within the programs.

Interviews with people with lived experience provided a wealth of information about alcohol use in Newfoundland and what folks are looking for in a harm reduction program. Alcohol consumption is pervasive in Newfoundland culture and folks not partaking can feel stigma and isolation. Alcohol's prevalence in our culture also masks some folks struggles and the harms they are experiencing. Programs that aim to reduce these harms need to be non-judgmental and be led by the participants, which are principals of harm reduction practices. The program also needs to go beyond alcohol management providing wrap around housing, accessibility, and social supports.

MAP models exist on a spectrum from safe supply to round the clock supervision and control. The programs in Regina and Halifax seem to be most in line with the SJSWC program and the SUAP funding

agreement. Knowledge from the other sites is still useful and individual practices could be adopted by the SJSWC MAP. All sites stressed the need for flexibility especially, for a new program.

Next steps are to consult with residential programs and complete part two of this review.

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Appendix A: Interview Cover Letter

ST. JOHN'S STATUS OF WOMEN COUNCIL

ST. JOHN'S WOMEN'S CENTRE
MARGUERITE'S PLACE
SAFE HARBOUR OUTREACH PROJECT

170 Cashin Ave. Ext., St. John's, NL Canada A1E 3B6 | T. 709.753.0220 | F. 709.753.3817 | www.sjwomenscentre.ca

Date:

Thank you for your interest in providing feedback on the St. John's Status of Women's new Managed Alcohol Program(MAP). We truly value lived expertise and will use the information gathered in this interview to inform the development and delivery of the program.

Participating in this interview is voluntary and you are free to leave out any question you do not wish to answer.

1. **You do not have to take part**
2. **Taking part will not affect any healthcare or community support you or your family receives.**

If you do wish to participate you will be compensated for your time and expertise through your choice of cash or git card in the amount of X.

There is a risk you may become triggered or emotionally upset while participating in this interview. There is an information sheet with supports you can contact if this occurs.

The information you provide will remain confidential, with a couple of exceptions:

- Immediate threat of harm to self or others
- Harm or threat of harm to a child
- Harm or threat of harm to a vulnerable adult
- We are subpoenaed by law to disclose

In any of these situations we would contact you and keep you informed of any resources we would have to reach out to.

Once the interviews are returned, they will be linked to a dataset only by identification number. Your name will not be included in any publications or reports prepared from the interviews.

Should you wish to withdraw at any time please contact Mary and any information you have provided will be removed from the dataset and destroyed.

If you have any questions about the MAP or the interview process, please contact:

Mary Walsh
Harm Reduction Researcher and Training Support
Phone: 709-725-7973
Email: mary@sjwomenscentre.ca

Thank you for taking the time to provide your thoughts and opinions.

Sincerely,

Mary Walsh on behalf of the MAP team

Appendix B: Interview Questions

MAP Lived Expertise Interview

Introduction

Managed Alcohol Program (MAP) is a pilot project harm reduction program delivered from a housing-first and trauma-informed approach. The aim of this program is to decrease harms and barriers associated with chronic alcohol use delivered to those whom other treatment options are not appropriate or available. It is operated by the St. John's Status of Women Council.

Participants will be supported by an interdisciplinary team of support, including a case manager/outreach worker, a counsellor, and Eastern Health's Harm Reduction Team. Participants will be provided regulated amounts of alcohol dosed to their needs, based on a care plan developed by the participant and their team. In addition to alcohol provision, MAP will also assist individuals who have been chronically underserved by the system, working to identify, and overcome barriers that have prevented them from successfully maintaining safety and independence in the community. This will be achieved through the development of Individualized Care Plans which allow individuals to identify needs, strengths, and actions to achieve specific self-identified goals. In other words, the participant will tell us what they want from the program, and this is what will be prioritized. We will not tell anyone what their goals should be or how to reach them.

MAP will be mainly an outreach-based program offered to women and nonbinary individuals living in St. Johns. Whole-person support will be provided to those in the program so that participants can identify, and be supported in, achieving their goals for harm reduction and wellbeing. The participant will identify what is harmful for them. Eligible applicants must:

- Face significant barriers to accessing a safe supply of alcohol
- Experience significant safety and health risks related to alcohol use
- Be a woman or nonbinary person over the age of 19
- Face significant barriers to maintaining safe and stable housing
- Agree to engage in low-barrier support from a harm reduction support team at a level appropriate to the participant's needs and goals
- Have income less than the Low Income Cut Off (LICO) standards set by Statistics Canada (In 2020, the 12- month LICO amount for a single person is $25,921.)

Questions

MAP

1. Do you see a need for supports for safer alcohol consumption in the community?
    a. Why or why not?
    b. Have you or someone you know experienced harms from alcohol consumption?
2. Do you think a MAP program could address the needs of people seeking to consume alcohol in a safer way?
3. What do you see as the challenges of a MAP?
4. What do you see as the benefits of a MAP?
5. What barriers do you think people will face who are trying to access the MAP?
6. Do you have any changes or improvements you'd like to suggest for the MAP?
7. Is there anything we haven't asked about that you'd like to share?

Demographic

Age:

Gender:

Do you identify as any of the following?

- ☐ Member of the BIPOC communities (Black, Indigenous, People of Colour). Would you like to tell us more?

  _____
- ☐ Racialized/ non-white
- ☐ Disabled/Differently Abled
- ☐ 2SLGBTQIA+

Have you ever experienced any of the following?

- ☐ Homelessness
- ☐ Involvement in the sex trade
- ☐ Poverty
- ☐ Been the victim of violence
- ☐ Interaction with the criminal justice system