

Clients Perspectives of Managed Alcohol Programs in the First Six Months and Their Relational
Shifts

By

Shana Hall
Bachelor of Arts, University of Victoria, 2007

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of
MASTER OF ARTS
in the Social Dimensions of Health Program

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Supervisory Committee

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Abstract

Background. The prevalence of alcohol dependence, defined as being physically and psychologically dependent on alcohol, among homeless people is 8%–58% compared to 4%–16% of alcohol dependence prevalence in the general population. Homelessness also contributes to alcohol dependence, and alcohol dependence is more difficult to treat and manage when combined with homelessness and alcohol-related harms. Alcohol harm reduction strategies for those with severe alcohol dependence and experiencing homelessness are gaining traction. There are 22 Managed Alcohol Programs (MAPs) in several cities across Canada. MAPs can reduce harms for people with severe alcohol dependence who live with acute, chronic, and social harms. In this research, I report on MAP participants views in the first six months of being in a MAP to provide insights into implementation of MAPs.

Research Question. My central research question was: What are MAP participants perspectives of MAP during the early period of transition into MAP? With an objective to understand implementation from participants perspectives, I specifically asked: How are MAP participants situated in the world, what are their experiences, and what are the relational shifts that occur during early transition into MAP?

Methodology and Theoretical Perspective. In my research, I used interpretive description informed by constructivism. I drew on relational theory to interpret my findings. The use of interpretive description, informed by constructivism and relational theory, brought forth greater insight into MAP participants views of and subsequent shifts in their relationships with the environment, alcohol, themselves, and others before and during MAP.

Results/Findings. Participants perspectives focused on four key findings: (a) participants shifting perspectives of non-beverage alcohol when beverage alcohol was available in MAP, (b) participants motivation to change and insights into their own drinking, (c) reasons for drinking outside of MAP, and (d) relational insights and shifts in their connections with others.

Conclusions. For individuals experiencing homelessness and severe alcohol dependence and its inherent associated harms, MAPs help to support relational shifts that support safer drinking patterns and/or meaningfully interrupt cycles of uncontrolled drinking as well as help to re-establish new relationships with alcohol, themselves, family, and friends.

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Acknowledgements

Dr. Bernie Pauly. I kept saying this to you: “You are so good at what you do!” to which you always replied, “It’s my job!” Thank you, Bernie, you offered obtainable guidance and wisdom, and you have a generosity and passion for this research. Thank you for fueling my confidence to accomplish my goal of completing a Masters.

Dr. Tim Stockwell. Thank you for your wisdom and expertise and, most of all, your good cheer and approachable nature! Your contributions made this a more rounded and thorough thesis.

My family. To my Uncle Thomas, who had faith and patience before anyone else understood what it truly meant to me to achieve this goal. To my mother, Sandra, who has never stopped cheering me on and who provided her own valuable insights. To my Auntie Jo, Auntie Linda, and Aunt Donna, who maintained their positivity and good attitude even when I was decidedly stormy. And to my sis, Sian, thank you for being you and for being so patient and understanding.

My friends. To the “besties” Claire, Ryan, and Stephanie S—amazing beings, thank you for sharing your unwavering love, humour, and support. To Shana O, Dawnna, Kara, Julie, Kristi, Nicole, Ramm, Monica, Katie, Ruth, Sara G, Janine, Holly, Rob S, Echo, Sharlene, Stephanie M, Katrina B, Sue B, Susan R, Darrin, Kate, Deana, Debbie, Cindy, the Salty crew, and Heather B. Each of you has played a very special role on this journey, and all of you were/are incredibly encouraging and supportive. I am the luckiest, I swear. PS, I can go out now!

Chapter One: Introduction

According to the World Health Organization (WHO; 2015), “5.1% of the global burden of illness and injuries are related to alcohol” (para. 3). When looking at prevalence on data from the 2002 Canadian Community Health Survey: Mental Health and Well-being, men are 3.9% more likely than women (1.3%) to experience alcohol dependence (Tjepkema, 2004, p. 14). In a review and meta-aggression analysis of mental disorders among homeless individuals in Western countries, the prevalence¹ of alcohol dependence among 1,791 homeless men is 8%–58% compared to 4%–16% prevalence range of alcohol dependence in the general population (Fazel, Khosla, Doll, & Geddes, 2008). It is important to note that single percentage estimates are unable to truly capture the dynamics and complexities of homeless individuals with alcohol dependence, thus a wide variation in prevalence range can be expected (Fazel et al., 2008). It is also worthwhile to acknowledge there are few studies on women experiencing alcohol dependence and homelessness.

Mortality is also significantly increased in homeless individuals, with causes of increased mortality correlated with substance misuse, disease, suicide, and unintentional injuries (Fazel, Geddes, & Kushel, 2014). Alcohol use among homeless individuals contributes to a standardized mortality ratio two to five times greater than the age-standardized general population (Fazel et al., 2014). Homelessness contributes to alcohol dependence and harms, in that it is more difficult to treat and manage alcohol dependence when combined with homelessness and harms in comparison to the general population (p. 1530). Life expectancy of homeless individuals who are

¹ Prevalence is used to measure a specific population with a specific disease characteristic within a certain time period.

living with risk factors, including alcohol, illicit drug and alcohol use, smoking, and mental disorders, is shorter, with homeless individuals dying 10 to 15 years earlier than the general population (p. 1532).

Drinking patterns that lead to alcohol intoxication, increased volumes, mode of use, and alcohol dependence are associated with alcohol-related harms (Young & Stockwell et al, 2004). Associated harms from alcohol dependence can be described as acute, chronic, and social. In terms of acute harms, physical injuries may be sustained for alcohol-related reasons, which place an individual at increased risk of acute injury due to alcohol use (Stockwell, Butt, Beirness, Glikman, & Paradis, 2012). Physical and acute alcohol-related harms include withdrawal and seizures (Stockwell, Williams, & Pauly, 2012). Acute harms from alcohol also include poisonings and spread of sexually transmitted diseases (Young & Stockwell et al, 2004).

In terms of chronic harms from alcohol dependence, alcohol-use related disorders, when drinking patterns and volume of consumption are severe, are among the most harms (Rehm et al., 2009). In 2004, an estimated 3.8% of global deaths from chronic harms, such as chronic diseases, including cirrhosis of the liver and acute harms such as intentional and unintentional injuries, were attributed to consuming alcohol (Rehm et al., 2009). Global disability-adjusted life years (DALYs) measure the impact disease or disability has on life expectancy. Alcohol use disorder was the 36th leading cause in 1990 (GBD DALYs and HALE Contributors, 2018). In 2007, the DALYs showed alcohol use disorder was the 26th overall leading cause of years lost due to disease or disability (GBD DALYs and HALE Contributors, 2018). In 2017, alcohol use disorder was relatively unchanged as a leading cause of years lost and was calculated at 27th overall (GBD DALYs and HALE Contributors, 2018). Alcohol-specific diseases like alcohol-induced pancreatitis, “especially for men, are among the most disabling disease categories for the global

burden of disease” (Rehm et al., 2009, p. 2223). Chronic harms from alcohol dependence, include certain cancers and blood borne disease (Young & Stockwell et al, 2004).

Social harms include social life impacts, legal, and financial implications (Young & Stockwell et al, 2004). When consuming alcohol, individuals can face a significant number of social harms towards themselves and others, including “physical and sexual violence, vandalism, public disorder, family and interpersonal problems, financial problems, unwanted sex . . . with levels of risk rising with increased consumption” (Stockwell et al., 2012, p. 131). The likelihood of social harms increases with increased alcohol consumption (Stockwell et al., 2012). When people with severe alcohol dependence lack stable housing, they are exposed to additional health risks related to homelessness, thereby facing a double burden of potential harm and health risk. Homeless individuals with alcohol dependence face considerable societal stigma and social exclusion, and they are often excluded from direct and indirect social and health supports (Pauly, Reist, Belle-Isle, & Schactman, 2013).

Under the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, Alcohol Use Disorder (AUD) combines “the two DSM–IV disorders, alcohol abuse and alcohol dependence, into a single disorder called alcohol use disorder (AUD) with mild, moderate, and severe sub-classifications” (National Institute on Alcohol Abuse and Alcoholism, 2016, para. 3). Alcohol dependence exists on a continuum of severity and ranges from mild to very severe and under the DSM-5, AUD severity is measured according to the extent to which the 11 AUD criteria are met. More than six criteria constitute severe AUD. In the context of my analysis, the term severe alcohol dependence will be used throughout this thesis to describe a small and significant portion of the general population defined as being physically and

psychologically dependent on alcohol equivalent to the definition of severe AUD as defined by the DSM-5.

In a 5-year population study on the demographical and clinical use patterns of all individuals visiting an Emergency Department (ED), Mandelberg, Kuhn, and Kohn (2000, p. 639) compared frequent users of the ED to all other ED visits. Frequent users accounted for 39% of all visits to the ED, with 12% describing themselves as homeless at intake; this was comprised of 38% of frequent users, 79% of these 38% were seen for alcohol dependence. Mandelberg et al. were able to reveal that frequent use of the ED was associated with urban social inequities of poverty, homelessness, alcohol use, and illness, essentially emphasizing the associated harms of acute, chronic, and social harms related to alcohol use.

People experiencing alcohol use problems and homelessness have long faced barriers to obtaining housing. Typical approaches to supportive housing follow an abstinence-based model, making it more difficult for those with substance use, including alcohol use problems, to be eligible for housing: “A dominating approach to homelessness has been the so-called treatment first: the homeless person should prove abstinence from substances in order to qualify for independent living” (Dyb, 2016, p. 77). This is also known as a continuum of care approach. This approach has been identified and critiqued by Housing First researchers, in which sobriety needs to be achieved in order to obtain permanent housing (Dyb, 2016). The abstinence-based housing model is problematic for individuals experiencing alcohol dependence and homelessness. The inherent difficulty between Housing First and other treatment first options is the behaviour associated with alcohol use. Disruptive behaviours such as vandalism and violence as a result of serious alcohol problems impact relationships between landlords and tenants and

make it difficult for tenants to retain their housing, often resulting in a cycle of lost housing, jail, emergency departments, and shelters (Collins, Malone, Clifasefi et al., 2012).

Housing First has gained political acceptance and support in Canada. Housing First incorporates a harm reduction philosophy and prioritizes direct placement into permanent housing as an alternative to the continuum of care model, where people are required to move through a series of transitions before obtaining permanent housing (Gaetz, Scott, & Gulliver, 2013). Housing First includes the principle of choice and putting choice into practice, including separating housing provision from other services, providing tenancy rights and freedoms and enacting a harm reduction approach to housing (Collins et al., 2011).

The fundamental difference between Housing First and continuum of care models requiring abstinence “lies in the understanding of the mechanism by which individuals are likely to change their behaviours to support a variety of goals (e.g., housing stability, alcohol behaviour change)” (Pauly, Reist, Schactman, & Belle-Isle, 2011, p. 932).

Previous studies have shown project-based Housing First is associated with 6-month reductions in jail time (Larimer et al., 2009), and that people with criminal histories are able to maintain their housing in supportive housing, such as project-based Housing First (Malone, 2009; Tsai & Rosenheck, 2012). Furthermore, Housing First has been associated with reduced emergency department visits and hospital admissions for people who were formerly chronically homeless with alcohol dependence (Larimer et al., 2009). Collins, Malone, Clifasefi et al., (2012) found 75% of the study’s 95 participants who were initially homeless with severe alcohol dependence and who were eligible for Housing First remained housed two years later, with reduced ED visits and reduced jail time.

While the rates of Housing First success are significant, there are some individuals for whom tolerance of alcohol consumption is not enough to reduce harms or ensure maintenance of housing. Managed Alcohol Programs follow Housing First principles, in that abstinence is not required and programs include the provision of either transitional, residential, or supported housing informed by harm reduction principles, but with the addition of alcohol harm and risk-reduction intervention for those unable to manage their alcohol consumption and/or with high rates of non-beverage alcohol consumption (Vallance et al., 2016).

Alcohol harm reduction strategies for those experiencing alcohol dependence and homelessness are gaining traction. Managed Alcohol Programs (MAPs) are in place in several cities across Canada, with a growing number of MAPs currently being implemented (Pauly et al., 2016). The Canadian Managed Alcohol Program National Study (CMAPS) underway is examining how people's lives change when they enter a MAP program (Canadian Institute for Substance Use Research) The CMAPS being conducted by the Canadian Institute for Substance Use Research, led by Pauly and Stockwell, focuses on implementation and outcomes of MAPs by looking at changes in clients' substance use, substance use-related harms, housing status, health, and quality of life as a function of being in a MAP (Canadian Institute for Substance Use Research, Stockwell et al., 2018).

The Podymow, Turnbull, Coyle, Yetisir, and Wells's (2006) study looked specifically at effectiveness of an Ottawa area MAP. As part of the Canadian Managed Alcohol Program Study (CMAPS), an evaluation of the Thunder Bay MAP found reduced police contacts, fewer hospital admissions, and a reduction in non-beverage consumption when compared to a control group who met the criteria for MAPs, but who were not enrolled at the time of study (Vallance et al., 2016). Non-beverage, or non-palatable, illicit alcohol, constitutes alcohol found in hand sanitizer,

mouth wash, rubbing alcohol, or hair spray that has a high concentration of alcohol and is not intended for consumption (Pauly et al., 2016).

Stockwell et al's (2018) study looked at participants changing patterns of alcohol use and found "long-term MAP residents (> 2 months) drank significantly more days (+5.5), but 7.1 standard drinks fewer per drinking day than did controls over the last 30 days" (p. 159). Beyond regularly administered alcohol, MAPs provide supported housing and direct and indirect social and health access. Evans et al. (2015) proposed that it is the combination of housing, beverage alcohol, and the immediate health and social supports in MAP that provides the perfect environment for change.

While evidence of MAP's effectiveness is increasing, less is known about clients' perceptions of MAPs and their views on the implementation of such programs (Pauly et al., 2016; Vallance et al., 2016). Thus, it is important to research perspectives of individuals who are new residents of a MAP program because their perceptions of MAP, could lead to better understanding of transition into the program and facilitate MAP implementation. In this thesis, I will focus on a subset of individuals who have severe alcohol dependence, homelessness, poverty and who met the criteria for entry into a managed alcohol program. Understanding their perspectives during the early transition phase is important, as individuals entering MAPs often have long histories of homelessness and have not been previously stably housed (Pauly et al., 2016).

I was first made aware of MAPs while employed as a manager in Mental Health and Substance Use Services in Island Health Regional Health Authority. My interest in research related to MAPs grew as I became more cognisant of Island Health's predominately abstinence based treatment approach to health care. While certainly necessary, I did not see a continuum of

care that was inclusive of harm reduction services. In particular, I did not see alternatives to abstinence based interventions but knew through my work that there was a need for a model that could provide controlled drinking. Because of this, I was interested in being able to produce recommendations for implementing a MAP that could help to introduce an alcohol harm reduction intervention into a large health care system. Learning MAP clients' perspectives of MAP seemed an ideal way to achieve this goal.

1.1 Research Purpose and Questions

Therefore, the purpose of this research was to examine MAP clients' views of MAP implementation in the first six months of their enrollment in a MAP program. The intent of the research was to take a closer look at clients' initial transition into a MAP, defined as MAP participants entering into a MAP during the first six months. Since less is known about MAP clients' views of how MAPs are operating, especially during this early transition period, this research contributes to growing the knowledge base for MAPs. Looking more closely during the first six months could provide insights into what is needed to support MAP clients to transition into MAP and to improve outcomes.

This research allowed me to better understand MAP participants perspectives in direct relation to their views *prior* to being enrolled in a MAP. My central research question was: *What are MAP participants perspectives of MAP during the early period of transition into MAP?* Specifically, what are participants saying about how they are relationally situated in the world before MAP and during the first six months in the MAP? With an objective to understand implementation from participants perspectives, I specifically ask: *How are MAP participants situated in the world, what are their experiences, and what are the relational shifts that occur*

during early transition into MAP? As well, participants perspectives could provide insight into future strategies for implementation of MAPs.

Understanding participants views is an essential component to any program implementation and, in the case of MAPs, of particular importance due to the potential influence clients' perspectives could have on future alcohol harm reduction interventions such as MAPs. Moreover, this study was focused on learning about participants views of program implementation and to share this knowledge through the development of a set of client-informed recommendations. Such recommendations could be used to influence existing and future MAP implementation.

1.2 Chapter Summary

In this chapter, I have outlined the description of increased risks of harms to individuals experiencing homelessness and severe alcohol dependence. In my analysis, AUD is being described and defined as severe alcohol dependence or alcohol dependence. These individuals experience increased mortality rates and are at greater risk for acute, chronic, and social harms associated with alcohol dependence and homelessness. Much of the available supported housing follow a continuum of care-based approach not necessarily suitable for people experiencing homelessness while living with alcohol dependence. Housing First is an approach that employs a harm reduction philosophy. Housing First, while rich with positive outcome evidence, still contends with a supported housing market that is mostly abstinence-based, leaving fewer options to implement more Housing First settings. MAPs provide administered alcohol in a residential or transitional housing setting, offsetting ongoing acute, chronic, and social harms associated with severe alcohol dependence and homelessness. There is evidence that MAPs can lessen harms for people who face the risk of alcohol-related acute, chronic, and social harms. MAP participants

views of implementation in the early period of their transition into a MAP comprise an area that is currently under researched.

In chapter two, I will review the literature on harm reduction history, philosophy, and treatment; touch on the foundation of alcohol harm reduction strategies and managed alcohol as a harm reduction intervention as well as MAP implementation; MAPs effectiveness; and identify the need to gather more information on knowledge related to implementation.

Chapter Two: Literature Review

I am interested in understanding clients' perspectives on MAP during the early transition period into MAP. This literature review is divided into distinct sections exploring (a) the concept of harm reduction and alcohol harm reduction history, philosophy, and treatment; (b) Alcohol harm reduction and MAP as a harm reduction intervention; (c) MAP implementation and effectiveness; and (d) current client perspectives on how MAPs are implemented, including the importance of gathering more information on participants perceptions. Better implementation has the potential to improve outcomes for clients and can inform the development of future programs.

2.1 Harm Reduction History, Philosophy, and Treatment

The concept of harm reduction first began to appear in the pre-1980s, in Europe, primarily in relation to heroin or diamorphine clinics and, later, methadone treatment for long-term users of heroin (Einstein, 2007). Prior to 1988, harm reduction was associated with a permissive attitude towards drug use and, thus, frowned upon by various establishments (Einstein, 2007). Safe spaces for intravenous drug use were perceived by the public as a “shooting gallery” and reinforcing drug use versus helping individuals safely manage their use (p. 260). The illegal nature of drugs also meant harm reduction was largely viewed as “enabling” addicts (Marlatt & Witkiewitz, 2010, p. 601). Additionally, harm reduction was often couched as a less-than-ideal approach to substance use and abstinence was the preferred end game (Marlatt, 1996). In the Mid-1980s, in part to address the HIV/AIDS epidemic, Holland was the first to introduce a needle exchange program (Ball, 2001; Marlatt, 1996). This was followed by the United States, Canada, the Netherlands, and the United Kingdom who began to develop harm reduction approaches through needle exchange programs (Ball, 2001; Marlatt, 1996).

Regardless, harm reduction itself was viewed as “manifesting a degree of civil disobedience” (Einstein, 2007, p. 261). Further, the criminalization of illicit substance use, such as the infamous US Regan-era War on Drugs, contributed to marginalization of harm reduction services (Marlatt, 1998). Only in the last several years have smaller regional public health organizations joined the United Nations’ and the WHO’s supportive stance on harm reduction approaches. As stated by Harm Reduction International (n.d.), harm reduction should be a practice that is commonly accepted and access and availability of harm reduction services considered a public and human right. Harm Reduction International (n.d.) focuses its mandate on better understanding of the drivers of the need for tailored harm reduction approaches and recognizing that individuals who benefit the most from harm reduction are also often the most vulnerable. People who use substances are not to be deprived of their right to fair access to health care and other supports, and in harm reduction, compassion and non-judgment are the underpinnings of respectful understanding of people who use substances. While harm reduction is both an approach of compassion and non-judgemental interventional care, the main issue is that interventions have primarily been focused on interventions that prevent the harms of illicit drug use. With this approach, public health organizations, writ large, have moved from providing simply harm reduction supplies to also implementing mostly non-alcohol-related harm reduction interventions and programs (Marlatt & Witkiewitz, 2010).

‘Harm Reduction’ situates programs, policies and practices “that aim to reduce the adverse health, social, and economic consequences of legal and illegal psychoactive drugs [including alcohol] without necessarily reducing drug consumption” together with harm reduction as an attitude and guiding principle (Harm Reduction International, 2018, p. 1). Philosophically, harm reduction is a pragmatic approach anchored in the realization that

substance use is a feature of society; some people choose not to abstain or cannot abstain from substance use and will continue to use substances despite the potential for associated harms occurring from their use (Riley & O'Hare, 2000). A harm reduction approach is well suited to individuals who may be unable or unwilling to stop their substance use. According to the British Columbia (BC) Ministry of Health (2010), harm reduction “focuses on keeping people safe and minimizing death, disease and injury associated with higher risk behaviour while also recognizing that the behaviour may continue despite the risks” (p. 6). Within a harm reduction philosophy, there is a range of interventions that can reduce the harms of drugs and alcohol without requiring cessation of use.

Beginning in the late 1990s, controlled drinking was introduced with some dispute as a potential “moderate drinking” treatment approach for men with alcohol dependence (Marlatt & Witkiewitz, p. 868, 2002). Moderate drinking was an “achievable goal” for those who drank to excess and for whom alcohol abstinence was not working (p. 868). The WHO, when referring to harm reduction approaches, stated that alcohol problems are to be viewed “on a continuum [together with] a broader range of prevention alternatives for particular populations and alcohol-related problems” (p. 869). The focus of this research is on MAP, an intervention to reduce harms of severe alcohol dependence and homelessness. MAP programs utilize just one of many alcohol harm reduction strategies and provide accommodation intended to reduce the harms of prolonged alcohol dependence.

2.2 Alcohol Harm Reduction

There is a considerable breadth of alcohol drinking patterns and associated harms from alcohol consumption, and with “respect to alcohol . . . consequences include alcohol-related mortality and alcohol-related crime, and . . . consumption patterns include any drinking, heavy

(or “binge”) drinking, drinking and driving, and initiation of use at a young age” (Flewelling, Birkmayer, & Boothroyd, 2009, p. 394). An international study of Emergency Department data found “that 74% of young single males presenting with an injury between 12:00 midnight and 4:00 a.m. had recently consumed some alcohol” (Stockwell & Macdonald 2009).

There are alcohol harm reduction strategies for those who consume alcohol that can address a large range of individuals who consume alcohol in varying degrees of severity (e.g., socially, to AUD, to severe AUD) and in a variety of ways (regular drinking, binge drinking, prolonged daily drinking) and situations (e.g., drinking on campus) (Flewelling et al., 2009). General alcohol harm reduction strategies include: reducing short term physical risk by choosing safer situations while drinking; not drinking and operating machinery or a vehicle, and if drinking, reducing drinking to a small number of standardized drinks per day (Stockwell et al., 2012). There are also strategies that use regulated breath ignition interlock devices in cars so individuals are unable to start their vehicles and strategies to create safer environments in bars: for example, not using breakable bottles (Stockwell et al., 2012). Significantly, in Australia, there is thiamine fortification of bread baking flour to prevent Wernicke-Korsakoff’s syndrome (Stockwell et al., 2012).

2.3 From Moderate Drinking to MAP as Alcohol Harm Reduction

Exploration of moderate drinking as a controlled drinking treatment approach was the subject of research more than 50 years ago, when Sobell and Sobell (1973) indicated that moderate drinking, as part of treatment, was a “viable and preferable treatment goal for some individuals who drink to excess” (Marlatt & Witkiewitz, 2002, p. 868). This led to debate related to defining treatment for alcohol dependence. Beginning over 30 years ago, there was the introduction of a pilot program for males with alcohol dependence (Marlatt & Witkiewitz, 2002).

It was also found that reduced drinking versus abstaining from alcohol was a path to recovery for those who were not in any treatment programs (Marlatt & Witkiewitz, 2002; Sobell et al., 2001). Later, the WHO (2001) suggested viewing alcohol use on a continuum and to have this seen as “within the broader goal of preventing and reducing alcohol-related problems at the population level . . . with the goal of reduction of alcohol-related morbidity and mortality” (p. 66).

In Canada, the rationale for a MAP arose from the freezing deaths of three homeless men in Toronto, Ontario, with recommendations to provide 24/7 shelter to men with severe alcohol dependence (Pauly et al., 2016). MAP programs are an alcohol harm reduction and homelessness intervention that operate out of homeless shelters and in low-barrier residential settings and, in rare instances, day programs (Pauly et al., 2018). MAP programs “are a harm reduction strategy that incorporates the provision of regulated doses of alcohol alongside accommodation and other supports to address the twin harms of severe alcohol dependence and homelessness” (Pauly et al., 2018 p. 2). MAP programs administer alcohol to clients in structured, scheduled doses, with staff members on site 24/7, keeping clients safe while also monitoring levels of intoxication and respecting clients’ independence (Pauly et al., 2016). Individual MAP programs may have some implementation differences, such as admission criteria, administered alcohol amounts and types and rules related to drinking outside of the program, but all share the common practice of regularly scheduled administered alcohol, while offering connections to psychosocial and health supports as well as programming intended to help with basic life skills (Pauly et al., 2016; Stockwell et al., 2018).

MAPs aim to:

- decrease or prevent alcohol-related harms by reducing heavy episodic drinking,
- use of non-beverage alcohol, public intoxication, drinking in unsafe settings and

high costs associated with police and emergency services while increasing access to primary care and other health and social services. (Pauly et al., 2016, p. 6)

MAP participants are “typically individuals with severe alcohol dependence and long histories of homelessness, public intoxication and regular consumption of non-palatable alcohol”

(Hammond, Gagne, Pauly, & Stockwell, 2016, p. 1). Those with severe alcohol dependence who also tend to be in a MAP are often individuals who have been through treatment options, such as abstinence-based programs like withdrawal management, commonly known as “detox,” many times and have experienced repeated and multiple failed attempts (Pauly, Stockwell et al., 2013). Of note, for individuals who have prolonged alcohol dependence, relapse is a common outcome in any treatment for alcohol dependence, including abstinence-based treatment. Next, I discuss MAP outcomes and implementation including issues in the implementation of MAP programs.

2.4 MAP Implementation and Outcomes

Pauly et al. (2018) looked at 13 MAPs in seven cities across Canada and identified six key dimensions of MAPs. Unsurprisingly, they found that “Canadian MAPs emerged out of a need for a more compassionate approach to care for people vulnerable to the harms of severe alcohol dependence and homelessness” (p. 3). These authors found that to implement a MAP, six operational elements merit consideration: (a) money management, (b) program goals, (c) eligibility criteria, (d) alcohol administration, (e) access to health services, and (f) food and accommodation (Pauly et al., 2018).

Several studies to date have looked at MAP programs’ effectiveness, implementation, alcohol consumption, and harms and experiences of clients within the program. Three of these studies emerged as part of the larger CMAPS (Pauly et al., 2016; Stockwell et al., 2018; Vallance et al., 2016). As previously noted, implementation includes the domains of housing, quality of

life, cost effectiveness, and alcohol consumption and harms. Outcomes and implementation issues related to these key components are discussed next.

2.4.1 Housing

The Housing First edict is based on providing choice to individuals and, thus, does not require residents to practice abstinence from substances. Instead, Housing First requires integrating harm reduction principles and approaches into housing (Pauly, Reist et al., 2013). Although harm reduction is a principle of Housing First, it is not always clear how harm reduction is being implemented. There are examples of Housing First that accept onsite drinking, and a good example of alcohol harm reduction that tolerates, but does not provide, alcohol was described by Collins, Malone, and Larimer (2012). These authors found that: “Participants receiving a project-based [Housing First] HF intervention reduced their alcohol use and experience of alcohol-related problems over a two-year follow-up as a function of length of exposure to [Housing First] HF” (p. 938). Housing First improved housing retention of people with alcohol dependence who were previously homeless, while also reducing their interactions with the criminal system (Clifasefi, Malone, & Collins, 2012).

In a 2009 case study of a homeless artist with alcohol dependence who participated in a MAP program, there was early indication of what it felt like to be a MAP recipient (Kidd, Kirkpatrick, & George, 2009). The MAP program, based in Vancouver, BC, provided housing while administering alcohol; the artist experienced freedom from the daily struggle of surviving street life and a newfound ability to focus on improving individual health (Kidd et al., 2009). Pauly et al. (2016) examined housing and quality-of-life outcomes. In this pilot study, 38 research participants, 18 of whom were MAP residents of one program, were evaluated on outcomes centred around environments that included assessment of “home life, safety,

satisfaction with physical environment, finances, transportation, and access to information and health services” (p. 4).

Pauly et al. (2016) found that participants retained their housing in comparison with controls who remained homeless. Further, they found that “MAP residents scored significantly higher than controls on the elements of housing quality and satisfaction in length of stay” (p. 4). More significantly, they felt safer in MAP than controls who were not in MAP, “highlight[ing] the importance of MAP as a safer environment compared to pre-MAP environments” (p. 5). In qualitative interviews, MAP residents described feeling safer in MAP than they did in pre-MAP settings such as on the streets, in jail, and in shelters (Pauly et al., 2016). Having housing supports fostered feeling safe and impacted participants quality of life. A key implementation issue for MAP is the need for permanent housing so that individuals do not have to leave their housing if they no longer need or choose to be on MAP (Pauly et al., 2018).

2.4.2 Quality of Life and Improved Safety

Podymow et al.’s, (2006) Canadian-based study studied a program focused on administering alcohol for those with alcohol dependence in a shelter-based setting. They found that prior to administered alcohol, study participants had higher rates of chronic illnesses, longer hospital stays, increased police interactions, and increased risk of mortality. Podymow et al. revealed that when enrolled in MAP, there was an association between participants improved quality of life, such as better hygiene, improved connectedness with other medical services and reduced alcohol consumption, reduced emergency department use, and reduced police incidents. Podymow et al. further demonstrated an association between MAP and participants improved health stability, improved hygiene, and improved housing retention rates for homeless individuals with severe

alcohol dependence. Even though there was an association between MAP and effectiveness, Podymow et al. had a small sample size and lacked a control group.

Pauly et al. (2016) found that pre-MAP clients' lives focused on day-to-day survival, with little regard to how food was obtained or an individual state of personal hygiene or safety; instead, focus was dedicated to finding a place to sleep and enough alcohol to get by. When in MAP, clients reported on "perceptions of the role of MAP in their lives" and spoke to an ability to focus beyond the struggle of daily survival when in a MAP (p. 5). According to Pauly et al., MAP clients had an improved sense of safety and inclusion, insomuch that participants felt generally connected for the first time in a while. According to McLellan et al. (1994, p. 1141), when referring to substance use treatment effectiveness, "outcome has rarely been defined merely as elimination or improvement in substance use only." Contrary to this, most published literature looked at elimination or improvement as the main measurement. Outcomes in the case of MAP programs are describing alternatives to substance use outcomes and, instead, point to alignment with quality-of-life improvement measures, such as hygiene and alcohol consumption or abstinence, improvement in feeling a sense of hope and life satisfaction, and improvement in attendance at various community appointments.

2.4.3 Cost Effectiveness

In this section, cost effectiveness is defined as how MAP is effective in terms of reduced social, health, and judicial systems' cost. Hammond et al. (2016) found that for the Thunder Bay MAP:

The annual cost of service utilization by program participants while in MAP was \$13,379 per person whereas the annual cost of service utilization by program participant prior to receiving treatment and the control group was \$45,304 per

person and \$48,969 respectively. The annual cost of the Managed Alcohol

Program was \$29,306 per participant. (p. 2)

Hammond et al. also reviewed the cost effectiveness of a MAP program, including staffing, in comparison to no treatment and accruing societal costs, total annual societal costs of homelessness of MAP participants while in MAP, MAP participants prior to MAP, and a control group. Based on this analysis, the annual cost savings, after factoring in the cost of homelessness (i.e., increased utilization of social, legal, and hospital services), there was a “saving between \$1.09 and \$1.21 for every dollar invested in a MAP” (p. ii). Pauly et al. (2013) found reductions in utilization of health, social, and legal services over a 6-month study period in comparison to a control group. This included a “43% reduction in police contact, 88% reduction in withdrawal management service utilization, 37% reduction in hospital admissions, 47% reduction in emergency department visits” (pp. 34-36).

2.4.4 Alcohol Consumption and Related Harms

In this section, I will present information on changes in alcohol consumption, beverage and non-beverage alcohol, as well as changes in alcohol-related harms. This literature is organized into two subsections: (a) beverage-based consumption and (b) non-beverage consumption. The impact MAP has on harms related to alcohol consumption will be described within each subsection.

2.4.4.1 Beverage-Based Consumption

Vallance et al. (2016) undertook research on patterns of alcohol consumption and self-reported harms of residents of a MAP program in Thunder Bay, Ontario. These authors were interested in determining whether entry into a MAP changes patterns of alcohol consumption and reduces alcohol-related harms. They found that residents consumed fewer non-beverage drinks

and had improved health outcomes, decreased police interactions, and decreased emergency department and hospitalizations while enrolled and when compared to controls.

A recent and significant contribution to understanding beverage alcohol consumption is Stockwell et al.'s (2018) paper on the impact of MAPs on alcohol consumption and harms for people with extreme alcohol dependence and also experiencing homelessness. Stockwell et al. evaluated drinking patterns and alcohol-related harms of MAP participants in six programs. They were compared to controls recruited from shelters and drop-in's in the same cities. Individuals evaluated were of three groups: (a) new to MAP, thus in their first 1-60 days of being in a MAP; (b) individuals considered long term in a MAP, thus two months or more; and (c) a control group of individuals who met the criteria for a MAP, but who were not in a MAP. One hundred and seventy-five people were either new to MAP or long-term residents of MAP across six MAP sites: two in Ottawa and one each in Hamilton, Toronto, Thunder Bay, and Vancouver. One hundred and eighty-nine participants comprised the control group and were matched locally to the 175 MAP participants (p. 160). These authors set out to compare the groups' frequency of consumption, reduction of non-beverage consumption, and reduced alcohol-related harms. The results indicated that "newer MAP participants drank 3.4 more days per month but did not differ significantly on number of drinks per day" (p. 162). Interestingly, the long-term MAP residents drank "significantly fewer drinks per day but for more days in the past month than did controls and newer MAP" however harms from volume of consumption was still a concern (p. 162).

2.3.4.2 Non-Beverage-Based Consumption

According to Pauly, Stockwell et al. (2013), those who undertake prolonged alcohol use may also use non-beverage-based alcohol, which can cause significant acute, chronic, and social harms. As described by Pauly, Stockwell et al.:

Prolonged, heavy alcohol use increases the risk of numerous physical diseases while episodes of intoxication increase risk of self-inflicted and accidental injuries. In this population such problems are especially prevalent and, as well, may be compounded by the use of non-beverage sources alcohol such as rubbing alcohol, mouthwash, hair spray or alcohol-based hand sanitizers. (p. 5)

Stockwell et al. (2018) found a marked reduction in non-beverage consumption of long-term MAP participants, resulting in improved overall health. Non-beverage alcohol consumption was higher prior to entry into MAP when compared to those new to MAP, where a slight reduction was evident, and for those in MAP longer than two months (Stockwell et al., 2018). MAP programs provide a treatment option for individuals with severe alcohol dependence who may also consume non-beverage alcohol. Individuals who also consume non-beverage alcohol often have more complex situational harms including violence, assault and criminalization (Pauly et al, 2016). MAP encourages the replacement of non-beverage alcohol with beverage-based alcohol (Stockwell et al., 2018).

According to Vallance et al. (2016, p. 6), when MAP participants were compared to non-MAP participants, MAP participants consumed non-beverage alcohol on “significantly fewer days ($M = 4.3$, $SD = 5.9$) than control participants ($M = 12.4$, $SD = 13.8$)” than in the past month. The results of the Vallance et al. (2016) study also showed a decrease in alcohol-related harms once in MAP when compared in the previous month to controls not in a MAP, inferring that MAP played a role in the reduction of related harms. In the next section, I endeavoured to capture what is known in the literature as it relates to client perspectives and, moreover, identify areas where further research centred on clients’ perspectives would benefit MAP implementation.

2.5 Client Perspectives on MAP Implementation

MAP outcomes and effectiveness has a growing body of research, but less is known about MAP residents' perspectives of MAP implementation. Overall, some studies included research on MAP client perspectives as described in Section 2.4.4. However, research focused solely on client perspectives was not specifically identified (Pauly et al., 2016; Stockwell et al., 2018; Vallance et al., 2016).

As outlined in the section on quality of life, MAP participants of one MAP described a safer environment, "in which the harms from alcohol use were reduced and a harm reduction approach [was] characterized by trust and respect" (Pauly et al., 2016, p. 10). Participants of this study also described feelings of interest in family and home; however, it is important to note this particular study was specific to one MAP, and, in the context of family and home connections, there is not a lot known about other MAPs. In addition to this, Evans, Semogas, Smalley, and Lohfeld's (2015) researched how MAPs generated feelings of safety among residents, with many in MAP acknowledging fears of a return to homelessness. It is important to gather more information on clients' views of MAP implementation during the early transition of the first six months into MAP. Further research on clients' views of MAP implementation during the first six months in a MAP could provide additional evidence of ways to improve MAP programming.

2.6 Chapter Summary

Based on the literature to date, it is clear there is a strong basis for harm reduction approaches to be considered in addition to potential abstinence-based models of treatment such as withdrawal management services. MAP as an alcohol harm reduction approach is just one of several alcohol harm reduction strategies. MAPs are ideally suited for those with severe alcohol dependence who may also consume illicit alcohol and are experiencing chronic homelessness

and poverty. Although harm reduction models are increasingly being considered in substance use services, dedicated formal service delivery for alcohol harm reduction models such as MAP are still under researched and have yet to be part of a health service continuum complementary to abstinence-based substance use treatment models. Noted in the literature review was the importance of undertaking research related to client perspectives and insights on MAP implementation within the first six months of enrolment. In the next chapter, I outline the methodological approach used in this study. Specifically, I will describe my research methodology, including my overarching philosophic approach, and outline my specific research design from data collection to ethics.

Chapter Three: Methodology

The research methodology for this study was interpretive description informed by constructivism. First, I identify and describe constructivism. Then, I describe my rationale for selecting interpretive description as my methodology and the relationship to constructivism. My philosophical stance of relational theory as described by Thayer-Bacon (2008) will be defined, described, and justified as the theoretical framework for this study. I drew on relational theory to interpret my findings. My purpose was to gain insight into MAP participants views of MAP implementation during the first six months of being in a MAP. The use of interpretive description informed by constructivism and relational theory brought forth greater insight into MAP participants views of and subsequent shifts in their relationships with the environment, alcohol, themselves, and others before and during MAP.

Constructivism originated in the last century in the disciplines of psychology and education and more recently within social sciences (Bommarito & Matsuda, 2015). Social constructivism, arising from the field of sociology, is the co-creation of knowledge, with knowledge produced through a shared reality between researcher and participant. In fact, with constructivism, there is a recognition that “social phenomena develop in particular social contexts” (Crotty, as cited in Opfer, 2008, p. 3). In constructivism, knowledge does not just exist; rather, it is created through an individual’s interaction with the world, the environments one finds oneself in, and how individuals decide to engage with and resolve a given conflict that may arise from a disparate position of commonly understood knowledge.

Interpretive description is well aligned with a constructivist paradigm because in

Interpretive description there is recognition that knowledge is co-created between the researcher and the participant. Interpretive description originated with Sally Thorne (2008), with

an intention of factoring in health professions' intimate experience with human health and illness. As an alternative methodological option, Thorne introduced interpretive description as a qualitative approach used outside of the social sciences and within health disciplines, including nursing professions, community development, and other fields that involve the human element. When an interpretive description methodology is applied, data that "sits somewhere between fact and conjecture" can be articulated in such a way that, in the instance of this study, data could be analyzed to appropriately elicit clients' perceptions of MAP implementation (p. 15). In contrast to grounded theory and ethnography, for example, interpretive description does not necessarily have a goal of producing theory. Although it may be informed by or inform theory, the primary goal is to produce knowledge inductively.

Application of a theoretical perspective is one way to interpret clients' experiences and perceptions of MAP implementation without pre-determining meaning. Importantly, interpretive description can be informed by a range of theoretical perspectives. In my analysis, I chose relational theory to inform the analysis. My goal was to use relational theory to gain insight into client perspectives (Thorne, 2008). I used relational theory with interpretive description to capture and highlight meaningful elements of participants' relations with the world. Relational theory was used as a theoretical framework to interpret and generate meaningful findings.

Thayer-Bacon's (2010) "(e)pistemology . . . [stems from feminism and pragmatism, where relational theory considers] "being" is directly connected to "knowing" . . . [and is an] activity done with others" (p. 2). With this perspective, knowledge is socially constructed and considered social knowledge (Thayer-Bacon, 2010). Thayer-Bacon argued that knowledge is always socially constructed, and as a researcher, there is no true "spectator's view on Reality. . . We are always situated and limited, our views are from *somewhere*" (p. 9). When people say

this, they mean anything they relate to in the environment, including for example, other people, the street, alcohol, and even one's self, and that these relationships to human and non-human dimensions are socially constructed and defined. Thayer-Bacon (2003) said that the environment itself is both socially and physically constructed, imagined, and formed; no two "environments" are the same because of how we each relate to our environment changes said environment. Simply put, Thayer-Bacon's (2003, 2010) relational knowing is looking at the world through not simply that of human relationships, but a much broader understanding of being in relation to self, others, and physical and emotional environments.

According to Thayer-Bacon (2003), individuals are situated in a complex set of relations within the world. It is not simply relationships but relations. Knowledge is constructed through understanding these relationships beyond human and non-human paradigms, and relational theory is a way of knowing about the world: "My relational (e)pistemology views knowledge as something that is socially constructed by embedded, embodied people who are in relation with each other" (pp. 8-9). Thus, relational theory looks at how individuals are situated in relation to the physical and social environments. Thayer-Bacon said, "We use 'relations' to make logical or natural associations" (p. 74). She also promoted an understanding of human relationships and the interactions of such as more profound, in that relationships are not anchored in simply human-influenced relationships, but extend to relational dimensions of life. Relationality, according to Thayer Bacon, can be understood from the perspective of personal, social, w/holistic, ecological, and scientific relations. Personal and social relations explore "the connection between individual knowers to other people, at a personal level and at a social level" (p. 77). W/holistic and ecological views as outlined by Thayer Bacon help us to understand connections between people as knowers and the larger spiritual, material, and natural world within which we live. She stated,

“Not only do we exist in relation to other human beings, we also live our lives in relation to our environment” (p. 11). Thayer Bacon provided a relational (e)pistemology as a way of knowing relationally in the world. It is a theory of knowledge as inquiry that sets up how one might explore a problem such as that of this research. Moreover, Thayer-Bacon noted that how relationality is undertaken is to not disallow or disregard any aspect of the knowledge gathering process.

3.1 Data Collection

As part of the CMAPS research, qualitative data were collected from MAP participants about their perceptions of and experiences of MAP within the first six months. My research set out to study the client interviews of MAP residents who participated in these CMAPS interviews. Particularly, I undertook an analysis of clients’ views of MAP program implementation during the first six months in a MAP. This analysis could potentially impact how MAP programs are improved for individuals new to MAP who have severe alcohol dependence and who may be experiencing ongoing homelessness. The initial CMAPS (Canadian Institute for Substance Use Research, 2014) occurred across six MAP sites, in five cities and in two provinces. In 2017, a seventh site was added to the National Study². The purpose of CMAPS is to examine the outcomes and implementation of MAPs in Canada (Stockwell et al., 2018). The objective of CMAPS is to rigorously evaluate the effectiveness of MAPs and outcomes related to alcohol consumption, alcohol-related harms, housing, and quality of life as well as exploration of implementation issues.

² For the purposes of my research, reference to the original six sites (in five cities) will be referenced throughout this thesis paper. There is a 2018 overview of the cities and sites:
<https://www.uvic.ca/research/centres/cisur/assets/docs/resource-overview-of-MAP-sites-in-Canada.pdf>

For this project, I made use of qualitative data previously collected by the CMAPS team for participants in six managed alcohol programs from CMAPS Phase I (Pauly, Stockwell et al., 2013). All of the interviews were conducted by trained researchers at each of the six sites. Questions were open ended and reflected understanding of the lived experience of those enrolled in a MAP program (Pauly et al., 2016). A completed interview meant that all questions as found in the *Qualitative Questions for MAP Participants Interview Guide* (Pauly, 2014. See Appendix A) were asked of each participant in CMAPS. Thus, I conducted a secondary analysis of the CMAPS qualitative data. I used interpretive description informed by Thayer Bacon's (2003) relational framework to inductively analysis the data from these qualitative interviews. It is of utmost importance to not discard any data or prematurely determine anything as irrelevant in order to ensure no false or subjective conclusions were made (Thorne, 2006, 2008).

The central research question for this secondary analysis was: "*What are MAP clients' perspectives of MAP during the early period of transition into MAP?*" Specifically, what are participants saying about how they are relationally situated in the world before MAP and during MAP? Thus, and with an objective to understand implementation from client perspectives, three sub-questions were also asked: "*How are MAP participants situated in the world, What are their experiences, and What are the relational shifts that occur during early transition into MAP?*"

3.2 Sample

The data for my study were drawn from the CMAPs qualitative data set (Pauly & Stockwell, 2014). Participants were part of CMAPS. Fifty-seven client interview responses from six MAP sites were reviewed for inclusion in my analysis. These 57 participants were randomly selected from six sites of the CMAPS: Vancouver, Ottawa (The Oaks and Wet), Hamilton, Thunder Bay, and Toronto. Canadian MAPS emphasizes provision of housing and improving

health for individuals who have severe alcohol dependence and had experienced enduring homelessness.

For my study, I selected all completed interviews collected as part of CMAPS, totalling 57. Forty-three of the 57 were male and 14 were female. The average age of the CMAPS participants was 49 and ranging from 25 years of age to 74 years of age. I reviewed all 57 completed client interviews from six MAP programs to identify and select MAP participants who had been in the program for the first six months. Of the 57 participants, eight were from Ottawa Oaks, five were from Ottawa Downtown MAP, 17 were from Hamilton, 14 were from Toronto's Seaton House, eight were from Thunder Bay, and five were from Vancouver. Of the 57, four were former residents of MAP. The focus of this study was to look at early experiences of participants in a MAP program and their perceptions of MAP implementation during this early transition period. Of the 57 client interviews, 22 interviews met the criteria of my study. Participants were from Hamilton, Toronto, Ottawa, and Thunder Bay. Vancouver CMAPS participants had all been in the program more than six months and, thus, were excluded. Looking at interviews of participants in their first six months of a MAP allowed for the data to be more manageable as well as provide insight to a time of transition into MAP.

Seventeen of the 22 participants were male, four were female, and one was not identified. While approximately six of the 22 self-identified as Indigenous, the remainder did not self-identify, thus there was insufficient demographical information obtained from the original study participants to include more here. However, of the 22, the average age was 42 within an age range of 25 years old to 63 years old. I was interested in the first six months' timeframe because I wanted to explore views of MAP participants who were new to MAP.

3.3 Sources of Data

My data sources for this study are secondary and qualitative in nature. Data originated from an initial review of 57 client interview responses to select 22 completed client interviews from across six MAP sites administered during the CMAPS (Canadian Institute for Substance Use Research, 2014). NVivo, Version 10, qualitative software was used to inductively code 22 interviews. I analysed the data using an inductive method of analysis, drawing on interpretive description and informed by relational theory as described by Thorne (2008).

3.4 Data Analysis

Relative to the constructivism and interpretive description approach being employed in my study, inductive analysis, as a qualitative method of analysis, was used to gain insight into individual participants perspectives. From this, broader themes and generalization of participants relationships were formed, “in order to develop conceptualizations of the possible relations between various pieces of data” (Thorne, as cited in Cohen & Crabtree, 2008, p. 11). Inductive data analysis permits an even broader interpretation than constant comparison: for example, in that the particular pieces of data, in this case participants words, are used to uncover and discover not yet realized themes in the data. This, in turn, was appropriate, in that commonalities and differences can be informed by relational theory in the interpretation of the interviews (Thorne, 2008). For my study, using interpretive description with an inductive analysis produced my findings. Use of a relational theory perspective was appropriate because I wanted to know MAP participants relationships with their environment, with alcohol, with MAP and with others, and how they relate to these components. This knowledge was used to better understand key elements of MAP implementation from client perspectives.

I began by breaking down the data into small elements and beginning to see that individuals' relationships with their environment informed what they believed, knew, experienced, acted, and felt. MAP participants views of implementation were directly connected to their relationships with alcohol, MAP staff other MAP residents, and how they saw themselves. Each interview was inductively analysed using interpretive description. This allowed for the inductive emergence of relational patterns from which primary themes around relationships emerged, such as that with alcohol and their social and physical environment. I used a relational perspective to not only interpret my findings, but to also qualify concepts that began to emerge from the participants interviews.

I continued to look for important and recurring themes using open coding and through a relational theory lens, which contributed to the creation of a coding framework. This led to further refinement of the analysis. I coded each interview against the emergent coding framework, which was comprised of the relational pillars of (a) Relationship with Alcohol, (b) Relationship with Environment, and (c) Relationship with Self and Others. Each relationship pillar emerged to comprise part of the framework, then was specified further by a subset of themes within that pillar.

Within the Relationship with Alcohol pillar, the subthemes were administered alcohol, beverage alcohol, drinking outside of the program, and non-beverage alcohol. Administered alcohol broke down further into two categories: (a) changes in biopsychosocial and spiritual health and (b) goal of reducing amount of alcohol consumption. Within Relationship with Environment, subthemes of emotional, physical, and social environment were used. The subtheme of emotional environment had feelings of being a drinker, while the subtheme of physical environment had several specific categories of relationship with MAP program,

relationship with MAP rules, relationship with shelters, and relationship with the street.

Relationship with MAP program was further broken into perceptions of benefits of MAP program. Relationship with Others included subcategories reflective of relationships with family, fellow MAP residents, health care, MAP staff, people who refer client to MAP, police or jail, self, street friends, and the public.

3.5 Program Descriptions

Program descriptions were obtained from the CMAPS and are used to describe each MAP. The CMAPS comprised of six sites in five cities: Vancouver, Ottawa (The Oaks and Wet), Hamilton, Thunder Bay, and Toronto. Station Street MAP in Vancouver began their program in 2011 because a not-for-profit agency, Portland Hotel Society, identified a need to house individuals who would be suitable for a MAP. The other MAP sites, all located in Ontario cities, have been in place for longer periods, with Ottawa The Oaks and Ottawa Wet both starting in 2001, Hamilton starting in 2005, and Thunder Bay opening its doors in 2012 (Canadian Institute for Substance Use Research, 2014). However, it was Seaton House in Toronto that unofficially began the first MAP in 1997. Because my analysis focused on the transition period of the first six months into MAP, only five of the six sites in five cities of the CMAPS were used for my study. This is because of the 57 interviews from the six sites, one site, Station Street in Vancouver, had no residents who were newly into MAP, defined as within the first six months of transition into MAP. The sources of data for my analysis are outlined in detail, providing further information of the five MAP sites, including origin, administered alcohol, program goals, and available services for residents (CMAPS, 2016).

3.5.1 Ottawa, The Oaks

In Ottawa, The Oaks program, run by Inner City Health, Shepherds of Good Hope, commenced in 2001 and moved into a new location in 2009. Approximately 45 spaces accommodate individuals suitable for MAP. Food is provided in what is referred to as nursing home-style programming. Wine in three varying strengths is provided or an individual's own alcohol is administered hourly from 7:30 am to 9:30 pm daily. The first pour is seven ounces, while subsequent pours are typically five ounces. There is also a stabilization program offered for people coming from Wet program before going to The Oaks. The Oaks does have a policy where drinking outside of the program is "discouraged." The Oaks have individuals set their own goals and offer mental health services and tobacco harm reduction.

3.5.2 Ottawa, Shepherds of Good Hope

The Inner-City Health, Shepherds of Good Hope also operate the Ottawa Wet Program. This program also started in 2001 due to community concerns about a high-risk group of individuals experiencing homelessness, while also living with severe substance dependence and poor health. The Wet Program differs from The Oaks, in that it is shelter based with 12 beds and is intended to stabilise alcohol consumption. Food is provided as part of the shelter structure. Alcohol administration is consistent with The Oaks, except a nurse determines individual schedules based on levels of inebriation. Drinking off site is also discouraged, but not forbidden. Participants are assessed for access to administered alcohol and may not be served, depending on their outside drinking consumption. The Wet program allows for individuals to set their own goals and like The Oaks offers mental health services and tobacco harm reduction.

3.5.3 Hamilton

In Hamilton, the Wesley Urban Ministries operate a 20-24 bed program that commenced in 2005. Hamilton also responded to a need for services that could support an extremely vulnerable population. Food is provided as part of residential housing. White wine, beer, or sherry is administered from 7:00 am to 10:00 pm daily, with every hour subject to individual discussions regarding varying amounts of alcohol served to each client. The first pour of the day is eight ounces, while the remaining pours throughout the day are five ounces. Drinking offsite is not allowed. Residents agree to no outside drinking prior to admission. Hamilton is focused on reducing the harms related to beverage and non-beverage alcohol consumption and has an overarching program goal that endeavours to secure MAP residents adequate and affordable housing. Other health services provided at Hamilton are unclear, but there is a focus on providing harm reduction through the provision of residential supports.

3.5.4 Toronto, Seaton House

At Seaton House in Toronto, MAP operates out of a 24-hour shelter in place since 1997. Up to 114 men are enrolled in the men only MAP program at any given time. Meals are provided to residents. White wine, U-Brew, or own alcohol is administered from 8:30 am to 11:30 pm or 12:00 am daily. Seaton pours are every 90 minutes, whereas the five other sites where interview data had been collected administer pours every 60 minutes. Drinking off site is overlooked; however, residents must be onsite 60 minutes prior to their next pour. Each pour is administered at a fixed time. Seaton House works to move people who experience frequent homelessness situated into the community and offer case management to residents.

3.5.5 Thunder Bay

The 15-bed program serves men and women who have severe alcohol dependence who have also been living outside or in shelters. Food at the Kwae Kii Win Centre is provided from Shelter House. Like Seaton House, alcohol is administered every 90 minutes, from 8:00 am to 11:00 pm. Each drink poured is generally white wine and is six ounces. Their first pour of the day is not the largest, as is part of the program in other MAPs. Money management, primary care, drumming, counseling, and life skills training are available. Drinking off site is discouraged, but not forbidden. Residents also need to be on site 90 minutes prior to being offered their next scheduled pour. Thunder Bay has an overarching program goal that endeavours to secure MAP residents adequate and affordable housing. Services provided at Kwae Kii Win are primary care and community supports, connecting to outreach, and training for life skills and work experience for clients when available.

3.6 Rigour

Qualitative research criteria for rigour are unlike that of quantitative rigour. However, ensuring any research is meticulously undertaken is of shared priority in both qualitative and quantitative research. Historically, qualitative-focused research has faced challenges in academic settings; primarily, the nature of how the data can be attained, collected, interpreted, presented, and replicated is different than that of quantitative research. Various well-established models have been developed to ensure rigour. Given my study was qualitative in nature, aligning with qualitative approaches to rigour made the most sense. Guba's Model of Trustworthiness of Qualitative Research, arguably the first fully conceptualised model for qualitative research, was identified as of value to this research (Krefting, 1991). According to Lincoln and Guba (1985), the four criteria for trustworthy research are credibility, dependability, confirmability, and

transferability. Guba's original model criteria were truth value, applicability, consistency, and neutrality. This was then updated and is now Lincoln and Guba's (1985) framework, with the four cornerstones of trustworthiness adapted to best inform qualitative research to this day. These criteria are widely used and respected amongst research scientists (Polit & Beck, 2008). Later, Lincoln and Guba added a fifth criterion of authenticity (Polit & Beck, 2008). I aligned my qualitative research practices with Lincoln and Guba's (1985, 1994) quality framework in an effort to meet requirements of rigour.

First, credibility was defined as having confidence in the researcher and confidence in the research design, in the participants, and in the context on which the research is gathered (Polit & Beck, 2008). In order to enhance my study's creditability, elements of confidence in the researcher and the research design, strategies I employed included persistent and prolonged engagement with the data in order to develop my own observations. I also used verbatim transcription of interview data collected as part of the CMAPS (Canadian Institute for Substance Use Research, n.d.), undertook documentation of quality enhancement efforts through development of early potential framework documents, and used a data filing organization system within the NVivo software program.

Second, dependability is defined as reliability (Polit & Beck, 2008). Credibility and reliability are dependent on one another, in that the researcher cannot use one and not the other (Polit & Beck, 2008). Essentially, the context of this criterion is the ability to replicate the findings with similar participants. My strategies to ensure dependability were to ensure careful documentation of all my interactions with the data through the development of an audit trail that allowed for iterative review of the steps I took as a researcher. My study incorporated the use of an audit trail to develop "an explicit reasoning pathway along which another researcher could

reasonably follow” (Thorne, 2008, p. 225). Throughout my study and to continually and comprehensively record my information, I employed a thorough audit trail to document and record, as objectively as possible, the emerging findings and subsequent themes that arose from the interview data. I used NVivo for coding to enhance dependability and developed a coding framework that was systematically applied and revised as new information was generated.

As well, with my academic supervisor, I reviewed transcripts during the process of developing my coding framework. While an audit trail is essential in keeping record of how results of analysis are arrived at, Morse (2002) noted that the use of an audit trail does not necessarily measure quality or the reasoning regarding how the researcher arrived at decisions. Thus, its purpose must be limited to a strategy to record comprehensive information. However, a decision trail contributes to rigour and trustworthiness, as it is the “documentation of the analytic choices made throughout the research” (Polit & Beck, 2008, p. 498). The decision trail is a bit different from the audit trail, in that it requires careful documentation of all produced interactions with the data, whereas an audit trail is used to document what was done and the decisions made throughout the analytic process. Both of these processes contribute to rigour.

Third, confirmability is defined as objectivity with the data (Polit & Beck, 2008). In qualitative analysis, removing bias is not the point; rather in order to meet confirmability, interpretation of the data requires neutrality versus personal predispositions. Confirmability in qualitative research should be comparable to objectivity. However, the researcher must also convey when personal interpretations have been applied (Shenton, 2004). Ultimately, “preliminary theories . . . not born out by the data should also be discussed. Much of the content . . . may be derived from the ongoing ‘reflective commentary’” (Shenton, 2004, p. 72). Favourably, interpretive description, my method of analysis, is consistent with the concept of

confirmability, as it allows for the inclusion of acknowledged personal insights that then inform the overall analysis (Morse, 2002). Confirmability does not set out to remove subjectivity, but rather meets reflexivity and verification processes in the context of integrity (Morse, 2002).

The last criterion, transferability, is more suited to qualitative research and “meets this criterion when the findings fit into contexts outside the study situation that are determined by the degree of similarity or goodness of fit between the two contexts” (Krefting, 1990, p. 216). This is consistent with my study because Lincoln and Guba (as cited in Krefting, 1991, p. 216) said that the responsibility is not the original researcher’s, but instead that transferability is more the responsibility of the person “wanting to transfer the findings to another situation or population than that of the researcher of the original study.” Strategies employed to ensure transferability included rich and thorough documentation complete with in-depth description as well as the completion of comprehensive notes as part of my research development.

An overarching characteristic of rigour is reflexivity. This was met in my analysis through the ongoing and constant process of self-reflection and application of checking myself and through discussion with my supervisor regarding any preconceptions I may have harboured. Through this process, I became aware of my own preferences for a “story” that wanted to fulfill my own personal biases. In fact, it was through a process of reflexivity that I was able to have the voices of participants rise from the data. I remained reflexive while themes and patterns emerged freely.

3.7 Ethics

This research adhered to the ethics guidelines of the University of Victoria (2018). The Research Ethics Board of the University of Victoria received and approved an application for *Managed Alcohol Programs: Implementation and Effectiveness* (See Appendix B). Reference to

potential future uses of the data, including secondary analyses of the collected data, were included within the application. I submitted an amendment of the original application for my research for the secondary use of qualitative data derived from client interview responses from six MAP sites in five Canadian cities studied as part of the CMAPS research (Canadian Institute for Substance Use Research, 2014). Access to the data was made available from the University of Victoria Research and Ethics Board, who approved the submission for amendment to CMAPS (Canadian Institute for Substance Use Research, 2014). CMAPS had University of Victoria Research and Ethics Board approval as well as approval from each of the seven sites. Research participants interview responses were made available for secondary use of the CMAPS qualitative data. Participants had already consented to participate or had participated in the CMAPS through a study consent form and had provided ethical approval for secondary analysis. The seventh site came later in the study and is not included in the 22 client interviews used for my analysis. It is important to state that no data analyses were undertaken by this researcher until approval was obtained from the principal investigator. With this permission, I submitted an amendment to the University of Victoria Research and Ethics Board.

3.8 Benefits and Limitations of the Research

I have reviewed and contributed to the current research base through my study. I set out to not only disseminate research findings, but to also better understand if MAP clients' perceptions of MAP implementation can be used to not only generate recommendations for MAP implementation, but could also promote system and structural change. I am interested in eventually adding MAP programs to current harm reduction intervention policy and services and integrating MAP into larger organisational systems.

3.8.1 Benefits

I see this study as essential work that will contribute to the research based on clients' perspectives of MAP programs. Participants personal experiences, opinions, and thoughts discussed with the original researchers (CMAPS) in the client interviews resonated in the completed interviews and could be initially perceived as a limitation of this study, as I did not have firsthand experience with the participants. However, the *distance* enabled a detached stance that supported the overall analytic process. Using data from a secondary source for purposes of this research was an early decision and within my control as a researcher. In the end, it was appropriate to use this data for a secondary purpose, given the observed distance needed to be as objective and yet able to interpret the data to generate new insights into MAP implementation.

3.8.2 Limitations

Qualitative in nature and with 22 participants from CMAPS (Canadian Institute for Substance Use Research) research providing a moderate sample size, analysing all 57 could have generated more themes and/or provided increased support for not only the themes that arose, but also rationale for health organizations to add MAPs to their programming. Importantly, but potentially a limitation, these data were restricted to the early transition time of the first six months into MAP and use of data previously collected. Related to this, another limitation of this research was not adding more research subquestions initially. This decision was made in order to focus more on MAP programs being promoted as a harm reduction health intervention in addition to current medically focused abstinence-based substance use treatment programming. Lastly, 22 participants were a reasonable sample size for qualitative research of this timeframe. The purpose of qualitative research is not to generalize, but rather to gain insights into experiences to enhance understanding of MAP implementation.

3.9 Chapter Summary

In this chapter, I have thoroughly outlined the methodological approach as well as the acknowledgment of efforts throughout the study to ensure research processes by the researcher were continuously reflexive. The benefits and limitations of my study were also noted and are further explored in chapter five, the discussion and conclusion portions of my thesis. In chapter four, the results section, I set out to articulate the findings in consideration and alignment with an interpretive description methodological approach, with particular attention paid to a relational theory perspective. Principally, because of interpretive description, voices of the MAP participants can indeed be heard and, in fact, largely comprise the results.

Chapter Four: Results

My central research question in this study was: *What are MAP clients' perspectives of MAP during the early period of transition into MAP?* Specifically, what are participants saying about how they are relationally situated in the world before and after entry into MAP? In particular: *“How are MAP participants situated in the world? What are their experiences? What are the relational shifts that occur during early transition into MAP?”* I analysed 22 client interviews of participants who were enrolled in a MAP and met the criteria of being in the program in the initial six months. These interviews were from five CMAPS sites: Thunder Bay, Ottawa Wet, Ottawa Oaks, Toronto, and Hamilton. No residents in the Vancouver MAP met the criteria for this study. My focus of interest was MAP participants relational views of the world during the early transition period into MAP.

In chapter three, I outlined my methodological approach (i.e., interpretive description within a constructivist worldview) and described my process of analysis. I started by looking at the data piece by piece, sorted these into patterns to identify broad themes and generalities, and then inductively analysed the data within those patterns. To interpret my findings, I used a relational theory framework to gain insight into MAP participants relationship with alcohol, the environment, themselves, and with others.

Four distinct themes arose from the analysis capturing the relational shifts experienced by participants during the first six months as they transitioned onto MAP: (a) changing from drinking non-beverage alcohol to beverage alcohol, with shifts away from non-beverage alcohol; (b) drinking outside to outside drinking while on the program; (c) insecurity to stability; and (d) self-introspection in relation to themselves and society. Each theme is presented through a relational lens to expand understanding of the relational shifts experienced by participants.

Taking a relational approach highlights the transformational, environmental, personal, and introspective changes that occurred for participants during the first six months of transitioning onto MAP. Insights into participants world views can provide deeper understandings of MAP implementation and potential strategies to enhance implementation.

4.1 Changing from Drinking Non-Beverage Alcohol to Beverage Alcohol

The theme of changing from drinking non-beverage alcohol to drinking beverage alcohol highlights the relational shifts that occurred for participants as they transitioned onto MAP. This section is organized into four subsections that describe this transition: (a) I gotta get it into me to more controlled drinking, (b) shift from non-beverage alcohol to beverage alcohol and influences on basic needs, (c) shift from alcohol controlling me to I am controlling me and (d) shift in awareness: I am controlling me. The concept of alcohol as a basic need is used to illustrate the shifting relationship participants experienced as they went from uncontrolled drinking on the street to controlled drinking with new insights and awareness into their drinking once in a MAP.

On the street, alcohol was seemingly a basic necessity of survival. When thinking of the necessities of life, one can think of the basic tools of survival such as food, shelter, and water. Prior to MAP, participants described alcohol as an additional basic necessity, seemingly more central to survival than food, shelter, or water, especially when these necessities were unavailable as was often the case on the street. Additionally, participants relationships with alcohol on the street prior to MAP influenced self-perception of control with alcohol. Specifically, participants perceptions of control once in MAP influenced how alcohol was viewed. Importantly, MAP participants highlighted that their drinking was impacted by experiences of staying in shelters, living on the street, and poverty.

4.1.1 I Gotta get it into me to more controlled drinking

Before MAP and administered alcohol, participants described their drinking as being out of control. One participant described this as, *“because when you're drunk all of the time, you don't realize how you're behaving. Like you're right out of control: you have no self-respect or self-care anymore. You lose it all”* (FR3011). Participants indicated that prior to entering MAP, access to and drinking alcohol was the most important relationship in participants lives. Participants prioritized alcohol over other relationships, including relationships to their physical environments and relationships with others. No matter what type of alcohol was consumed, be it beverage or non-beverage alcohol, participants shared their perceptions that alcohol was a primary focus of their lives: *“Like, imagine literally, you're in the back of an alley freaking crying or passed out and you're doing it constantly and you can't stop even when you're dying”* (R3015). Not being able to stop even though it was detrimental to continue could be an example of how alcohol was prioritised while on the street, but also was a sign of Alcohol Use Disorder, especially: *“I sleep two weeks outside. Outside, the park, sleep. Drink, I sleep, drink, I sleep”* (R6001). For participants, if there was available alcohol on the street, it seemed to be consumed with no control. This meant amount, duration of consumption, or even type of alcohol consumed, perhaps contributing to participants inferring their drinking was uncontrolled: *“I ended up drinking, drinking, drinking; ended up [hospital name], in the hospital for ninety days and then ended up here”* (R6004). Throughout my analytic process, what became evident to me was the sheer dominance of alcohol in participants lives. In fact, severe alcohol dependence made it even more difficult to control drinking on the street because the very act of drinking was paramount and above all else.

However, once in a MAP, there was a clear contrast between life on the street prior to

MAP and feelings about the street. As one former resident noted: *“It’s tough. I’ve been on the streets for 30 years. . . As soon as I walked out of the [MAP] building, and the panic started, you now??”* (FR3018). As this participant illustrated, leaving a MAP site meant moving into street mode:

I’ve got to turn on street mode. Which is survival. You know? Like I said, I’ve been living on the street for so long, it’s so second nature to me to be able to turn on and off, right. (FR3018)

Pre MAP, one participant indicated the difficulty of street life: *“Like, you know, because, street life is not a- it’s not a walk in the park. I give my- I give my hat to these guys, so many people, how they survive”* (R3007). Participants recall of street mode included stories of uncontrolled cycles of drinking while reflecting on the struggles of being on the street, which seemed to be factors that influenced uncontrolled drinking: *“Out there, there’s so many, so many variables that you can get caught up in and booze is a really vicious, vicious drug”* (R3007). Another participant referred to dying from lack of control and drinking prior to MAP: *“I think [MAP] is for the worst of the worst that have the impulse and control problems that are dying in the alleys”* (R3015). This view spoke to the potential for death, in that the inability to control drinking made death a reality.

The nuanced shift in perception from uncontrolled street drinking to controlled drinking in MAP was expressed on practical and introspective levels by many participants. Participants referred to the role MAP played in the shift to managed drinking, as described by one participant: *“Well, it’s given me a chance to re-evaluate myself and to look at things, like, differently, which is important when you’re coming out- when you’re coming out of street mentality, you know, you’re walking out a lonely line”* (R3007).

For many participants, a shift to consumption of alcohol in a more controlled manner came with an awareness of uncontrolled drinking prior to MAP:

So, it's not like I'm chomping at the bit to get out and get a bottle in my pocket or anything. It's curbed the- not the desire; the desire is always going to be there. But it's curbed the . . . the antsy, just, got to get out and do it. Right? (R3005)

This participant was able to delay his drinking while also being self-reflective and able to see his/her former drinking differently. Indeed, this participant's relationship to drinking alcohol was viewed in a changed way.

4.1.2 My body starts crying for alcohol; shift to basic needs being met

Findings in the context of physical dependence and administration of alcohol transformed participants experiences, which allowed for a shift to meet basic needs. These were found to be meaningful discoveries for the majority of participants. Described in this subsection are the shifts and changes in physical dependence experienced by participants once in MAP in contrast to life prior to MAP.

Participants described experiencing withdrawal symptoms such as nausea, seizures, shakiness, and sweating that decrease or stop once alcohol is consumed. Administered alcohol is described as beverage-based alcohol, usually wine or beer, generally consisting of hourly pours, with most sites making the first pour of the day larger. There was overall appreciation of the larger first pour in MAP because of the physical benefit to participants. Participants were able to receive enough alcohol to ward off worry about getting sick and to avoid physical withdrawal through accessible, safe, and consistently offered beverage-based alcohol:

The first pour in the morning is a good pour. It's up to about here, and after that, a little bit less, but it still takes—well it takes the edge off, and that's . . . by saying the edge, I mean the shakes. Yeah. (R4004)

Another participant described not having alcohol in the morning: “*My body starts crying for alcohol. Like it needs the alcohol*” (R5002). Another participant described the physical dependence from alcohol withdrawal:

It's not that I want to get drunk; it's just, it's my body. Like I've been drinking since I was 17. Like, my—it's like my body needs the alcohol, so, it's not to—so I can get drunk every day; it's just to keep my body level. (R5002)

Consumption of alcohol was no longer about euphoria; rather, it was about acquiring a basic necessity to combat the physical dependence all participants experienced.

The shift that occurred while on MAP was that all participants no longer felt as physically sick as they did prior to MAP. Participants were aware of how dire their physical health was prior to MAP and in MAP; they were able to have access to food, gain weight, and feel physically stronger. This change in participants environment allowed for insight into their decreasing withdrawal symptoms. One participant described the shift away from physical dependence as: “*For someone whose actually sick all the time, especially from alcohol, I would say this here's actually a . . . like a . . . a savior. Because it kind of brings you off slowly instead of like cold turkey, so you won't be so sick*” (R5003). Participants were starting to see they had control over their drinking once physical dependence was assuaged.

Another aspect prior to MAP was the aspect of meeting other basic needs such as eating and suitable shelter. However, once in MAP, participants conveyed an ability to shift their attention to meeting basic needs such as eating occurred. As one participant stated, “*I got my*

appetite back since I've been here, which I didn't have out there. I could hardly even eat"

(R3014). Whether unable to eat because of street life, eating in MAP met an otherwise mostly unmet basic need prior to MAP. Moreover, participants appreciated MAP not only because of the access to alcohol, but also for the shift in being able to have consistent access to food and shelter,

Actually, . . . it's curbing some bad habits. Like, first thing in the morning, reaching for a drink. Instead I'm going to the fridge and making a sandwich, having a coffee . . . I haven't woken up with one single hangover since I've been here. (R3005)

So, instead of starting with drinking to survive the day, this participant described having access to food and resources that help to shift drinking patterns:

But I put on about twenty-five pounds, which is good. I got my appetite back since I've been here. Which I didn't have out there. I could hardly even eat. So it's . . . it's improved my eating, here. I can taste the food now, where I wasn't tasting it out there, (R3014)

Being able to have food on a regular schedule reinforced that participants were not eating very often prior to MAP. Additionally, participants were also able to alter patterns of drinking because they had access to food and resources that supported shifts in drinking patterns.

Another interesting shift was how most felt about independence and hope prior to MAP, and as one participant reflected on fellow participants:

These guys, I it wasn't for-they'd be screwed right now because they can't manage their lives: they can't pay their rent, they can't do anything. So that means they would be living on the street with no food, no money, no whatever. (R6004)

The program provided a stable foundation for participants, which then enabled hope for the future. Once in MAP, the future looked differently. According to another participant, *“I’m hoping to get healthier. Hopefully end it with a decent place to live. And control my drinking”* (R3014).

From a relational perspective, it was apparent that many participants, once in MAP, changed their views of alcohol and disrupted their relationship with street drinking to survive in a context of poverty and homelessness. Importantly, MAP allowed for critical reflection on life prior to MAP. A shift to controlled drinking came with a desire to get healthier. MAP met basic needs beyond alcohol such as food and shelter.

4.1.3 Shifting away: I don’t drink hand sanitizer unless i have nothing else

There were additional shifts including a shift away from non-beverage alcohol consumption once in MAP. In this subsection, I describe the inter-related environmental factors, such as poverty, severe alcohol dependence, and street life, that contribute to non-beverage consumption prior to MAP. Furthermore, once in MAP, the availability of beverage alcohol contributed to personal insights and changes in consumption of non-beverage alcohol. This change also illuminated an increased personal awareness by participants of the reasons for their non-beverage consumption.

Prior to MAP, poverty and severe alcohol dependence were two of the factors that perpetuated non-beverage consumption by participants. These findings suggest that living on the street strongly influenced non-beverage consumption. However, the perception of and need for non-beverage alcohol shifted once in MAP. If alcohol was a basic necessity for physical survival, it became clear in this analysis that once in a MAP, with food and shelter provided in addition to beverage alcohol, participants experienced a reduced need to drink non-beverage. As one

participant revealed, there was a lack of desire to consume Listerine or rub again: *“It keeps me good; like, I don’t drink that other stuff”* (R1002). Access to beverage alcohol seemed to curb the need for non-beverage.

Participants highlighted the reasons for drinking non-beverage outside of MAP, including a lack of money: *“I don’t drink hand sanitizer unless I have nothing else, and no money”* (FR3011). Another participant echoed how poverty influenced alcohol consumption: *“At Dollarama, it’s only a dollar thirteen for a bottle. It’s a dollar thirteen. It’s enough to make a person drunk for a day, and I would have four or five bottles”* (R4004). From these and other participants it became clear that (a) poverty was linked to drinking non-beverage alcohol; (b) non-beverage was consumed to meet alcohol dependence; and (c) if no beverage alcohol or money were available, prior to MAP, drinking regardless of type of alcohol was prioritised above all else. One participant summed this up as:

The reason people drink it is because it’s cheap, and the reason why they’re drinking cheap alcohol is because they’re getting robbed every fucking month when they’re on the street because they’re alcoholics. (R6004)

The general perception that arose from this participant and the majority of participants, was that non-beverage alcohol consumption was an effective way to obtain high concentration alcohol fast and cheaply. When coping with environmental factors and living on the street, one MAP participant stated,

I probably would’ve drank myself to death because I started getting into the rubbing alcohol and everything. Now I’m not into that anymore. I was used to rubbing alcohol, was just a lot stronger, like 99%. That’ll kill you. (R5003)

Often, blackouts were inevitable, which, as one participant explained, after non-beverage consumption blackouts were part of life pre-MAP: *“I’m usually just told the next day, “You did this, you did that, you passed out, your eyes were rolling back, you were incoherent, you were being loud, you were being obnoxious”, I don’t even remember anything”* (R3015). Another participant also referred to blackouts due to non-beverage consumption: *“This stuff was all up at 60 and 70%. So black outs were just unbelievable”* (R3007).

Additional, compounding factors that contribute to non-beverage consumption prior to MAP included a culture of non-beverage alcohol as an activity undertaken amongst only those on the street: *“These guys are just rub—Well, they see someone starting that, they’re instantly into it themselves, and their health problems have just gotten worse, and they’re going to get worse, much worse”* (R6001). Another participant reflected on what he perceived: *“These guys are just rub-well, they see someone starting that, they’re instantly into it themselves”* (R6004). This perception illustrated how it was conceivable to see how the culture of street life could also influence the perpetuation of non-beverage consumption. With MAP, exposures to the environmental factors that contribute to non-beverage alcohol shifted along with a new awareness. Living on the street led to non-beverage consumption for one participant who was apprehensive about MAP because of life pre-MAP. For this participant, there was a changed awareness due to MAP:

It was iffy because coming off the street and doing this—drinking the stuff that I was drinking, like hand sanitizer, pure . . . pure ethyl alcohol . . . Because, the stuff that I was drinking will kill you. Literally kill you, but you know, it’s where the alcohol part comes in. (R3007)

MAP could be viewed as a catalyst for participants shifting relationship with non-beverage alcohol, insomuch that MAP enabled the shift away from participants non-beverage consumption. As one relayed: *“Well I’m not out there drinking Listerine, dying for 14 days sitting there shaking like a leaf, freaking sweating . . . like I’m sitting here, I’m healthy, my brain’s functioning to a degree”* (R3015). This shift was fundamental because when participants were able to view their non-beverage consumption differently, indeed within a different environment, their perspective of drinking changed: *“I see people improving, but I also see the other side, too. Then I see myself, which I was there. But I see myself getting better”* (R6013). The “other side” being referred to by this participant was how non-beverage alcohol was consumed prior to MAP. When beverage alcohol was provided, one participant indicated that it would *“probably keep a lot of people from going out and drinking the rubbing alcohol, which is going to kill them”* (R6007).

The relationship with non-beverage shifted when the environment changed from drinking on the street to drinking inside. More precisely, participants were highlighting that non-beverage alcohol was largely no longer consumed once in a MAP.

4.1.4 Shift in awareness: I am controlling me

With the physical need for alcohol being addressed in MAP, as well as basic needs for food and shelter, participants indicated that they were largely no longer consuming non-beverage alcohol while in MAP. A new awareness was described by many participants in relation to their control over alcohol. This subsection highlights how participants perceived their drinking prior to MAP and once in MAP.

Some participants viewed their former life on the street and their uncontrolled drinking as a cycle that was difficult to get out of. They described MAP as shifting their perspectives as

described when comparing their former life to where they were now: *“Maybe this program will give me a chance to go out and drink-drink a couple of bottles of beer and say, “okay I’m going home” instead of staying there getting drunk”* (R5003). These findings indicate that through a model of administered alcohol, MAP facilitated an awareness and intentional shift towards controlled drinking. One participant described how MAP provided a means to reflect, *“I would say if you want to control your drinking . . . lay off the drinking, slow down, this is a good place to come to”* (R3015). As suggested earlier in the findings, it could be inferred that even though MAP participants world views still centred around alcohol, it was *how* they chose to relate to alcohol that shifted. One participant was able to see life in a different way while in MAP, *“I’m learning there is life without alcohol”* (R3012). MAP afforded a shift in how alcohol and thus life was perceived by this participant. One former resident reflected on his drinking prior to MAP and the influence of MAP to control drinking:

Its all, you know, the ungodly race like: “I gotta get it into me. I gotta get that buzz happening.” Whoa! This is one of the reasons I went there, to stop this, and now, in essence, I’m stopping it by myself. (FR3018)

Noteworthy here was that with MAP, there was a shift in how this individual applied self-control. He still drank alcohol, but in a more controlled manner and with an awareness that prior to MAP was seemingly not present. MAP enabled this shift with a stable access to alcohol, and this, in turn, seemed to influence feelings of control. Another participant indicated the shift from pre-MAP while in MAP: *“I’m starting to realize that I don’t want to drink. More focused. Realizing that I got a general dislike for getting inebriated; I don’t have to have much of a desire to get inebriated”* (R3015). This participant went on further to say, *“I’m able to look at things, and even though I can see that it’s either logical or illogical, I’m frustrated, or upset. I’m not*

running back out and freaking, just being like ‘Screw it’” (R3015). This participant, like others, highlighted that in MAP, was able to look at things, recognize emotions, and not freak out. Most commonly in such scenarios on the street, individuals would likely have turned to alcohol to cope.

Additionally, one participant was able to indicate the difference in realities of the street to life in MAP: *“The transition part’s the hardest. Because you’re taking one world. You’re going from one world into a new world. It was there before you started drinking, you started drinking, you lost it. Now you’re finding it again”* (R3007). This participant stated, *“Because I’m getting back to being normal again. I don’t need that crutch”* (R3007). This same participant described how alcohol was controlling him and relayed feelings of incongruence between his physical and mental self:

You know, because your mind is saying, you know like “Maybe you should take it easy and only have a couple of drinks” and then your body is saying “Bullshit, go for it” Booze just . . . to hell with you and that’s just the way it is. It’s my way or the highway, but when you’re straight, it’s a whole different world. (R3007)

Overall, participants provided insights into how being on MAP was an opportunity to regain a sense of self of who they are and who they were before their lives became that of drinking while on the street. Another participant saw himself prior to MAP and reflected: *“The way I talk before, before I was meaning dirty bad words to friends, to the people, but, it wasn’t all my fault right, because [of the] the liquor”* (R3001). Specifically, reflection may not have occurred if not for the shift to managed alcohol and, thus, in participants relationships with alcohol itself. For example: *“Because whereas before, we would go out, and we’d just drink, and drink, and drink,*

and drink, and drink, but now we get a certain amount each time, which I find is very helpful. I like it” (R5003).

Likewise, there was insight and hope as a result of managing alcohol consumption. In the case of one participant, it seemed hope was felt:

Because right now, I’m on a high right now because I’m feeling so good about what’s happening, and maybe that’s just me, but there’s a couple of other guys that feel the same way too. It’s like: “Wow, this is like pretty good.” (R3005)

What is very interesting is the connection between MAP and some participants new ways of seeing themselves in the world. As one participant illustrated:

Now self-control is starting to happen and I feel secure. . . . Well, it’s a way up, and it’s a way out. A way up, and you can look at things differently. You can open your eyes and actually see, you know, things around you. Things that mean something to you . . . things that used to mean something that you forgot about. (FR3018)

The shift in awareness allowed for focus on other areas, such as looking towards the future and stabilizing their physical and mental health. This was exemplified in an interview conversation between a CMAPS researcher and one participant:

I: So you’re starting to see the joy in life?

P: Uh huh.

I: You have hope now.

P: Yeah. And I’m really striving to get housing now. Yeah.

I: changes in terms of your mental health?

P: Yeah. Yeah, I’m doing better. Better than I have been. (FR3011)

Many participants described benefits from this new way of drinking, demonstrating that MAP supported a change in how many participants related to alcohol. This ability to have introspection about consumption may speak to the shifts in perceptions that participants were feeling due to more controlled drinking in MAP.

Also interesting was that with MAP came ready access to alcohol, and this, in turn, seemed to enable participants to stop and consider why they drank, why they prioritised drinking, and for the first time, possibly had a way to drink better. An example of how managed alcohol allowed for other perceptions to arise was shared by one former resident participant: *“I like who I am now, but don’t like when I’m in . . . like I’m out here getting fucking drunk every day and . . . I don’t even shower for two days at a time”* (FR3013).

In MAP, there seemed to be a renewed ability to consider the consequences of drinking. Another participant revealed, *“[Drinking is] self-inflicted, so nobody to blame but myself. . . It means settling my act, . . . and it’s already working”* (R4004). This indicated both insight into how drinking was prior to MAP once in MAP, but also may speak to the influence of the early transition period of zero to six months. Several participants indicated appreciation for the changes that occurred almost immediately upon joining MAP. One expressed her/his perspective on first coming onto MAP: *“Yeah. And like I say, it’s only been two weeks. But it feels like it’s been a good two weeks. Yeah. So it’s . . . your physical health has improved, you’ve gained some weight”* (R3005). These observations suggest that the transition period onto MAP was a factor in this participant’s feelings of appreciation. This participant was noticing changes that were seemingly perceived as positive.

4.2 Drinking Outside to Outside Drinking While in the Program

The theme of drinking outside to outside drinking is presented in this section. Reasons for outside drinking while in MAP and the subsequent shift participants experienced is used to illustrate how participants shift their relationships with alcohol once in MAP. Interwoven throughout the findings was the perception of outside drinking being permissible, despite program rules clearly indicating otherwise. Outside drinking is captured as alcohol consumption in addition to administered alcohol in MAP. The findings are organized according to the reasons participants chose to drink in addition to MAP drinks: (a) dissatisfaction and satisfaction participants had with administered alcohol such as type, amounts, and times alcohol were served; (b) perceptions of program rules; and (c) the shifting social relationships of participants and their relationship with money and money management.

4.2.1 Dissatisfaction/satisfaction with administered alcohol

In many instances, participants expressed dissatisfaction with the timing of alcohol administration as well as dissatisfaction with strength and amount of alcohol served as factors resulting in participants drinking in addition to MAP. This subsection is organized to emphasize these practical factors and the perceptions of program rules by participants that contributed to outside drinking.

Administered alcohol was supposed to provide residents with exactly what they required: regular access to and administration of alcohol. Instances of how this affected MAP participants and their perceptions of this varied across the sites. Times when alcohol was administered was a key aspect for one participant: *“No, I think people are, will often go outside and drink. Because it’s too long of a period. I’d like the wine program to start earlier”* (R6013). Whether it was program rules of administered alcohol every 60 minutes: *“I enjoy the wine per hour”* (R4004),

or every 90 minutes: *“Like, yeah, people get a glass of wine every hour and a half”* (R6004), or if it started too late: *“I’d like the wine program to start earlier”* (R6013), times of administered alcohol had an influence on all participants and was a risk factor for outside drinking according to one participant’s perception of the wait being too long: *“Why don’t you put it back to every hour like it used to be? Probably keep a lot of people from going out”* (R6007). Dissatisfaction with times of pours influenced outside drinking as perceived by this participant.

For others, the strength of the administered alcohol was less than they desired: *“Because this water, it’s nothing for me. I go outside and drink”* (R6001). Another participant from the same site indicated that staff members were watering down the beverage alcohol: *“A lot of times I think they—we see them take the jug of water in there, and they take—they put the water in with the wine”* (R6002). The strength of the program alcohol also seemed to influence choices in alcohol type, and in one instance, a participant explained his perception of why some drank in addition to MAP: *“I think some of them just want a little extra kick, but other individuals take it too far”* (R6004). One participant reflected his opinion when stating, *“But a lot of others, they don’t feel that they get enough here”* (R5004). Another participant observed, *“They are trying to get these guys to get in, not go out for drink. That’s why they have this program, but that is not enough for that guys because they are the alcoholic. It’s nothing”* (R2014).

Conversely, there were many participants who were satisfied with administered alcohol, with one former resident stating, *“One glass an hour and I maintained that way, because you know what, that’s all they give you, right. And that’s your main maintenance. And it was a good thing”* (FR3013). Another participant indicated satisfaction when referring to a basic need for alcohol: *“You don’t get enough alcohol here to get you smashed, but you get enough alcohol here to take the edge off which helps”* (R4004). Yet another participant referred to his/her

satisfaction in keeping them away from non-beverage alcohol: *“And then, finally, when they feed me that alcohol, it helps me. Then I feel a lot better, so that puts a smile on my face”* (R5002).

Overall, administered alcohol seemed to influence participants satisfaction and dissatisfaction with program implementation of alcohol. These differences in perception of the strength of alcohol highlight the need for individual assessments related to strength and dosing of alcohol.

4.2.2 Perceptions of program rules

A compelling feature was the link between outside drinking while in the program and the perception of rules. Rules in all five MAP sites within this study were such that no drinking was permitted outside of the program. Outside drinking was experienced by all MAP participants when first introduced to MAP. The rules of no outside drinking impacted one participant: *That’s what happened, that’s why I got kicked out the first time, when I came back sob- drunk. Make stricter rule, maybe make stricter rules”* (R1002). This participant went on further to say that the risk of being kicked out of the program was too great, yet still this participant chose to drink outside despite being unable to return to MAP: *“That’s why I don’t come home when I’m, when I’m intoxicated”* (R1002). Interestingly, participants thought rules of no outside drinking while on the program were not only largely overlooked by themselves, but also by MAP staff. As an interviewer probed:

I: You signed an agreement that you can’t drink outside the program?

R: Everybody has to sign one. You can’t drink outside of the program, but yet you see everyday people coming in clearly intoxicated and nothing’s being done about it.

(R3015)

This closer look at the rules of outside drinking at one MAP site highlighted general insights for improvements in implementation, such as prioritizing clients’ perceptions to individualize

administered alcohol. While individually tailored administered alcohol is important, so too is operating MAPs with an intention to also reduce alcohol-related harms.

The participants who chose not to drink in addition to MAP seemingly did not want to jeopardize access to their managed alcohol. This, in itself, is a huge shift in thinking when it comes to uncontrolled drinking prior to MAP and participants insights while in MAP. Overall, once in the program, many saw administered alcohol as a preferred alternative to drinking outside, as summarized by one participant: *“I think because they know we need it, or whatever. Because if they didn’t give us wine, a lot of people would be outside drinking, coming in drunk”* (R6002).

Further, I discovered the motives to drink outside of the program were complex, in that some participants desired to be outside to experience the feeling of relative freedom. An example of the complexity was that some felt pressured: *“I know way too many people in this city, and they see me being healthy, and it’s like: ‘Oh, you’re looking good, c’mon, you can have a beer with us’”* (R3007), while others desired the freedom to be themselves with others: *“And it’s more of a social event, not to go out and get drunk, but while you’re there, you’re just drinking sociably, right, and that’s pretty much it”* (R5004). A new relationship with drinking seemingly included practicing appropriate social drinking outside of the program, which was in direct violation of program rules. Yet this unintended practice by participants resulted in profound shifts that had participants finding different ways to drink sociably.

4.2.3 Go out to Don Cherry’s Bar

In this subsection, in the context of outside drinking, I take a closer look at participants shifted relationships with money and how money influenced social connections. I look at the relationships participants had with money prior to MAP and how, in MAP, money was used in

social connections with friends and social drinking outside of the program. Also presented in this subsection are findings on how money management in MAP seemed to foster a new appreciation of money. Though consumption of alcohol was still seen as *the* priority above all else, there was still a shift in how participants viewed money because of money management and, in particular, how this shift sometimes influenced social connections.

Prior to MAP, all participants of this study were unable to save the little money they may have had. Little or no money was a common factor in participants street environment pre-MAP. One participant explained his/her relationship with money prior to MAP: “*There’s been times when I’ve been broke and I’ve been panhandling, because you need that almighty goddamn drink*” (R3007). Factors of street drinking included lack of money and hustling for enough money to get the next drink; the social connotation pre-MAP was perhaps not the priority.

An unexpected and interesting finding was the perceptions participants had regarding the shifts in connecting with others and the role money played in that shift. As one participant elucidated how he drank before and while in MAP:

If I got a hundred bucks in my pocket, I’d go out by myself and get drunk. Now I’d rather have a buddy of mine come with me, I’ll buy him a beer and vice versa if he had the money, and then we can sit and chat and watch a hockey game or . . . so on and so forth. (R5004)

MAP influenced a shift in how participants wanted to engage socially with others. In fact, managed alcohol likely facilitated social drinking in addition to MAP.

Spending on additional alcohol was common among participants, as indicated by one MAP participant’s observations: “*They go outside; they’re going to go buy liquor*” (R3001). Again, it was the “social event” together with money that some enjoyed:

I've done it a couple times, and I'll tell you what they do. Like when I've had money, say, I'd go out to Don Cherry's bar with a couple guys. They get their cheques same 28th of the month when I get mine. We'll sit there and drink three or four pitchers of beer watching the hockey game. (R5004)

This MAP participant felt that going outside while in the program was about drinking socially and seemed to drink outside not to be alone, like some, but rather to be part of something that was happening, like watching a hockey game. The ability to focus on other “normal” experiences, such as connecting with people and spending money seemingly responsibly, promoted the desire for social connection. In response to drinking outside, one participant stated, *“To see other friends. Because they pan, our other friends may pan as well”* (R3015).

Money management influenced participants ability to drink in addition to MAP. All but one of the 22 MAP participants indicated they had little or no money and primarily relied on social assistance. A portion of their money went towards implementation of MAP through a monthly payment received from individuals in the program. Money left over seemed to last longer when managed by staff. Participants defined money management as either MAP staff or a designated caseworker holding onto MAP participants money and providing an allowance or money upon request by a MAP participant: *“Here their money's managed, they're safe, you know what I mean?”* (R6003). Many were challenged with trying to save money while living on so little, and some were challenged by the cost of MAP. Yet, many MAP participants seemed to want to save their money: *“About \$250 a month I can save. That's to take care of myself while I'm here for anything external like cigarettes or whatever basic needs”* (R3015). Money management was appreciated by participants, in that MAP implementation included support and safety around their own money. One participant indicated appreciation:

That's the good thing about this program. It prevents that, because they manage our funds. They got too disheartened by people stealing their money every five minutes. Here their monies' managed, they're safe, you know what I mean? As safe as you can expect to be on this street, which is good. There's nowhere else for anyone to go, so it really helps.

(R6004)

This shift in views of how it feels to have money could be related to MAP affording a new perspective, in that alcohol was now provided. Moreover, it could be interpreted that MAP fostered a new awareness of money and a desire to keep money for not only alcohol, but also to connect socially with others. Money management contributed to some participants commitment to save money in MAP. Thus, participants could afford to drink in addition to MAP. What is known from the findings was MAP residents' habits with money changed (they were able to save), and outside drinking occurred while in the program: *"When they have the chance to go out, they'll go out, and if they have money on them, every time it's money, everybody's coming back drunk"* (R3015). Even with money management, all participants primary relationship still was alcohol; however, the ability to save money was the notable shift.

In yet other instances, some were reticent to drink in addition to MAP. This seemed to be associated with a perception of a lack of control: *"Because I know if I get a drink when I'm outside, I'll just . . . keep on drinking"* (R3005) or not wanting to jeopardize access to their managed alcohol: *"Like you go out if you want but you miss a wine shot"* (R1002). Generally, participants were present so as to not miss their pours, and in the case of one participant, still surprised that alcohol was administered: *"'You get a drink every hour?' I say, 'Yeah, every hour, you get in the line, and you get a drink of wine, five ounces, and that's cool'"* (R5004). One participant seemed to possibly have enough alcohol with MAP: *"Well yeah, big time, and I*

stopped drinking outside” (R3016). Even though all participants indicated they had drunk in addition to MAP, many of the same participants also said they reduced their overall consumption. Overall, once in the program, many saw administered alcohol as an alternative to drinking outside, as summarized by one participant: *“I think because they know we need it, or whatever. Because if they didn’t give us wine, a lot of people would be outside drinking, coming in drunk”* (R6002).

4.3 Insecurity to Stability: From Out There to I Feel Safe Here, Yeah

The theme of insecurity to stability is presented in the context of “out there,” a reference made by almost all participants to life on the street prior to MAP. This theme is organized to illustrate the relational shifts that occurred for participants, who prior to administered alcohol, food, and shelter found in MAP, may not have had personal stability or stable family connections nor feelings of security and safety prior to MAP. Life prior to MAP was dominated by insecurity that came with the street. In the first section, I will highlight the changes participants felt as they went from insecurity on the street to security when in MAP and how these changes influenced connections with others and shifted thinking about how to work with MAP. In two subsections, I will present these findings further to first describe the shifting relationships participants felt with others and then to illustrate the new way of thinking many participants experienced once in MAP.

The general sense of insecurity combined with uncontrolled drinking prior to MAP, while also facing the realities of the dangers that come with street life, perpetuated an unsafe feeling. Prior to MAP, many participants felt insecure in the outside world, perhaps because of the lack of safety. One participant’s perception of life pre-MAP was quite clear: *“It’s safer for me in here than out there”* (R3005). One former resident indicated his feelings when he left MAP: *“I was*

scared. Back on the street again” (FR3018). Another resident referred to out there in the context of uncontrolled drinking and an unsafe inference: *“You know, out there, I go drinking straight. Plan to get up, and one car hit me, or somebody stealing whatever I have”* (R3001). Another participant described pre-MAP as monstrous: *“Because it’s . . . it can be a real bugger out there. It’s . . . it’s not- it’s not kind, it has no feelings. And it’ll- it’ll attack”* (R3007). Feelings of insecurity when “out there” made participants perceptions of the shift to experiencing stability and safety that much more apparent.

With MAP, participants moved from a life of instability to feeling stability. One participant indicated just that: *“Before, I’d be climbing the walls to get it, but now I’m finding that I’m in here and I’m safe, I’m secure”* (R3007) and in MAP seemed to experience a relational shift in how he/she viewed the world: *“I feel safe here, yeah”* (R5004). Another participant acknowledged the importance of security at a deeper level now as a participant in MAP: *“Security’s a big thing. If you’re not secure with yourself, you’re a mess”* (R3007). Participants also felt improvements in their general health once no longer living on the streets: *“Oh yeah. My breathing became easier. There was no anxiety. The anxiety part was the killer, ‘cause I panic, eh, I start to panic”* (FR 3018). Prior to MAP, participants felt the environment of street life included insecurity and lack of safety, but MAP changed their relationships to the environment and, thus, their perceptions of safety. Stability also meant being able to safely sleep. One participant described MAP as: *“Oh, what is the word I am looking for? Comfort isn’t the proper word. There’s a safety involved though. Like, there’s . . . I feel safe, but not hiding away safe”* (R3005). Although almost all felt generally and personally safe within a MAP program, there was one instance where a fellow resident described feeling unsafe, *“There was one client*

living in there, and he was being a bully, so I felt very unsafe” (R5003). However, this was an exception.

Overall, MAP was valued by residents for its sense of security: *“It’s given me a warm place over my head. Like a warm place to stay and a roof over my head. There’s food in my stomach, should I feel hungry”* (R3015). This inferred a potential shift towards feelings of stability, in that MAP removes instability. Specifically, MAP indirectly encouraged stability in how participants not only felt themselves, but also in how they saw their world. This suggests MAP influenced how people felt about their safety and stability. The security of having scheduled, administered alcohol meant they could shift their focus from the need to hustle or panhandle for their next drink: *“Stability, really. Not flying by the seat of my pants working for my next drink or . . . because I did a lot of hustling”* (R3005). Perhaps linked to satisfaction in terms of a new environment with MAP were participants being able to physically remain in the MAP setting. They were not kicked out as they would be if they were in a shelter setting: *“The good thing about this place, you’re not kicked out at seven o’clock in the morning”* (R6004). Having the ability to stay sheltered influenced shifting feelings of security.

Additionally, in terms of feelings of trust while in MAP, many participants felt more secure in sharing what they felt with MAP staff versus with fellow residents: *“You can’t really open yourself up too much. . . You do not know what you are going to walk into. So the only people you can actually open up to about any feelings you got is the staff”* (R5003). Another aspect of trust that led to feeling secure in a MAP was that staff members were available around the clock. As described by one participant:

Knowing you’re safe; knowing if you don’t want a drink you don’t have to; knowing if you can drink, will drink. They’re there twenty-four seven like we said, especially in the

middle of the night when I can't sleep, because when I can't sleep I get extremely tired and then I don't function the next day. (R3012)

Implementation of a MAP staffing model that included 24-hour staff availability seemed to contribute to MAP participants overall security and fostered trusted relationships between MAP staff and MAP residents. As well, participants identified MAP staff as helpful when it came to making sure MAP residents were on their medication: *“That's why they only give you like five or seven ounces every hour because a lot of medication, with respect to depression and anxiety, don't mix well with alcohol”* (R5004). Staff also helped MAP residents make it to their appointments, which prior to MAP was less likely: *“The staff are going to ensure that you're going to make all of your appointments, your doctors, so on, and so forth. You just let them know what's going on, and they'll make sure you attend all of these”* (R5004). MAP participants garnered support from staff: *“But the thing is, with being here and talking to the staff here, they're showing us ways to balance things out, to work them out”* (R3007). This new shift to trust the help given by staff was appreciated by MAP participants, and as one participant relayed:

That's the thing that I like about the staff. Like if they see something going on, and you're not following the rules and regulations of the community and this and that, they'll take you aside and have a chat with you about it, which I like. (R5004)

There may have also been a sense of security and stability through previous relationships that transitioned from the street to MAP: *“Keeps my focus happening, and I kind of enjoy the people. I know everyone here. I've known everyone here for years, from the streets. You know?”* (FR3018). There may have been some trust in some of the friendships developed while on the street. With the help of MAP, previous relationships some participants had with their fellow residents may have contributed towards a further shift towards stability and trust.

4.3.1 A shift in connection with others

A shift in connection with others while in MAP occurred for most MAP participants. There were different ways relationships with family and friends were experienced prior to MAP and once in MAP. Participants defined connection as connection with friends, family, and others. This also included connections made with fellow participants inside MAP. Also described in this subsection are participants perceptions of connections that ranged from damaged relationships, to no change in relationships, to improved connections with others. Findings of connections experienced with fellow MAP participants are also presented.

Many participants indicated they had burned their familial bridges because of their drinking, and because of this, there seemed to be little or no change in family contact and support and prior to the stability of MAP. This was exemplified by one former resident participant as: *“I don’t even have a family anymore. They don’t want me. They don’t understand me. They don’t understand that my drinking was not me”* (FR3011). Several more participants indicated their family ties were either broken or damaged. A participant mentioned how perceptions of his connections with family were that of being irrevocably damaged: *“So I absolutely have no family support. I messaged my dad, and haven’t talked to him in over a year. He hasn’t messaged me back”* (R3015). Another participant referenced his connections as likely broken: *“Before, I was sober. I was getting myself better, then everyone disappeared. Things fell apart”* (R4014). Overall, life prior to MAP, with the cycle of uncontrolled drinking all participants experienced, likely influenced how connections were either unchanged, broken, or maintained.

This was poignant to me because many MAP participants articulated that actions and consequences of drinking were separate from the individual’s true self. With another participant, a lack of insight may have been exposed: *“I having no real, real problem with my wife, right.*

Only problem is because I drink” (R3001). Others felt that family support simply expired: *“Before, I was sober. I was getting myself better; then everyone just disappeared. Things fell apart. My mom just stopped calling, my uncle got mad. . . . It’s just been crazy”* (R3015). In the case of one former resident, when asked if any relationships had changed, his response was: *“No, not really. I’ve lost a lot of friends but . . . I buried five this year”* (FR3018).

In the case of many participants, and even though some experienced no real change in their family dynamics, there were several instances of positive family experiences for MAP participants or where MAP facilitated their reaching out to family. In the case of one participant: *“I know he loves me. I love my son. He’s happy that I am here, so I’m happy that he’s happy”* (R4004). MAP influenced participants shifts in wanting to engage with others, and when asked if MAP helped in making connections, one participant indicated he was reaching out: *“Yeah, I’ve called my uncle, phoned all my aunts and cousins”* (R1002). There also seemed to be more consistent contact made on behalf of MAP participants to family:

Mom and dad will always be mom and dad. I love them. . . . My sisters, I’ve called them, and they’re very supportive; my son and daughter, I don’t know. I can’t find their number, but I know they’ll reconnect with me. (R3012)

Whether this was an improvement or whether MAP influenced consistent connection, the findings suggest shifting views when participants became more connected generally. Participants were learning to be and wanting to be with others and reconnect in MAP: *“I’ve kind of re-established relationships from my past”* (R3015). In the case of one former resident, it was the chance to connect and socialize that had him coming into MAP even though he was no longer part of the program: *This is where my friends come, this is where my social life- you know, I’ve only got a few friends, and they come here. And that’s why I come, in order to socialize”*

(FR3011). MAP in its capacity of providing security enabled this participant a means to stay reconnected.

Material resources such as a computer and phone made connection with family and friends generally easier in MAP: *“I have easier access being here because we have computers available and my kids are online, Facebook”* (R5004). Some MAP participants were able to reach out to friends and family unlike ever before through social media such as Facebook. Furthermore, there were several instances where MAP improved reconnection with family. As one former resident participant indicated: *“Yeah, my mother is talking to me again, My cousins are talking to me again. They wanted me to stay in the program”* (FR3013). Also, there were those who felt that others would be pleased to know they are in a safe and supported environment: *“[Name]’s especially going to be shocked that I’m in a program for four months already, but it’s a good shock”* (R3012). A shift in relationships with others was influenced by MAP, in that it seemed family also had opportunity to be hopeful.

Regarding fellow MAP residents, a common history prior to MAP may have influenced connection while in MAP: *“We’re seeing each other for what we really are, not from what we saw before. Before it was just a drunken haze, but now, we’re actually saying, ‘Hey, whoa, you do have a brain’”* (R3007). This relational shift was evident in the renewed ways of how participants were seeing with each other. In the instance of one participant’s views of his fellow residents, it was connection with others who were also in the program that helped:

Support thing is really important, to have somebody going through the same thing as you’re going through, maybe you’re not seeing what’s happening. And he will see it. And he will pick up on it, or maybe I’ll do the same. (R3007)

In this case, perhaps connection was seen as camaraderie or a sense of community. Specifically, in MAP, there was a shift to support each other: *“We’re all suffering from the same problem, and we all help each other”* (R3007). This sense of being positively connected in MAP was further indicated by yet another participant: *“The people-the people who reside here, they’re almost all close friends, which I appreciate that they’re friends”* (R4004). However, life in MAP wasn’t always about positive connection, as one participant commented:

Like if somebody doesn’t like [what] I’m doing . . . even though it’s not stupid . . . and they start throwing an argument at me, then sure enough I will argue back, but the thing is I try not to put up a fight. (R5002)

As is the case in most shared residences, an expectation of some disagreements was reasonable. Generally, MAP influenced how participants perceived themselves and others in MAP, with one participant summarizing this as: *“Because they’re just like me. There’s nobody better or worse. We’re all even. We just-came in here because we got a problem”* (R5003). The shift to acceptance and a shared history may have influenced the majority of participants ability to connect and to get along with their fellow residents

Although there was little evidence in the findings that suggested MAP participants could have perceived family reconnection as a structured part of MAP programming, it was clear to me that for all, relationships with others in general and with fellow residents in MAP had shifted. In the case of many of the participants, technology and access to material resources were found to be tools that influenced connection. Importantly, the findings also suggested that no participants experienced nor reported worse or worsening relationships once in MAP.

4.3.2 Shift to a new way of thinking: Work the program

Relational shifts occurred for many participants in how they viewed themselves in relation to the program. Some participants did not use MAP to meet their personal goals and ‘work the program’, while others did use MAP in this way. Though, all participants of this study were satisfied with MAP. This subsection is organized to illustrate how some participants either: did not or did express formal goals; how some participants identified goals as part of working the program and, how informal goals in MAP may have influenced participants shifts in views of their drinking.

Many participants still recognized that alcohol was their primary relationship and a basic necessity and, therefore required for daily survival, as illustrated by one participant: *“I still get anxious. Like I look at the clock a lot waiting for the next pour, I’m not going to lie, I do”* (R5003). The purpose of MAP for this individual was more related to getting through the day versus using the program to set formal goals. Within MAP, some participants were able to recognize their life pre-MAP was not sustainable: *“I needed a rest. And I was just getting worse out there. Not sure of myself”* (R3014). The findings suggested that without MAP, a shift in perspective in how to view life pre-MAP may not have occurred. Some participants were able to seemingly await their administered alcohol as indicated by one participant: *“Having the one drink an hour is satiating any cravings and helping me without my benzos”* (R3015). Informal goal setting was not indicated. However; the structure of the program was seemingly working for this participant. While others could see their shifting relationship with alcohol and were able to informally reduce their consumption in MAP: *“I can see it helping me. I can see it cutting me down and realizing I don’t need to drink as much as I can* (R3014). However, as part of the changing relationship with alcohol some participants expressed in the early transition into MAP,

some participants were influenced by fellow participants. When asked if MAP was working, one participant remarked: *I just- seeing other people who, hate to say, but they're in a worst situation. They're falling all over the place*” (R6013). Some participants acknowledged their informal goals of reducing their alcohol intake: *“I was drinking too much beer before. Now, every one hour, sometime I don't feel, I don't take”* (R3001). In this sense, some participants focused on the program to work for them and did not also seek outside alcohol, and in one instance, even changed their drinking altogether: *“I've skipped a couple of beers, and felt alright doing it”* (R3005).

Working the program meant using the structure of MAP to get better, establish and meet goals and to accomplish tasks otherwise not addressed because prior to MAP, protecting oneself on the street was important: *“When we're bombed and loaded, we all got shields of armour, you know? We just put that mentality on: ‘You can't hurt me, I'm invincible.’* (R3007). Though, once in MAP there was a shift in perspective, the same participant indicated that there was an ability to open up: *“but when you drop that, now you're a baby again”* (R3007). One participant stated, *“I'm going to work the program. And the program's going to work for me. I feel I need it because it's a good program. It's like . . . it helps me maintain, and I like, and I need maintenance”* (FR3013). For this participant, the structure of MAP meant that the participant was able to use MAP to potentially identify sustained ways to reduce harms related to alcohol.

Several participants who chose to focus on the program realized a remarkable shift from how they drank prior to MAP. They used MAP as a means to look at things differently and, in essence, to interrupt the cycle of how they drank outside prior to MAP. One participant stated, *“Get my head together first, and then I'll deal with the outside situations after. . . Why go out there . . . and come back here stumbling drunk? You're defeating your own purpose”* (R3007). In

this instance MAP was supporting insight into how this person drank. Moreover, some of the participants noted that with MAP they may have lacked some of the additional supports to dig deeper into why they drank:

That's why I'm trying to make it a program for myself. There's no classes, there's nothing being taught or whether it's theory or getting down to the emotional level, there's nothing whatsoever. I mean, you get back out into the street, there's no- you haven't worked on anything of why. Just not working on the reasons of why you're drinking. Now you don't even have any theory. Basic theory. (R3015)

In MAP during the early transition period, there may be opportunity to support some participants in a more tailored ways and provide means to support individual participants in identifying and setting personal goals while in the program.

Others, however, were less prescriptive about goal setting and instead relied on their MAP program to replace the need to drink outside of the program. One participant described what he hoped to get out of MAP:

A place to build a foundation, get out there, practice getting in and out and not letting the impulses and compulsions take control; building a foundation, regaining possessions, saving money, keeping in contract with my . . . my accountability network, my social network, and my . . . resources and . . . eventually transitioning out of here. (R3015)

With MAP, this participant and others felt that they were given an opportunity to start over and get their lives potentially on track. As one participant stated, *"They're giving me opportunities, options, that's what it is. You can sit there and make a choice. It's not just one choice, you have choices. . . We're all getting better"* (R3007). When in MAP, and as noted earlier in these

findings, there was a new relationship with alcohol that seemed to contribute to thinking beyond alcohol. Some participants found this as a space to reflect while also looking forward:

So you're—now you're clearing up your mind. You're evaluating the situations, and instead of acting . . . instantly acting, you think, "Engage brain before opening mouth." Like, "Am I going to say something that's going to hurt somebody? Then better not say it at all," but that's when you start thinking to yourself, like, okay, "Why am I thinking this way?" So you're self-evaluating yourself all of the time. (R3007)

Another factor that supported a notable number of participants goal setting was the value many placed on having connections with fellow residents, as described in subsection 4.3.1 and here in the context of the program itself, one participant stated:

Most of the guys are great, go sit down, have a game of chess, or a game of checkers, a game of crib, cards, seven card rummy. And we entertain ourselves and kind of . . . go with the managed alcohol program. (R3005)

The findings suggested MAP enabled goal setting and connection that went beyond alcohol inasmuch support of fellow residents was found to be helpful in working towards new goals.

4.4 Self-Introspection in Relation to Society

This theme introduces and describes participants views of their relationships to society and how participants view MAP as a unique program and how the program is a way to help participants try different things. This theme is presented in two subsections; one subsection will illustrate society's labelling of individuals with severe alcohol dependence. The second subsection will capture participants views of MAP as a program designed to fit their unique needs. Implications for MAP implementation are meaningful in terms of how to assist future

MAP clients in their transition into MAP. Importantly, participants insights can help to break down the stigmatizing labels society uses to identify people with severe alcohol dependence.

4.4.1 Because I'm an alcoholic, right?

The majority of MAP participants referred to themselves as 'alcoholics' or as having alcoholism. In this analysis, when participants used 'alcoholic' to describe themselves, it was not clear if this was associated with feelings of unworthiness: *"Like I said, I'm an alcoholic, and its kind of ironic, making the change to come in here because I'd be at the LCBO at ten o'clock"* (R5004) or if it was something intrinsically tied to self-identity, the findings were unclear. What emerged from the findings for me was a general acceptance by MAP participants and an understanding that when describing themselves as alcoholic, participants were also explaining the reasons behind why they drank and using a label often applied to them by society. Specifically, many MAP participants self-identified as alcoholic when they referred to their drinking. WHO initially defined alcoholism as a chronic or acute disease that has become unmanageable: "alcoholism, characterized by the individual's loss of control over drinking and thus over his or her life, was a "sickness" [and] was carried into the scholarly literature in the 1950s in the form of the disease concept of alcoholism." (Edwards et al., 1995, p.25). The term alcoholism has since been recognized as a socially constructed label. Perceptions that repeatedly emerged in the analysis were the ways in which MAP participants used the term "alcoholic" and how they felt prior to MAP. Alcoholism and alcoholic were defined by MAP participants in relation to how they saw their and others' alcohol consumption. For example, at one site, a resident observed, *"Like, you can—alcoholism—there's people that can drink, and there's people that shouldn't drink"* (R3007). Reference to alcoholism in the findings seemed to be a commonly known term to describe uncontrolled drinking prior to MAP. As one described the

way he drank prior to MAP: *“I’d get probably a quart of vodka or a pint of vodka, and I’d drink that in 20 minutes, and then go back and get another one”* (R5004). Feelings of understanding were felt by some participants that program-administered alcohol was available. As one MAP participant put it: *“because I’m an alcoholic, and they give you drinks of wine here. That’s why it’s called a MAP program”* (R5004).

As I analysed the words of the participants, it also seemed that these terms were also culturally identifiable, accepted and reinforced by society. Interestingly, use of alcoholic and alcoholism seemed to be associated with society’s use of labelling and meaning. Specifically, using these terms was a clear instance of how participants associated with the outside world relative to alcohol and their drinking. In the case of one participant: *“I didn’t want to drink, but I did. A lot of times, I did the whole duration, right, because I’m an alcoholic right, but anyway, yeah, yeah”* (FR3013). The term alcoholic was used in this instance as an explanation for why this person drank. The findings suggested participants perceived their street life as seen and thus stigmatized by society: *“But it’s hard sometimes because some people, when you ask for change, they like walk by, ‘Get a job pal.’ No, whatever, they say stuff like that”* (R5002). This, in turn, internalized stigma which led to feelings of unworthiness.

The majority of participants expressed shame and a lack of worthiness generally, in their life on the street prior to MAP: *“I’m outside, and I’m like I’m on the street pan-handling, begging people for money, and that don’t make you feel good, right”* (FR3013). Prior to MAP, public intoxication was a regular occurrence for participants, who were also homeless, making their experiences even that much more cause for internalization of shame, as one participant’s explained his life prior to MAP:

all drunk up and not remembering where you were and blah blah blah way you're not just getting shitfaced and passing out and thinking "Where the frig was I last night" or getting thrown out of the drunk tank at five in the morning. (R5004)

Feelings of shame was further conveyed by one participant who reflected when asked how they felt about being in MAP: *"Safe from me. Because I hated me. I still struggle with that. Because when I am here [MAP], I get this stigma in my head that I am still sick"* (R3012). Emotionally a lack of feeling worthy is connected to experiences of self-stigma furthered by the notion relayed by this same participant of *"existing and not living"* as society's stigma was a common perception held by many participants. Another example of feelings of unworthiness are the perceptions of who they were pre-MAP, relayed by one participant: *"Stop being an-like, you're an animal. You become an animal"* (R3007). In MAP, because of the shift in drinking, there was opportunity to see themselves in a new way and to potentially interrupt the feelings of internalized stigma.

4.4.2 I find the program is unique

Overall, across all sites analysed within this study, MAP participants felt MAP programs were unique and MAP participants showed their awe when being introduced to a program such as MAP. Considered a unique or novel program, MAP participants were amazed by the formation of and being offered to participate in a MAP; this inferred MAP participants did not have initial awareness of a program that administered alcohol. Many described not being offered this type of programming prior to entering a MAP. One MAP participant reflected on not having been in a MAP before:

Being her[e] with the managed alcohol program, you know you're getting a drink every hour, you're not getting slopped and sloshed, and you're not getting thrown in jail. . . I

find the program is unique for me, because I've never really been in a program where they give alcohol every hour, right. (R5004)

Having a program that understands an individual's need to drink was found to be an essential component of MAP for many participants. One participant indicated his/her satisfaction with managed drinking: *"Actually, I really like it because we're controlled. We can't go overboard or anything else. [We are] simply controlled"* (R5003). A former resident participant indicated MAP meant to them more than control: *"I think it is to give hope; and to teach . . . peoples that, who have a drinking problem, get them sobered up a bit, to see how they are when they're sober"* (FR3011). For others, it was shifting ways to drink and increasing awareness of moderate drinking, in comparison to prior to MAP as one participant noted: *"teaching us to drink in moderation, say, one an hour, is better than having four an hour"* (R6007). MAP was a program that seemingly met participants where they were at while also influencing feelings of hopefulness.

Potentially related to MAP as a unique program, some MAP participants seemed to prefer MAP over traditional abstinence-based treatment such as detox, with some feeling MAP was more appropriate for them: *"This is the first time I've ever sought any help for alcohol whatsoever"* (R3005). Another participant indicated that detox was not suitable: *"Um because you wanna drink, like I tell my, I tell my PO too, 'I don't wanna go to treatment, I'm gonna end up drinking anyways, it's not gonna stop me from drinking'"* (R1002). Another participant felt otherwise and indicated detox had its purpose: *"Detox is . . . when you're so sick that . . . you know, you've lost—you've lost about everything you've got, so you know it's time, you need a safe place to be . . . to . . . to get healthy again, to—No, to feel again!"* (R3007). When considering MAP as a unique program, there seemed to be a link between MAP as a unique

program and feeling safe: *“I’m here because I’m keeping myself safe”* (R3015). This seemed to illustrate that without a unique program such as MAP, there could be individuals who remained unsafe and, thus, who remained at risk.

4.5 Chapter Summary

In this chapter, I outlined the results of a secondary analysis of interviews with 22 MAP clients who were in the early transition period into MAP. I applied interpretive description underpinned by a relational theory framework. Through this approach, the research addressed the experiences and perceptions of MAP participants against the backdrop of a relational theory perspective. Specifically, participants relational shifts in not only their relationship with alcohol, but also with their environment, themselves, and others were highlighted in this chapter. Shifts in how participants related to alcohol created global relational shifts for many participants. Moreover, MAP participants insights provided exciting new ways to inform MAP implementation. Alcohol and access to alcohol *shifted* once in a MAP program, with participants experiencing new relationships with alcohol, non-beverage consumption, connection with others, and the program itself. The approach of a relational framework allowed for deeper analysis of the general themes that emerged. Discussion of these results in contrast with the literature will be provided in chapter five. The recommendations and conclusion will also be provided in chapter five.

Chapter Five: Discussion

I used interpretive description to analyse 22 MAP participants interviews collected as part of the CMAPS. I drew on relational theory to gain insight into MAP participants world views. How participants related to alcohol, their environment, themselves, and others changed with entry into a MAP. Relational theory draws out a shift in individuals' relationships with alcohol, with MAP, and with all aspects of their physical and emotional environments. This distinction became evident when analysing participants lives before a MAP and their lives during MAP. Within this study, the principal salient finding was that drinking alcohol informed all aspects of their lives, including perceptions of MAP implementation, such as when alcohol was served, what type of alcohol, and how much influenced participant perceptions of MAP. MAP also influenced participants feelings of connection with others, motivation, and stability and allowed for introspection into why alcohol was paramount in their lives. In this section, I will discuss the findings in relation to the literature and to generate recommendations for MAP implementation from participants perspectives.

These findings highlight participants perceptions and world views about aspects of their physical and emotional environments pre-MAP and the shifts once in MAP. Specifically, the findings show a shift in patterns of and attitudes towards alcohol consumption during early transition into MAP. Shifting relationships with alcohol are central to the four key areas I will explore in the discussion: (a) participants changing perspectives of drinking non-beverage alcohol when beverage alcohol available in MAP, (b) participants motivation to change and the insights they had into their own drinking, (c) MAP implementation and reasons for drinking outside of MAP, and (d) MAP's influence on insights and connections with others.

5.1 Participants Changing Perspectives of Non-Beverage Alcohol Once in MAP

The findings suggest that participants had insights into how non-beverage alcohol consumption was influenced once in MAP. In particular, participants experienced a shift in their relationship towards non-beverage alcohol because of their entry into MAP. Prior to MAP, participants consumed non-beverage alcohol because of poverty and homelessness, with non-beverage being a cheaper alternative. Illicit alcohol consumption is “rooted in complex and often structurally violent processes of colonisation, economic processes of capitalism and policies of exclusion that are often visible in the process of trauma, poverty and stress” (Pauly et al., 2018, p. 1).

Individuals who meet the criteria for MAPs generally have long histories of alcohol dependence, ongoing and frequent experiences of homelessness, and a history of hospital encounters and police interactions in part due to alcohol use, with research suggesting that MAP positively impacts the outcomes of each criterion (Pauly et al., 2103; Pauly et al., 2017; Pauly et al., 2018; Stockwell et al., 2016; Stockwell et al., 2018; Vallance et al., 2016). Findings of this study indicate that once in MAP, participants no longer sought out or purchased non-beverage alcohol, thereby greatly reducing or eliminating its consumption once in MAP.

The findings indicated participants were also aware of their non-beverage consumption prior to MAP, thus further suggesting the availability of administered alcohol provided an opportunity to reflect on previous non-beverage and beverage alcohol consumption. Relative to patterns of non-beverage consumption, this is not a surprising finding and is similar to research conducted by Pauly et al. (2017), in that when offered MAP-administered beverage alcohol, consumption of non-beverage alcohol decreased.

However, what may be unique in the findings of this study are the shifting relationships participants shared with non-beverage alcohol. In MAP, participants are provided with accommodation, food, and other supports, including beverage alcohol. Participants are not in a set of circumstances where they are forced to drink non-beverage alcohol because it is cheap and high strength and can help them to cope. The findings of this analysis suggest MAP, with these structures in place, allows for a change in perspective. For all 22 participants, their primary relationship with alcohol remained but there were shifts in this relationship. Participants highlighted that the shift in their relationship with alcohol. Specifically, shifts away from non-beverage alcohol because of the availability of beverage alcohol. The findings further suggest another aspect of the shift was participants personal realization that non-beverage consumption was harmful to their health.

Stockwell et al. (2018) studied participants changing patterns of alcohol consumption once in MAP in comparison to consumption prior to MAP. Stockwell et al. (2018) showed a reduction in non-beverage alcohol consumption when beverage alcohol in MAP was provided, along with meals, supported housing, and access to direct and indirect health and social supports. However, there was no accompanying personal perspectives of how individuals related to the change in alcohol patterns captured within this study. Vallance et al. (2016) documented whether MAPs changing patterns of drinking influenced reduced related harms. In their research, perceptions of participants are included:

MAP clearly had an impact on participants concept of self as well as their overall health and well-being. Participant reports of making the switch to beverage alcohol and reducing NBA [non-beverage alcohol] consumption as a positive step” yet whether this

research explores if participants experienced a shift in their relationship with alcohol is not known. (p. 9)

The findings of this study contribute to participants understandings of these shifts including connections to feelings of safety (Pauly et al., 2016).

In Pauly et al.'s (2018) study on MAP dimensions and implementation, one of the aims of this research was to increase understanding of MAP's importance in reducing the harms associated with illicit alcohol consumption and homelessness. Pauly et al. illustrated the need to look at MAP as a respectful harm reduction intervention that can help individuals who are experiencing homelessness and severe alcohol dependence. Their research found that MAP consists of more than alcohol administration and includes components of housing, primary care, food, and social and cultural supports as key aspects of MAP programs. It would be an oversight not to also include well-documented research on Housing First models, whereby non-beverage alcohol consumption is also reduced as a result of provision of housing. However, what is unique in the finding of the in Collins et al. (2102), study is that it provides insights into how these shifts are experienced by participants.

Additionally, the findings of my study suggest that while in MAP, it is the shift in relationship and how participants changed their views of non-beverage alcohol that is a powerful factor contributing the reduction in non-beverage consumption. Moreover, data collected indicated it is the personal, individual realization that non-beverage consumption was influenced by experiences of homelessness, severe alcohol dependence, and poverty. Data indicated that participants would largely choose not to consume non-beverage if beverage alcohol, which also likely tasted better, were available. Interestingly, once in MAP, participants hindsight into what

drove their consumption was influenced by the stability and safety felt in MAP in comparison to prior to MAP.

5.2 Participants Motivation to Change and How They Felt About Themselves

In the findings of my analysis, the majority of participants revealed that MAP enabled the perception of controlled drinking in comparison to the uncontrolled drinking they experienced prior to MAP. Moreover, MAP influenced feelings of security and stability with the provision of shelter, food, and regular access to alcohol. Once in MAP, participants also indicated their renewed ability to look at themselves with feelings of hope and gratitude. With the introduction of a changed physical environment within MAP, participants indicated meaningful linking between their motivation to change and how they felt about themselves. In this section, specific findings of participants motivation to change while in MAP are presented as well as the shift in how participants related to their physical and emotional environments in comparison to research to date.

It is well documented that Housing First influences change in alcohol use-related outcomes of those in Housing First who also have alcohol dependence (Collins, Malone, & Larimer, 2012). Housing First, guided by harm reduction principles and philosophy, is an option for those experiencing homelessness and substance use dependence. Significantly, research on Housing First residents and alcohol use outcomes identified: “Behaviour changes are more lasting if it is client-driven and therefore reflects clients’ own motivation to change” (Tsemberis, Gulcur, & Nakae, 2004, p. 654). Collins et al. (2012) defined motivation to change for individuals who are homeless with substance use dependence as their being willing to engage in any behaviour change. Similarly, participants in this study identified that having housing as part of MAP enabled motivation to change. I found that being housed in MAP influenced how MAP

participants viewed themselves and their relationship with alcohol in new ways. Having the opportunity to control and shift their relationship with alcohol while in MAP also highlights that help from MAPs is needed to shift participants perceptions of uncontrolled drinking to feeling like their drinking in a more controlled way.

The findings of this study suggest that when basic needs such as accommodation in a harm reduction setting were provided, there is a motivation for individuals' to shift their relationship with several aspects of their world, including alcohol, family, and friends, and how they perceived themselves. There are many studies on motivation to change and alcohol and Housing First and motivation to change (Collins et al., 2012). There is also a growing body of literature relative to individuals in MAPs who experience quality of life improvements (Pauly et al., 2018; Vallance et al., 2016). Several studies identify quality of life outcomes such as improvements with overall physical health, longer term shelter, decreased hospital visits and police interactions once in MAP (Pauly et al., 2014; Stockwell et al., 2018; Vallance et al., 2016). Specifically, MAP participants consumed less non-beverage alcohol, had fewer police contacts, and fewer withdrawal occurrences than controls (Vallance et al., 2016). However, less is known regarding perspectives of how MAP influences how people see themselves and the shift in world views once their physical environment changes. Participants of the Evans et al. study (2015) identified similar positive changes, where they identified "three inter-linked actor linked networks: togetherness, awareness and self-management" (p. 120). The findings of my analysis are supported by Evans et al.'s (2015) and Collins et al.'s (2012) research of participants changing views of themselves within their MAP experiences. This included the influence of more controlled drinking in MAP on participants motivation to change. The findings of my study add to this knowledge base in relation to MAP and motivation to change.

In general, findings of my analysis of how participants experience changes in motivation as their environments change is consistent with well-documented MAP and Housing First research (Collins et al., 2012; Pauly et al., 2013; Stockwell et al., 2013). However, what may be a unique contribution of this study is the connection between how participants shifted their relationship with alcohol once housing and alcohol needs were met. This allowed for a shift in their ability to want to help themselves.

5.3 Implementation and Reasons for Drinking Outside of MAP

The findings of my analysis indicate that how participants feel about the administration, strength and amount of program alcohol has an impact on their relationship with the program. Specifically, the findings indicated reasons for drinking outside of MAP were influenced by both alcohol administration policies and dosing as well as seeking a different social connection ultimately found outside of MAP. Regardless of environment, be it in MAP or describing their lives prior to MAP, participants primary focus was to consume alcohol. This subsection is organized to describe the similarities and differences with other research to date and to also highlight areas of the findings that are unique to my study.

The MAP participants in my study described how the administration of beverage alcohol influenced their choices regarding drinking outside of the program. Participants indicated it was the strength (too weak), times served and how much served that influenced their choices. MAPs intend to provide the appropriate amount of beverage alcohol. Pauly et al. (2018) identify key dimensions of MAPs which included the provision and administration of alcohol. Their research indicated that eight of the programs generally administered alcohol every 60 to 90 min, approximately 11-12 pours a day.

Wettlaufer et al. (2018) reported that participants of their study identified alcohol as not being strong enough. In the Wettlaufer et al. study, there was inference that if alcohol were stronger, avoiding withdrawal was one of the reasons to drink outside of the program. None of the 22 participants of my study identified avoiding physical withdrawal symptoms as a reason to drink in addition to MAP.

Linked to drinking outside was a general disregard for rules regarding drinking outside of MAP even though all six sites in this study had a rule of no outside drinking while in MAP. Rules around consumption of additional alcohol could result in a consequence of potentially missing out on a pour if too intoxicated (Pauly et al., 2018). Participants of my study reflected they would still drink in addition to MAP, and as a result, sometimes missed a pour. This did not deter most participants from continuing to drink in addition to MAP, insomuch they still often would get the next pour because the rules of outside drinking were not strongly reinforced. In fact, 20 of the 22 participants of this study indicated they drank in addition to MAP.

With consistent access to alcohol in MAP, participants quantity of beverage alcohol consumption increased: “A high frequency of drinking (28/30 days) was maintained at six months among the five MAP participants” (Vallance et al., 2016, p. 6). Participants of my study seemed to appreciate the structure and controlled drinking in MAP and perceived they largely reduced their consumption of alcohol because their relationship with alcohol shifted to more controlled drinking. Generally, the majority of participants shared the reasons for drinking outside the program were because the program alcohol was weak, not administered frequently enough or there was a desire to socialise with alcohol. Socializing with alcohol outside of MAP seemed to be connected with less activities offered in MAP and general boredom. If there were

activities, some participants of this study did not partake as they did not want to risk not being present for the next pour.

5.4 MAPs Influence on Insights and Connection with Others

A significant goal of this research was to better understand whether participants views shifted when their physical and emotional environments changed. Much of the existing research is focused on outcomes of MAPs along with some participants perceptions of quality of life. My analysis set out to examine the influence of MAPs specific to participants perspectives of MAP implementation. In my analysis, which served a different purpose from existing research on MAPs highlighted a level of introspection that was compelling and was maybe even not expected by this researcher. So too were the relational shifts participants experienced regarding connection with others. With MAP, participants gained insight into their own behaviours and this may have influenced connection with others. This subsection is organized to describe the similarities and differences with the research to date and to also highlight areas of the findings that are unique to my analysis. The findings illustrate that MAPs may have a meaningful influence on participants perspectives of how they saw the world in comparison with pre-MAP. Pre-MAP, participants indicated they were primarily focused on acquiring alcohol and surviving the twin harms of homelessness and severe alcohol dependence. Once in a MAP, participants reported a key aspect that fostered reflection was the sense of personal security and stability. Beyond regularly administered alcohol, MAPs provide supported housing and direct and indirect social and health access. In Evans et al.'s research (2015), they propose it is the immediate health and social supports in MAP that provides the perfect environment for change. Similarly, the findings of my study found there was an energy around how participants felt about their relationship with their new environment. These findings are supported by other research where connection with others

and a sense of togetherness are two of the personal changes that occur for people coming from homelessness and into MAP (Evans et al., 2015; Wettluafer et al., 2018). In my findings, many participants reflected on their connection with others and how this was either mostly positive or no real change. Wettluafer et al. (2018) found that “MAP played a role in reducing social isolation, specifically by providing stability in their lives and opportunities to reconnect with families” (p. 7). While stability was identified by some participants of my study as a grounding force that could result in participants wanting to seek connection, stability was mostly associated with how participants were able to shift their views of themselves because they felt secure once in MAP. Interestingly, in my study, many participants previously knew their fellow residents from street and shelter environments, and reflected a sense of community already established. This connection within MAP was perhaps a result not of MAP but because of life pre-MAP, literature to date touches on togetherness but not in the context of renewed connection with street friends (Evans et al., 2015).

5.5 Recommendations

1. Implementation of participant goal setting to shift overall drinking patterns

Several participants identified “work the program” as a means to improve their overall life trajectory. Findings of this study point to a lack of activities that could have been helpful to support the emotional changes many participants experienced. Having a program participant care plan co-created by the participant and MAP health staff in the early transition period onto MAP could support independence or a means to move beyond MAP without repeating a cycle of falling back into uncontrolled drinking. Examples of goals that have been reflected in recent research are reducing non-beverage alcohol consumption, improving well-being and improving relationships with health care providers (Wettlauffer et al., 2018). Recommendations of this study

are consistent with Wettlaufer et al. (2018) and proposed are goals associated with ways to maintain safer, long term drinking, ongoing improved hygiene, obtaining and retaining permanent housing and positive ways of contributing to personal self and society, including the recommendation of choice of abstinence.

2. Review early transition period onto MAP for potential to motivate change

There is something essential for motivation to change that arose in this study in regards to the early transition period of the first six months onto MAP. What makes the first six months a key period where participants experience meaningful behavioural shifts? Is it the combination of participant readiness to shift their behaviours or is it the changed physical environment that creates the necessary emotional shift? More understanding is needed to determine the key elements that comprise participants perceptions of the early transition period of MAP and whether this could be integral to motivation. Studying the early transition period identified that participants were appreciative of the structure and control of MAP. This seemed to influence how participants chose to “work the program”. Creating positive habits and changing drinking patterns in the short and long term are implementation cornerstones of Canadian MAPS. Identifying specific positive implementation aspects such as having staff be encouraging and positively reinforcing controlled drinking within MAP. Building in dedicated time for connections with others including staff, fellow residents, friends and family through structured group times is beneficial to MAP programming. MAP could also contribute to longer-term controlled drinking, improved overall quality of life and would reduce the harms of severe alcohol dependence.

3. Revision of program alcohol administration including type, amount, frequency

Many participants identified that administered alcohol helped them in shifting their thinking about their alcohol consumption and almost all participants were appreciative. However, an equal number of participants were dissatisfied by the strength, times served and quantity of administered doses of program alcohol, often times resulting in drinking in addition to MAP. Recent research reported that participants were not significantly reducing their overall consumption of alcohol while in MAP though the related harms from alcohol use were reduced as were the overall consumption of non-beverage alcohol because the pattern of consumption and setting had changed, independent from volume (Vallance et al., 2016; Wettlaufer et al., 2018; Stockwell et al., 2018). The findings of my analysis identified the majority of participants perceived reduced their non-beverage alcohol consumption while in MAP. Most participants of my analysis reflected on their changed relationship with alcohol, being able to think about other aspects of their world because in MAP, participants were no longer in survival mode. Furthermore, drinking in addition to MAP did not seem to overly impact participants ability to still obtain their next pour. Related to amount of doses, all 22 participants of this study appreciated the larger first pour of the day, all citing that this worked well in offsetting withdrawal symptoms which were more severe upon waking. Providing some larger pours at various times of day may help to keep participants from also drinking outside of the program. Drinking in addition to MAP could be contributing to an overall increase in alcohol consumption which in turn could run an increased risk of chronic diseases. Changing administered alcohol protocols cannot be in done in isolation from also developing ways to develop means to change overall drinking patterns. As in recommendation #1, developing co-created participant plans with goal setting could include how to work with the administered alcohol. Lastly, it could also help

participant's day-to-day if type and strength of administered alcohol were consistent. One approach is to allow participants in any MAP to purchase store bought alcohol and have this as their administered alcohol.

4. Develop outside drinking program in coordination with MAP to support connection

Outside drinking was undertaken by 20 of the 22 participants of this study, indicating that outside drinking was more than just MAP administered alcohol, rather the shifted relationship participants were experiencing with alcohol from uncontrolled drinking prior to MAP to the structure of controlled drinking while in MAP. Controlled drinking in MAP reduced alcohol-related harms for the majority of the participants in my analysis. Participants reflected that going for a few drinks in a pub and connecting socially was something to be enjoyed primarily because the controlled nature of drinking in MAP allowed for the ability to enjoy drinking versus having to seek alcohol to survive. Furthermore, rules associated with drinking in addition to MAP appeared to be largely overlooked. Providing a supervised outside program that could be part of a graduated process where controlled drinking was achieved in phases, with the first phases being to allow supervised drinking outside to connect socially then later phases could provide social connection in settings where alcohol was not included but social connection outside of the program was. How this would work with administered alcohol would be directly related to recommendation #1 where individualised program participant plans would include goals that reduce overall alcohol intake.

Chapter Six: Conclusion

I explored MAP participants views of MAP through a relational lens that allowed for the shift in how participants related to alcohol, their physical and emotional environments, themselves and others to emerge. Those who met the criteria for CMAPS have higher mortality rates with causes of increased mortality correlated with substance misuse, disease, suicide, and unintentional injuries (Fazel et al., 2014). Alcohol use among homeless individuals contributes to a standardized mortality ratio two to five times greater than the age-standardized general population (Fazel et al., 2014). MAPs evidence indicates effectiveness in the areas of reduced police contacts, fewer hospital admissions, and a reduction in non-beverage consumption (Vallance et al., 2016). While evidence of MAPs' effectiveness is increasing, less is known about clients' perceptions of MAPs and their views on the implementation of such programs (Pauly et al., 2016; Vallance et al., 2016). Thus, currently, literature reflects more study is important on MAPs' implementation from the perspective of the individuals who are residents of a MAP program. My study highlighted that participants have valuable insights on MAP during the first six months of transitioning into MAPs. My study aims to contribute further understanding of participants perspectives during the early transition phase, as individuals entering MAPs often have long histories of homelessness and have not been previously stably housed (Pauly et al., 2016).

In the context of my analysis, meaningful findings emerged of participants views of MAP that could serve to better understand MAP implementation from client perspectives. This is important because current MAP implementation does not reflect how to best implement MAPs from MAPs clients' point of view. Using interpretive description and a relational theory perspective allowed for examination of participants relationship with alcohol, their environment,

themselves and others. I used data generated from CMAPS to analyse 22 participant interviews and gathered information about participants perspectives. I analysed the data with an idea towards generating themes. Shifting relationships with alcohol were central to the four key areas of the findings: 1) participants changing perspectives of drinking non-beverage alcohol when beverage alcohol available in MAP, 2) participants motivation to change and the insights they had into their own drinking, 3) MAP implementation and reasons for drinking outside of MAP and, 4) MAPs influence on insights and connections with others. Discussing these four main areas in contrast to the literature to date illuminated the need for a set of recommendations that could help in increasing our knowledge of MAP implementation.

There is a growing body of literature that is emphasizing a closer analyse of MAP clients' views of implementation and how to best inform future MAPs success in helping individuals who meet the criteria for MAP (Vallance et al., 2016, Pauly et al., 2012, 2018; Stockwell et al., 2012; Wettlaufer et al., 2018). Future research could look at client-informed alcohol harm reduction interventions comparing different settings for MAPs. A focus on not just risk reduction of alcohol-related harms but, so too, thoughtful consideration of alcohol harm reduction that focuses on volume and drinking patterns would be beneficial to the harm reduction continuum. For individuals experiencing homelessness and severe alcohol dependence and its inherent associated harms, it is imperative to foster future health harm reduction strategies, policy and practice that aim to improve quality of life and prevent, change drinking patterns and meaningfully interrupt cycles of uncontrolled drinking.

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Appendices

Appendix A: Interview Guide

MAP National Study - Qualitative Questions for MAP Participants Interview Guide

Qualitative Questions for MAP Participants with Greater than 30 days Experience

1. How long have you been in the MAP?
2. Where did you live before you came to the MAP?
3. Tell me about how you came to be in the Managed Alcohol Program at [location]?
4. How would you describe the MAP to someone who did not know about such programs?
5. What changes, if any, have you seen in yourself since coming in the program? These may be positive or negative?
 - a. Have you experienced a change in your housing? What difference has this made?
 - b. Have you experienced a change in your income? How have you handled these?
 - c. How has your drinking changed?
 - d. Have you noticed any changes in your health (either physical, emotional or mental)?
 - e. What about changes in your relationships with others either in the program or outside the program, family, friends?
6. What do you like about the program?
 - a. What works for you?
 - b. What is helpful to you?
7. What do you not like?
 - a. What does not work for?
 - b. What is not helpful?
 - c. Any rules you don't like?
8. Tell me whether or not you feel safe and welcome in the program? Tell me more about that?
9. How does this compare to other programs (e.g. substance use programs detox, treatment) you have participated in?
10. What are some reasons that you might drink outside the program? What are the reasons you think others might drink outside the program?

11. What do you think are some problems in the Managed Alcohol Program?
12. What would you like to change about the program to improve it? Is there anything you do not want to change?
13. What advice would you give to others who are new to the program?
14. What do you hope to get out of this program?
15. Anything else you would like to say about MAP?

Demographic Questions

16. Age: _____(years)
17. Gender:
18. Ethnicity:
19. What is the highest level of education you have completed? (check ONE box only)
 - ☐ No schooling
 - ☐ Some elementary schooling
 - ☐ Completed elementary school
 - ☐ Some high school
 - ☐ Completed high school
 - ☐ Some community college
 - ☐ Some technical school
 - ☐ Completed community college
 - ☐ Completed technical school
 - ☐ Some university
 - ☐ Completed Bachelor's Degree
 - ☐ Post graduate training: MA, MSc., MSW
 - ☐ Post graduate training: PhD, "Doctorate"
 - ☐ Professional degree (Law, Medicine, Dentistry)
 - ☐ Don't know
 - ☐ Refused

Canadian Managed Alcohol Programs Study (CMAPS). (2014). *Qualitative questions for managed alcohol program participants*. Victoria: Canadian Institute for Substance Use Research.

Appendix B: Certificate of Renewal Approval



Office of Research Services | Human Research Ethics Board
Administrative Services Building Rm B202 PO Box 1700 STN CSC Victoria BC V8W 2Y2 Canada
T 250-472-4545 | F 250-721-8960 | uvic.ca/research | ethics@uvic.ca

Certificate of Renewed Approval

PRINCIPAL INVESTIGATOR: Bernadette Pauly	ETHICS PROTOCOL NUMBER: 13-002 Minimal Risk Review - Board members
UVic STATUS: Faculty	ORIGINAL APPROVAL DATE: 14-Feb-13
UVic DEPARTMENT: NURS	RENEWED ON: 07-Jan-19
	APPROVAL EXPIRY DATE: 13-Feb-20

PROJECT TITLE: Managed Alcohol Programs: Implementation and Effectiveness

RESEARCH TEAM MEMBERS: CO-PI: T. Stockwell (UVic); PRINCIPAL KNOWLEDGE USER: G. Thomas (BC Min. of Health); CO-IS: C. van Zoost (Dalhousie U.), E. Gray (MacEwan), J. Zhao (CARBC), J. Evans (Athabasca), N. Giesbrecht (CAMH, U of T), T. Svoboda (U of T), E. Hyshka (U of A), C. Mushquash (Lakehead U), V. Stergiopoulos (CAMH), A. Crabtree (EIDGE), C. Graham (York), J. Turnbull (OICH), Justyna (KBS), H. Klingemann (Bern UAS), R. Schiff (Lakehead), C. Kauppi (Laurentian); CO-ORDINATORS: A. Wettlaufer, K. Vallance; CO-ORDINATORS/COLLABORATORS: B. Graham, C. Chow; COLLABORATORS: D. DePape, A. Bond, M. Orr, M. Steward, Sue Taylor, Stephanie Taylor, R. Skipper, J. Rodgers, Katelyn, C. Cox, R. Brown, D. Waterfield, K. Stinson, I. Gidora, K. Keating, P. Kurdyak, R. MacQuatt, R. Kuhlke, G. Mack, M. Jordan, M. Waldman, C. Cunningham, Scott Page, M. Henyk, N. Manuel; CONTRACTOR/COLLABORATORS: J. Saunders, J. Chick; MASTER'S STUDENT: S. Hall (UVic); KNOWLEDGE USERS: P. MacDonald, C. Sutherland, M. Wishart, K. Reid, J. Power, P. Melanson, J. Muckle, W. Muckle, C. Rose, K. Smith, J. McGuinness, A. Wainberg; RAs: C. Larocque (CARBC), B. Kryswaty (Lakehead), M. Brown (CARBC), A. Ivsins (CARBC)

DECLARED PROJECT FUNDING: Canadian Mental Health Association, Sudbury/Manitoulin; CIHR

CONDITIONS OF APPROVAL

This Certificate of Approval is valid for the above term provided there is no change in the protocol.

Modifications
To make any changes to the approved research procedures in your study, please submit a "Request for Modification" form. You must receive ethics approval before proceeding with your modified protocol.

Renewals
Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.

Project Closures
When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.

Certification

This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Participants.


Dr. Rachael Scarth
Associate Vice-President Research Operations

Certificate Issued On: 07-Jan-19

13-002 Pauly, Bernadette