




MANAGED ALCOHOL PROGRAMS IN

MANITOBA

FEASIBILITY REPORT



This report was researched and written on Indigenous land – Treaty One Territory in the heart of the Metis Nation. It was supported through a pipe ceremony led by Peetanacoot Nenakawekapo, a Knowledge Keeper connected to Sunshine House and the Aboriginal Health and Wellness Clinic. We called in the ancestors to guide the process and help keep it on a good path that leads to true healing, recovery, and community for those that choose to walk with us. We set our intention to work together in partnership with one another and to do this work in a way that centers the people that a Managed Alcohol Program is intended to serve. This report has been conducted in line with these principles by speaking extensively with Peers and community members that might themselves be candidates for a MAP. The wisdom that they shared has shaped the tone of the report as well as the recommendations for practice. We are grateful to these participants and their willingness to support this project, serve as guardians of the model, and ensure that, as we move forward, the right voices will be amplified and their expertise honoured.

MANITOBA

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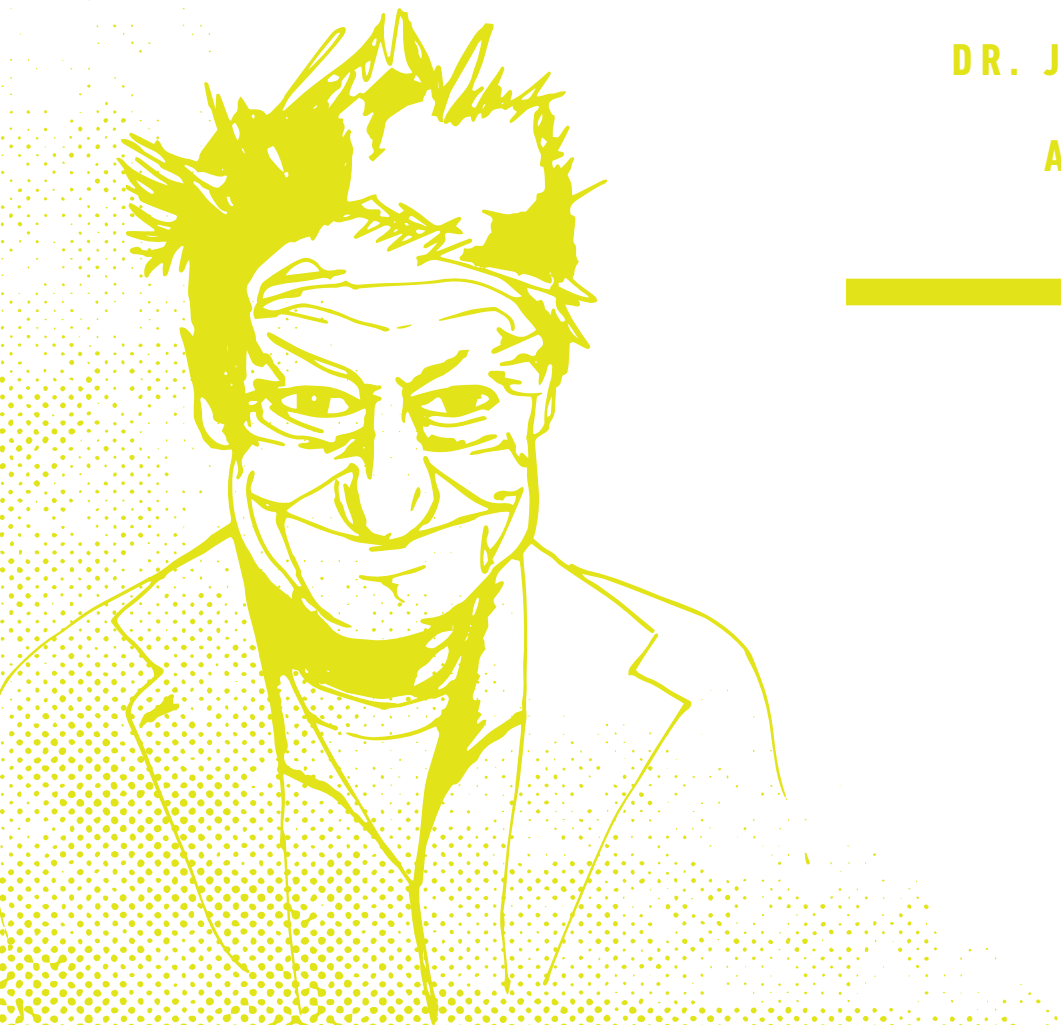
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**WHAT DO YOU DO WHEN
SOMEBODY DOESN'T,
CAN'T OR WON'T STOP
DRINKING? DO YOU
ABANDON THEM?**

**DR. JEFFERY TURNBULL
OTTAWA MANAGED
ALCOHOL PROGRAM**



INTRODUCTION



INTRODUCTION

The stigma that people who are using drugs and/or alcohol chronically face due to their use can be staggering and systemic. Social, health, and justice policy are often informed by common place myths and misinformation that comes from a collectively held belief that drugs and alcohol are bad, therefore if a person uses them they are also bad (Count the Costs, 2015). Being characterized this way has meant that, for people who are using alcohol chronically and who are experiencing harms related to that use, the options for care and treatment have not been able to meet their needs, especially if they are not interested in abstinence, or are pre-contemplative, or contemplative about their substance use (Prochaska & DiClemente, 1981). In a study conducted with individuals with lived experience of homelessness and alcohol use disorders, Collins et al. (Collins, et al., 2016) found that, on average, their interviewees had attempted 16 abstinence-based treatment programs during their lifetimes. In this way, harm may be seen in repeated “failed” treatment experiences in terms of failing to foster feelings of self-efficacy necessary for future behavior change.

People deserve better. Our communities deserve better. Harm reduction oriented programs that believe in the intrinsic value of human life and that prioritize dignity and care have begun to address the stigma that people face in relation to their substance use. And, in doing so, have improved people’s overall health. In short, if the stigma related barriers that people face can be minimized, then health outcomes for people who use alcohol chronically and who experience harms because of their use may be improved.

Of equal importance is the work being done to decolonize healthcare systems and harm reduction approaches by centering Indigenous ways of doing, knowledge, and science in programs that serve Indigenous people who use drugs and alcohol in Canada. For Harm Reduction programming to be meaningful for Indigenous people, it must be led and informed by Indigenous people (Truth and Reconciliation Commission of Canada). If Indigenous people make up a part of the participant population, the program must be culturally grounded.

There is no question that programs that use an Indigenous lens to address harms associated with substance use are a critical component of the treatment pathway, and indeed are in line with work being done in Canada by Indigenous peoples that emphasizes healing, community, and culture as specific and effective recovery interventions (Dell, 2012). At this point, and given the specific research that supports culture as healing intervention, to ignore the role of culture and ceremony in healing and recovery for Indigenous people impacted by alcohol use would be, at best, an egregious lapse in judgment, and, at worst, a dangerous example of institutional racism.

Finally, using a decolonized Trauma Informed approach to develop, implement, practice and evaluate new and innovative programs will provide a grounding framework that underscores and enhances the strengths and gifts of participants and staff. It is understood that trauma impacts

THERE IS NO QUESTION THAT PROGRAMS THAT USE AN INDIGENOUS LENS TO ADDRESS HARMS ASSOCIATED WITH SUBSTANCE USE ARE A CRITICAL COMPONENT OF THE TREATMENT PATHWAY, AND INDEED ARE IN LINE WITH WORK BEING DONE IN CANADA BY INDIGENOUS PEOPLES THAT EMPHASIZES HEALING, COMMUNITY, AND CULTURE AS SPECIFIC AND EFFECTIVE RECOVERY INTERVENTIONS

most Canadians, and disproportionately impacts people with substance use problems. Designing a program model that accounts for this reality among staff and participants is more likely to create an environment where people can experience the safety that they need in order to engage with the program in a way that makes sense to them. (TIP Project Team, 2013) Essentially every decision that is made about program model, physical space, and staff should be intentional and consider how it relates to the 4 key components of Trauma Informed Practice (TIP Project Team, 2013) Trauma Informed Practice creates the conditions required for engagement and recovery.

This, along with a commitment to Harm Reduction and Culturally grounded practice, builds a program environment that is safe for anyone who comes through the door. This is the model foundation that emerged as we began to discuss the feasibility of Managed Alcohol Programs for Manitoba.

'This way at least people are getting help'

-MANITOBA PEERS' RESPONSE TO THE IDEA OF A MAP IN MB.

THE FEASIBILITY REPORT

The consultant, Margaret Bryans, worked with the community to learn about what was important, what challenges might exist and what community strengths that could be integrated into the development of a MAP. Following these consultations, analysis and synthesis of the data took place and resulted in this feasibility report.

This feasibility report will provide

- A summary on the intersection of alcohol use and homelessness
- A background on Managed Alcohol Programs and what they look like in practice
- An overview of the work done to date in Manitoba on Managed Alcohol Programs
- Project goals for the feasibility study
- Project Participants
- Methodology
- Support for MAP's in Manitoba
- Key findings from the review
- Recommendations
- Next Steps

ALCOHOL USE AND HOMELESSNESS

Chronic alcohol use is common in individuals experiencing or at risk for homelessness. Nearly 40% of people who are homeless are chronically using alcohol (Muckle, Muckle, Welch, & Tugwell, 2012). People are drinking for a lot of different reasons that make sense for them (or made sense for them in the past). Many people experiencing homelessness are not able to access establishments that serve beverage alcohol due to fixed income and stigmatizing policies/accepted practices related to substance use, poverty and mental health problems. This has meant that non-beverage alcohol plays a significant role in this population's alcohol use. Restricted access to beverage alcohol has left people with little choice but to seek out non-beverage alcohol for consumption. In addition to the fact that the consumption of non-beverage alcohol will compromise an individual's physical health, it is also inhumane to create a barrier to safer alcohol consumption based on socio-economic status. Limiting people's access to beverage alcohol has not been shown to be an effective way to support people impacted by homelessness and the chronic use of alcohol. (Olson) 'The only responsible, healthy, and compassionate way to support those who consistently consume non-beverage alcohol is to understand that, [in many of these cases], abstinence is potentially a dangerous...and unrealistic treatment [option], and that reducing the harms [associated with chronic alcohol use] means assisting people with the consumption of safe forms of alcohol' (Olson). People impacted by chronic alcohol use who are experiencing homelessness should be able to access safe alcohol, treatment, and care. People deserve dignity, a sense of safety and support, the opportunity to get their wellness needs met, and the opportunity to heal, if needed. That is where alcohol harm reduction and Managed Alcohol Programs come in.

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HISTORY OF MAP'S IN CANADA

Managed Alcohol Programs have developed primarily from housing initiatives that saw the need to help participants manage their alcohol consumption more safely. One of the first programs was started in 1996 after the freezing death of two men who were turned away from Seaton House shelter in Toronto because they would not relinquish their alcohol. (Vitalla, 1998). It was discovered that people who were using alcohol chronically would use excessively prior to accessing a shelter bed to avoid withdrawal for as long as possible while accessing dry shelters, and then discharge themselves early to begin drinking again to prevent withdrawals (Podymow, Turnbull, Coyle, Yetisir, & Wells, 2006). This pattern of use amongst homeless people can prove harmful and even life threatening in extreme cold weather (Podymow, Turnbull, Coyle, Yetisir, & Wells, 2006).

An additional service was then developed which included the monitored provision of measured doses of alcohol throughout the day by trained staff. The goal was to provide enough alcohol to prevent both intoxication and withdrawal (Vitalla, 1998). This was the beginning of managed alcohol programs in Canada.

WHAT ARE MANAGED ALCOHOL PROGRAMS (MAPS)

Managed Alcohol Programs are a part of an alcohol harm reduction approach that seeks to improve the overall health and wellness of people impacted by chronic alcohol use who are experiencing homelessness and who often use non-beverage alcohol. MAP's do not require abstinence from alcohol as a condition of participation. Instead, they are programs that provide access to safe, beverage alcohol to minimize the varied potential harms associated with chronic alcohol use. While it may seem at first glance to be counterintuitive to treat the problems associated with chronic alcohol use with alcohol, what we now know is that MAP's are highly effective programs that significantly improve outcomes for the individual and the community, at a significant cost savings to the health and justice systems.

Preliminary evidence from a non-randomized controlled sampling study done with a MAP in Thunder Bay Ontario examined records of police contacts and use of health services. They found that both hospital admissions and the amount of police contacts that resulted in detention decreased after participants enrolled in the MAP. In addition, the total self-reported volume of alcohol consumed and use of non-beverage alcohols were lower for MAP participants compared with controls (Vallance, et al.).

Various cost-benefit analyses have also been undertaken that suggest that Managed Alcohol Programs are a cost-beneficial way to address harms for those with severe Alcohol Use Disorder. In a study by Hammond et al. (2016) they estimated that there was a saving of between \$1.09 and 1.21 for every dollar invested in treatment (Hammond, Gagne, Pauly, & Stockwell, T, 2016).

Qualitative interviews examining housing and quality of life data found that satisfaction with physical environment, finances, transportation and access to health services was rated significantly higher among MAP participants compared to controls (Evans, Semogas, Smalley, & Lohfeld, 2015). Themes of family, home and safety were expressed in participants' reports of how the program had helped them to reconnect with their families and rejoin in cultural practices that they had neglected previously:

"I was sick most of the time. Not only alcohol sick but like body sick, spiritually sick. I believe in my culture and my traditions and plus the creator and I lost that you know. I lost that part there where we would you know smudge in the morning and you know and say thank you to our creator and then somehow I just quit doing that. Quit praising, quit praising our creator, I used to be able to, you know, join the celebration, you know there's pow wows and all that. I don't even do that anymore you know, put on my regalia and go celebrate. But now I, I haven't picked it up yet again but it's like, like I'm slowly getting there. I don't think you're ever a whole person because there's always something new that's gonna make you whole, you know a fuller person" (EVANS, SEMOGAS, SMALLEY, & LOHFELD, 2015)

TYPES OF MAP'S IN CANADA

1. **Residential:** This model melds day programming and regular dispensed alcohol at specific doses with on site-residence. These programs sometimes include medical beds for people who require more intensive stabilization as they begin with the MAP. These MAP's are often connected to shelter services from which participants are referred.
2. **Drop-in:** This model combines measured alcohol dispensed throughout the day with drop-in programming. It does not have onsite housing.
3. **Trade-in:** This model will exchange a certain amount of beverage alcohol for non-beverage alcohol (mouthwash, hands sanitizer etc.). The goal here is to minimize the harms associated with chronic alcohol use by ensuring that, at the very least, people are consuming safer alcohol.
4. **Co-op:** Participants join the MAP Co-op and participate in brewing alcohol and are then eligible to access a certain amount per day. This is a Peer led model that exists in Vancouver.
5. **Informal:** Arrangements are made between individual participants and an agency they engage with.
 - Long term care facilities administer alcohol (purchased by residents or their families) to residents that have a long history of chronic alcohol use.
 - Case Managers at community agencies support participants in purchasing brew kits and work with participants to brew and then deliver daily doses to the participant as agreed upon by the participant themselves.
 - Physicians in acute care settings provide alcohol prescriptions to dependent patients to minimize withdrawal symptoms while in hospital for care.

MOVING FORWARD MEANS KNOWING WHERE WE COME FROM: PROJECT BACKGROUND

In early 2016, the board of Sunshine House began a discussion with participants and a consultant around how to support participants attending the house who use alcohol chronically. Many of these folks were not interested in changing their patterns of use, or did not believe they could- even if they had a strong desire to change. Most had attended multiple, abstinence based, substance use treatment programs and had not found them to be helpful in the long-term. Additionally, many of these participants were experiencing harms related to their alcohol use. Physical and health related harms were prevalent, but most important for Sunshine House was the how the social harms of their use were also impacting their quality of life. Folks could not access alcohol in a safe and legal way, they could not afford

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the amount of beverage alcohol they needed to avoid withdrawals, they were having to spend all day hustling to get enough money to pay for their alcohol, or they were stealing non-beverage alcohol for consumption. Homelessness and unstable housing appeared to be worsening what folks had to do to avoid alcohol withdrawals. People who have similar drinking patterns who are housed and who have access to resources are cushioned from many of these specific alcohol related harms by their socio-economic status.

This inequity did not sit well with folks involved in Sunshine House. Staff, participants, and the board began asking the question they always ask: how could we make it better?

In the fall of 2016, a group was formed to engage in a formal process to look at Managed Alcohol Programs for Manitoba. A small group of folks interested in MAPS began to meet every few months. This group included physicians, Sunshine House Staff, Participants, and interested community members, and together they began to think about how to get the MAP ball rolling in Manitoba. This group applied for and received a small grant that allowed them to engage in a MAP feasibility study.

From here, the consultant, along with Sunshine House staff, and the MAP group, hosted a Pipe Ceremony led by Knowledge Keeper Peetanacoot Nenakawekapo. This group asked for support and guidance in bringing them to people who could support this process and whose wisdom would shape the report overall. Beginning this whole project with ceremony allowed us to slow down, set our intentions, and move forward in a good way, centering the knowledge and wisdom of community.

Through the work on this project it became clear that there already were leaders in the community who have been working towards this goal for a long time. This report is not the first time in Manitoba that Managed Alcohol Programs have been discussed. Many local physicians, agencies, policy makers, politicians, and community members have been invested for some time on managed alcohol for Manitoba. Indeed, there have been many conversations and meetings with many different folks that have helped lay the groundwork for this current feasibility study.

The following feasibility report includes many potential stakeholders, but certainly not all. The goal was to honour the voices of Peers, learn from those working on the frontlines, and move the MAP project forward overall. And, as a MAP moves forward in Manitoba there is no doubt that other partners will come forward to share their expertise. This is not meant to be an exhaustive report, but rather a first step in a much longer and in depth process to develop, implement, and evaluate a unique and effective managed alcohol model in Manitoba.

WE CAN'T KNOW WHAT WE DON'T KNOW: FEASIBILITY STUDY GOALS

The MAP group developed key goals for the Feasibility Study.

- Ensure the engagement of Peers and potential participants
 - ✦ It was critical to the group that emphasis be placed on the needs, thoughts, hopes, and recommendations of people who identify with the priority population.
- Explore the logistical details around MAPS
 - ✦ The group had many questions around program specifics such as: MAP licensing in MB; quantities of alcohol required for participants per day, week, month; brewing vs purchasing alcohol; how people could be transitioned from community to hospital if they are engaged in the MAP; etc.
- Consult and develop relationships with related stakeholder groups and potential MAP partner organizations.
 - ✦ The group wanted to not only solicit feedback from various community sources, but also gauge interest in formal partnerships, moving forward. In particular, and given the recommendations from Canada's Truth and Reconciliation Commission and current evidence related to working with Indigenous peoples, the group wanted to ensure an emphasis on Indigenous agencies, organizations, and individual practitioners that are using an Indigenous model for their practice.
- Connect with community in Thompson to discuss interest/readiness for a MAP there.
 - ✦ Consideration of programming outside of Winnipeg is another goal of this group. There was interest from the group in a Northern MAP that could help prevent alcohol related hypothermia. Exploring this possibility was also identified as a goal.

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INTRODUCTION

LEARNING FROM COMMUNITY: FEASIBILITY STUDY PARTICIPANTS

The *MAP Working Group* at Sunshine House is made up of MAP champions from the community, and from various organizations, including:

- Sunshine House
- Health Sciences Centre Department of Psychiatry
- Addictions Foundation of Manitoba
- Main Street Project
- Winnipeg Regional Health Authority
- Health Sciences Centre Emergency Department
- Northern Connections Medical Clinic
- Manitoba Harm Reduction Network
- Department of Community Health Sciences – University of Manitoba
- University of Winnipeg

For this report, we consulted with over 75 individuals* from a variety of organizations and communities, including those listed below:

- The Sunshine House
- Director, Community Learning and Engagement, University of Winnipeg
- Director - Indigenous Health Section – Department of Community Health Sciences, University of Manitoba
- Executive Director – Ka Ni Kanichihk
- Director of Wellness - Aboriginal Health and Wellness Clinic
- Mothering Project/Manito Ikwe Kagiikwe at Mount Carmel Clinic
- Health Outreach and Community Support (HOCs) team at the Winnipeg Regional Health Authority (WRHA)
- Healthy Sexuality and Harm Reduction team at the WHRA
- Community Area Director – Downtown/Point Douglas - WRHA
- Northern Social Work Program – Thompson
- Safer Choices Coalition - Thompson
- Northern RHA STBBI Prevention Coordinator - Thompson
- Liquor and Gaming Authority of MB
- The Manitoba Harm Reduction Network
- The Bell Hotel – Main Street Project – Staff Nurse
- Chair Community Advisory Board – Homelessness Partnering Strategy - Thompson
- Experimental MAP coordinator, Regina, Saskatchewan

* Attached as an appendix is a full list of people and organizations that were consulted for this report. (Appendix A).

Additionally, we hosted four events – A pipe ceremony with our Knowledge Keeper to start the process in a good way, followed by two Peer led events,

and one event targeting service providers, policymakers, and managers. Our goal was to gather community wisdom together, especially Indigenous knowledge and expertise, and to engage this process using a decolonizing lens to explore program development.

GATHERING WISDOM: THE METHODOLOGY OF LEARNING

For this report, information was gathered from a variety of sources in a variety of different ways. Our goal was to identify several key stakeholders in the community to speak to AND provide an opportunity for any additional people with an interest in MAPs to engage with this process. A multitude of methodologies were used to accommodate different comfort levels for the people who shared their wisdom for this report. People could request a certain type of methodology OR could volunteer to attend a consultant organized event. Information was gathered primarily through interview, facilitated gathering, informal conversation, meetings, focus group, sharing circle, online queries, a survey, and the first-hand reports and experiences of those who have visited other MAPs.

Focus Group

There was one Peer based focus group as a part of this study. This focus group took place over several weeks. Participants at Sunshine House were introduced to the consultant – many of whom were already acquainted with her. She spent a couple of weeks in the drop-in chatting with folks, getting to know them, and letting them know about the project and the focus group. The focus group took place upstairs at Sunshine House and involved 13 people who watched a MAP documentary and then had a facilitated discussion about MAPs following the viewing of the documentary.

Facilitated Gathering

This was a 90-minute facilitated discussion for service providers who were solicited via a poster that was circulated by the MAP committee at Sunshine House (see Appendix B). This event asked people to work in small groups answering questions following an overview and update on MAPs in Manitoba. This event ended with each participant voting for their top three recommendations. This event was attended by physicians, educators, frontline staff, managers, nurses, social workers, and senior managers.

Interviews

The consultant met and facilitated 12 separate interviews. She took notes during, and summarized these interviews afterwards. Interviews were 30-60 minutes long. The interviews were not formal and the consultant prepared several questions to help lead and direct the conversation, but, in general, participants took the conversation in the direction that made most sense to them.

***This work was primarily conducted in Winnipeg, but the consultant also traveled to Thompson MB to meet with local community and agencies about a MAP in their community.

Informal Conversations

Multiple conversations took place with colleagues and community members regarding the MAP feasibility study. Once the consultant began work on the feasibility study, she was approached regularly with questions and suggestions about MAPs.

Sharing Circle

The consultant participated in a sharing circle that explored the unique needs of women who are impacted by alcohol and homelessness. This sharing circle was made up of women who identify as Peers, some of whom would likely be accepted as potential MAP participants. The circle, which took place in a round room filled with medicines, drums, and other sacred items, opened with a smudge, and created an open and safe environment for complex conversation.

Meetings

The consultant attended 6 organizational meetings. Most often this meant attending staff meetings, network meetings, or specific MAP meetings. This approach met people in a familiar context with established relationships between participants and allowed for nuanced conversation that provided rich content for this report.

Online queries

The consultant contacted and gathered data from 14 online interactions with folks from Victoria, Edmonton, Thompson, and Winnipeg. This approach offered an accessible way for folks living and working across the country to engage, particularly policy consultants, who preferred email to in person meetings

First Hand Reports

Some MAP committee members traveled to MAPs in other parts of Canada. Their observations of the work being done elsewhere informed this report

Surveys

While the consultant did not use surveys for this study, a partner agency surveyed their participants about MAPs in early September 2017, and their responses have also informed many of the recommendations.

SUPPORT FOR MANAGED ALCOHOL PROGRAMS IN MANITOBA

Across the board, Peers, frontline staff, and policy makers who were consulted were all extremely supportive of Managed Alcohol Programs and saw a real need for a MAP in Manitoba. People identified the importance of a MAP that was culturally grounded and Indigenous led. Indigenous Peers commented on how much they valued services that have been developed by Indigenous people as well as by Peers with lived experience. It was important to Peers and to many service providers that services be innovative and meaningful, and not simply a repackaged version of what already exists.

It was understood that current addiction/substance use services were not enough for some people and that, for people using alcohol chronically, MAPs may provide an effective alternative that addresses their specific needs. Furthermore, it was emphasized that people needed access to services that did not demand sobriety as a condition of access. For example, a Winnipeg based social worker who works with people experiencing chronic homelessness stated “People’s need to continue drinking prevents them from accessing services that require sobriety. This means people who need care don’t get it’. He went on to express that people should be able to get care that meets them where they are at, even if they are nowhere near quitting, and even if quitting drinking isn’t something they want at all. This sentiment was echoed several times across service disciplines, and by Peers.

There was a recognition by most respondents that non-abstinence based programming could facilitate participant engagement more effectively. One provider talked about the protective nature of their client’s alcohol use, stating ‘when they are sober, they are often overwhelmed by trauma’. Abstinence based programming does not always recognize the potential benefits of use. MAP’s help provide stability and slowly engage people at a pace that feels safe, and employs a unique perspective in that they do not ignore the possibility that alcohol has kept people alive up to this point.

There was also a sense of urgency felt by people with lived experience who strongly expressed an acute need for support. They spoke of clients and friends who were in liver failure and still drinking non-beverage alcohol. They also described how important a Managed Alcohol Program could be in minimizing the dangerous effects of withdrawal. One participant said ‘Alcohol will kill you. If you don’t have a drink you can go into withdrawals and die’. She then explained that this kind of program could protect people from that danger. She saw that as a real benefit for people especially given her own experiences with alcohol.

ABSTINENCE BASED PROGRAMMING DOES NOT ALWAYS RECOGNIZE THE POTENTIAL BENEFITS OF USE. MAP’S HELP PROVIDE STABILITY AND SLOWLY ENGAGE PEOPLE AT A PACE THAT FEELS SAFE, AND EMPLOYS A UNIQUE PERSPECTIVE IN THAT THEY DO NOT IGNORE THE POSSIBILITY THAT ALCOHOL HAS KEPT PEOPLE ALIVE UP TO THIS POINT.

GUIDING PRINCIPLES OF A MANAGED ALCOHOL PROGRAM IN MANITOBA

Culturally Grounded

A significant portion of participants underscored the importance of providing culturally grounded care and specifically emphasized the importance of the MAP model being grounded in Indigenous Knowledge. Miller, Omidian, and Quraishy (2006) explore how to create culturally grounded approaches and state that ‘Identification of culturally specific ways in which distress is expressed and understood is especially important: the development of effective interventions requires an understanding of the ways in which people in particular cultures experience and articulate the ways they have been affected by adverse life events’. (Miller, et al., 2006) Culturally grounded models are not just about providing access to an Elder or smudging, it is about designing programming that centers Indigenous people and knowledge .

Although symptoms of chronic alcohol use may be similar across cultures, the context in which those symptoms are understood are often different and require different approaches to intervention and engagement. (Miller, et al., 2006) Western models of care have not been designed to be responsive to the needs of Indigenous peoples, therefore it is of significant importance to ensure that any new services that are likely to be accessed by Indigenous people are designed and informed by Indigenous people.

Indigenous healing models in Canada have demonstrated that ‘culture as intervention’ in alcohol and drug treatment programs provides an important and life changing framework for Indigenous participants. (Dell, 2012) The Managed Alcohol Program in Edmonton, Alberta is an excellent example of a MAP that has been designed and evaluated using Indigenous knowledge and science. Ambrose Place provides an Indigenous cultural environment where smudging, ceremony, Elder supports, language, and food are available. They prioritize Indigenous staffing and have designed their model to address First Nations, Metis, and Inuit cultural and traditional needs and beliefs. According to staff in this program, working from an Indigenous world view ‘assists in the decolonization of Indigenous peoples and recovery from government laws and policies that have left people traumatized.’ In the Ambrose Place model *all people are welcome* and there is a strong belief that ‘we are all related, we are all connected, and natural law guides our work’. (Niginan Housing Ventures) This model is meaningful and makes sense for Indigenous people accessing the program and has demonstrated significant reduction in Emergency Department visits, less in-patient hospital admissions, ambulance services, and a 67% reduction overall in health services costs. (Decision Support Services and Addiction and Mental Health)

A commitment to a model that embraces Indigenous knowledge was echoed repeatedly by participants in this feasibility study. Many identified the 7 sacred teachings (love, respect, humility, wisdom, courage, honesty, truth) as

core values for the MAP. One of the first things a Peer said about what could make a MAP safe was ‘Treat others with respect – number 1 is respect’. This was affirmed by most Peers, who have often not felt respected when accessing conventional services. Several interviewees talked about how people know when they are not welcome in a place and they know when they are. They spoke about the importance of creating a place that feels right to Indigenous people. Culturally grounded models support the creation of welcoming spaces that make sense culturally to Indigenous people.

Honouring the strengths and gifts of participants and creating a place for those gifts to flourish was identified as a priority by service providers in focus groups and interviews.

- ‘Give people a chance to give back.’
- ‘Peer leadership gives first-hand experience, creativity, and harm reduction skills.’
- ‘Participants need to feel ownership of [the MAP] and have a voice.’
- ‘Create opportunities for participants to volunteer and be involved.’

Frontline staff were clear about the need for representative staff, a commitment to cultural safety, and opportunities for participants to explore their culture, ceremonies, and traditions in a way that feels safe and meaningful for them.

- ‘All individuals should be viewed as a whole.
We need to listen at every step.’

Peers spoke at length about the importance of culture and spirit in programming, for many of them it was critical to have the option of exploring their identity and culture, for others just having a space that felt comfortable and safe to them was what they were looking for.

- ‘Drumming saved me.’
- ‘This program needs to think about spirit and nature, the old teachings should be brought back and we want to learn how to live on the land.’
- ‘It’s about getting a spiritual connection with yourself.’
- ‘This program should be connected to nature, medicine picking and stuff.’
- ‘We want to be safe and we want our kids to be safe.’

Harm Reduction

Harm reduction approaches seek to reduce the harms associated with substance use without necessarily requiring abstinence. Additionally, harm reduction philosophies are about providing the right option at the right

time as identified by the person themselves and make room for all kinds of treatment options at all points along someone's journey. Harm reduction is a human rights focused philosophy that believes in the intrinsic worth of people who use drugs. Harm reduction approaches support lifesaving interventions regardless of sobriety. At their core, harm reduction philosophies are about love for all people and communities who are keeping themselves safe in the best ways that they can. MAPs are by nature harm reduction oriented programs. They meet people where they are at, and support them in stabilizing while not requiring abstinence. Additionally, people are afforded agency and control within the context of the program which is an important tenant of a harm reduction model. Participants in the facilitated discussion identified harm reduction as a core component for the Manitoban MAP model. They also highlighted the importance of a MAP model that is aware of and sensitized to the benefits of substance use and able to provide alternatives where necessary. For example, there is a social component to drinking and given that peer/social support often happens over a drink, a MAP should be concerned with maintaining this important benefit and create other opportunities that facilitate social support.

People understood that for some, alcohol was how they managed their lives. They stated that it was clear that many people were using alcohol to treat pain – both emotional AND physical and that this needed to be considered in the development of a MAP, specifically including pain assessments and treatment at intake and over time. One of the peers talked about a loved one's relationship to drinking, 'My grandpa had to have alcohol every day - it's almost like a car you have to have gas to make the car run every day. You have to have a drink to just get through'. She thought that a program like this could have helped him live a good life.

Another Peer talked about the value of a harm reduction model for people not being served elsewhere, stating 'This program is for people who for everything else they have tried they have failed at, this is pretty much the last stop. It's like if they had chemo and it wasn't working, you wouldn't give up on them. They should still have those opportunities if they want to better their lives even if they can't quit.'

Trauma Informed

Trauma informed practice is an approach that acknowledges that most people have experienced trauma in their lives and, that for those impacted by chronic and sometimes problematic substance use, the rates are much higher (TIP Project Team, 2013). This means that program models that are serving people who are likely to have a trauma history should prioritize trauma informed practices. There are 4 main components to trauma informed care:

- Trauma Awareness
- Emphasis on safety and trustworthiness

- Opportunities for choice, collaboration and connection
- Strength based and skill-building

(TIP Project Team, 2013)

The consensus from participants is that a Manitoba MAP model must be trauma informed.

- ‘No rushing, give people the space they need to talk.’ (emphasis on safety and trustworthiness)
- ‘Emphasizing choice.’ (Opportunities for choice, collaboration, and connection)
- ‘Genuine and authentic approach.’ (emphasis on safety and trustworthiness)
- ‘Staff need to know how to manage shit and not be easily offended.’ (trauma awareness)

Peers also described how they would want the program to be set up, which was also in-line with the components of trauma informed practice.

- ‘The model needs to be predictable, calendars for people would be good’ (emphasis on safety and trustworthiness)
- ‘I want people to live not just sit there waiting for that hourly drink.’ (strength based and skill building)
- ‘Do something constructive every day.’ (strength based and skill building)
- You don’t know what kind of problems people have. We want the ones who have gone through it and experienced it, they know what to talk about. (opportunities for choice, collaboration, and connection)

A Psychologist who works on a team focussed on supporting people who are homeless that was consulted during this process believed that it was important to consider the lived experience of participants and to ensure that any ‘people who were participating in the MAP, and who wished to do so, could access high level psychotherapy’ and ‘have people available to hear people’s story’. He and many others talked about the importance of storytelling and sharing with someone who has compassionate curiosity and how this relational engagement can help people figure out what they need to move forward. Participant access to trauma specific services was a core issue for him.

There was discussion that underscored the importance of a MAP also assessing and treating pain. Pain management strategies to support alcohol replacement were raised by multiple providers in several contexts.

Peers also identified how meaningful counselling and access to Elders would be in successfully engaging in a MAP. Nearly every Peer mentioned the importance of spiritual health as a marker of wellness for participants.

**UNDERScored
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MAP SERVICE MODEL

Extensive conversation took place about what this Manitoba model could look like. One very clear message was that the clinical care must be as low barrier as possible while maintaining medical rigour. Participants will need to be followed by an exceptional medical team that has tremendous clinical skill as well as the capacity to be non-threatening and the willingness to work in a low threshold environment that emphasizes safety overall. The clinicians consulted for this report all shared an interest in an interdisciplinary model for the care of MAP participants.

The following is a list of additional considerations, highlighted by participants in the feasibility process, for the model as the project moves forward:

Physical Space

- Geographically accessible for people
- Physical space – ‘needs to feel like a place I would want to hang out in’. Soft lighting, comfortable seating, familiar objects.
- Should feel like a place people want to come.
Welcoming reception area and staff.

Program Components

- Low barrier access and a self-referral process.
- Paid opportunities for participating in program.
- Alcohol distribution hourly pour vs am/pm pour vs Individualized pours?
- Nutrition component.
- Emphasis on recreation.
- Drop-in option – people can stay, do not need to leave after their drink.
- Support meetings/sharing circles for participants.
- Access to Elders and Knowledge Keepers who embrace/incorporate harm reduction when working with people who use drugs and alcohol.
- Participant driven advisory committee
- Volunteer opportunities
- Access to trauma specific services as needed.
- Occupational Therapy for participants?
- Psychotherapy
- Recreation therapist
- Harm Reduction Drug and Alcohol Counselling
(recovery planning, wellness planning)

Practice Approaches

- Clear understanding between community and hospital teams to safely transition participants to and from care.
- Staff with lived experience who are willing to share their stories/knowledge is essential.
- Peers in leadership positions.
- Clear, consistent, transparent guidelines
- Decision needed on whether the clinical team emphasis should be on MAP management AND primary care, OR shared care model where primary care is provided elsewhere.
- Substitution therapy as an option when cannabis is legalized. Further investigation of evidence and practice needed.
- Opportunity for storytelling as a therapeutic intervention.
- Opportunity for skill building with opportunities to feel/be successful.
- MAP needs to be integrated with other organizations – NOT AN ISLAND.
- Practitioners should have deep, demonstrated, engagement in harm reduction practices

Practice questions

- Initial stabilization needs for new MAP participants – Partner org? Could the region support this care for a MAP drop-in pilot?
- Working with Elders and other Knowledge Keepers to reconcile access to ceremony, medicines, and teachings with alcohol harm reduction. (Consensus was that there are ways to make this work and other national examples to look to for support).
- Do we need to develop a document/pledge/teaching that explains and provides context for how the MAP Elders, Knowledge Keepers, Medicine people practice in this setting?
- What does the team look like? What kind of training is necessary to ensure staff are prepared for the work that they will do.
- How can we explore a partnership with Manitoba Liquor Control Commission social responsibility department to provide required alcohol for participants?
- What does a trauma informed management approach look like?
- Confidentiality – How to best keep participants safe.
- Create options for participants that don't feel safe in groups or who don't trust their peers to keep what they say private?

CREATING MEANINGFUL ENGAGEMENT WITH PARTICIPANTS

20

FEASIBILITY REPORT

MANAGED ALCOHOL
PROGRAMS IN
MANITOBA

'I want people who work there that have been through what we are going through. Like when I was at [the last treatment program], there was no one who worked there who had ever done drugs, or had to do stuff for money that they didn't want to do, they got a car for their sixteenth birthday, and their parents are still together, now are they going to tell me that what I did and my choices were wrong? I want somebody who has been through something similar that I have been through. This is a job to you and to us it is life. I want people who have been through what I have been through to show me that they made it. Like this person that works here made it, they were just as drunk as I was, or on the corner with me, and they are there helping me, they made it, so I want some kind of something that shows me that I can do it. This is new to me this treatment stuff, fixing my life is new, I have been on drugs and alcohol for the last 10-15 years. I want to see somebody else give me hope and say like I did it so you can do it, and then if I can do it, that means you can do it.' – PEER PARTICIPANT

The most critical and emphatically stated point overall was that Peer engagement at all levels of the program are essential for recovery and healing. Peers are defined as people who are a part of the participant population and who have direct lived experience that is similar to the participant population. In this case, it might mean people who use alcohol and who have experienced homelessness in the past and/or in the present. Peers want to see themselves represented in the experiences of the staff. In the context of harm reduction, trauma informed practice, and culturally grounded approaches, lived experience and peer support are foundational. New programs should be developed by Peers, implemented by Peers, evaluated by Peers, and include Peers on the staff team. This means that in developing the MAP model there must be consideration for how to best engage and interact with Peers at each one of these levels. It is not enough to just hire a Peer, there must be consideration for how the program will support their staff in sharing their lived experience in a safe way with participants. Several suggestions were made by folks around Peer engagement:

- 'There should be paid opportunities for participating in the program.'
- 'People need a chance to give back.'
- 'People who are out about their lived experience need to be hired as staff.'
- 'Participants should feel ownership and like they have a voice.'
- 'Staff who look like us.'
- 'You need somebody on that level same as you, who have been through what you have been through.'

UNIQUE CONSIDERATIONS



NORTHERN PROGRAMS

Stakeholders in Thompson Manitoba were also consulted for this report. In addition to the feedback above, specific Northern considerations were identified by people living in Thompson, Manitoba.

Unique context of housing in Thompson, MB: In Thompson, there are no private rental housing options that fall within the budget allowance of someone who is on social assistance as a single person. There are two specific housing projects that attempt to address this issue. Both are full and do not meet the housing needs of all single people on social assistance living in Thompson. This means that there are a number of Thompson residents who are homeless with no foreseeable opportunity to be housed in the near future.

There are 26 people in Thompson who are chronically homeless, most of whom would likely be appropriate for a referral to a MAP. These 26 people cost one million dollars a year in service usage. Many have periods of sobriety, but stability in other parts of their lives are a challenge in maintaining housing and sobriety. (Donovan, 2017) (Community Advisory Board on Homelessness, 2014).

People who are homeless or at risk of becoming homeless and who also use drugs and alcohol are a priority for the City of Thompson Community Advisory Board. For people experiencing homelessness in Thompson alcohol use was identified as a significant barrier to accessing housing, with only economic factors (high rents, low income) being considered a more significant barrier (Bonnycastle, Simpkins, Bonnycastle, Mckay, & Hayter, 2016).

Despite a strong belief that there is/would be community support for MAP in Thompson, the pressing need according to those who were consulted, was increasing housing stock and housing affordability in Thompson. Even if the 26 people identified by the Community Advisory Board (2014) could be stabilized in a MAP, without residence or rental options available to them there is an urgent need to answer the question, 'what would we do next?'. Participants expressed a strong support for managed alcohol in Thompson, but were less confident in how a program or pilot might be executed given the current housing conditions.

Ultimately, consensus from those consulted in Thompson was that Managed Alcohol in Thompson would be most beneficial if it was developed alongside a specific housing plan for those folks who are homeless and impacted by their chronic alcohol use.

Because of the unique contexts of remote and rural experience, it is of the utmost importance that programs like a MAP be developed by and for the community themselves. Local expertise cannot be overlooked as it is this expertise that will create the optimal conditions for success.

PEOPLE WHO ARE HOMELESS OR AT RISK OF BECOMING HOMELESS AND WHO ALSO USE DRUGS AND ALCOHOL ARE A PRIORITY FOR THE CITY OF THOMPSON COMMUNITY ADVISORY BOARD. FOR PEOPLE EXPERIENCING HOMELESSNESS IN THOMPSON ALCOHOL USE WAS IDENTIFIED AS A SIGNIFICANT BARRIER TO ACCESSING HOUSING, WITH ONLY ECONOMIC FACTORS (HIGH RENTS, LOW INCOME) BEING CONSIDERED A MORE SIGNIFICANT BARRIER

UNIQUE CONSIDERATIONS

GENDER

How women participate and engage in MAP's was a focal point for some participants. Questions around parenting and children and how a MAP would intersect with child welfare programs were raised. Consideration of how women are included in the context of a MB MAP is important to female Peers and should be addressed as the project moves forward.

LICENSING

For a MB MAP to be successful, understanding how liquor licensing might work in the context of a MAP was critical. It was important to the committee that participants not be required to pay for their alcohol since this is a significant barrier for many in the first place. Devising a way to overcome this barrier considering the legal restrictions of the MB Liquor Act was a priority. As such, part of this process included meeting with Liquor and Gaming Authority of Manitoba. Service licences have strict limitations on how alcohol can be gifted, and so a liquor license for the proposed facility would not work. Kadri Irwin, the Director of Licensing for Liquor and Gaming Authority of Manitoba, suggested that the project work under a specific section of the ACT.

Section 72 of the act reads as follows:

No application to health care professionals

72 Nothing in this Act prohibits

- (a) a pharmacist from preparing or dispensing a preparation containing liquor on the basis of a prescription under *The Pharmaceutical Act*; or
- (b) a physician, dentist or other health care professional from providing liquor or any preparation containing liquor for medical purposes if permitted to do so in the scope of practice of his or her profession.

She suggested that this exemption might work for the MAP and that any oversight needed could be carried out by pharmacist or physician governing bodies. She also recommended that moving forward we consult with the LGA along with the colleges governing health care professionals to ensure safe practice and practice clarity moving forwards.

HOW MUCH ALCOHOL IS NEEDED FOR A PILOT PROJECT

An informal cost analysis of potential alcohol costs for a MAP was conducted by one of the board members at Sunshine House. This example is based on an in-house brewing model where the MAP makes their own alcohol. This assessment also made a few assumptions about the alcohol quantity consumed per day by most participants which would ultimately end up being prescribed and overseen by the clinical team. For the purpose of this estimate, this example is based on what other established MAPs are providing.

If the MB MAP is open for the first pour at 10 am with the final pour at 8pm (Open from 9am-9pm) and each person receives 200 ml at each pour that amounts to 2 liters of alcohol per day per participant.

The alcohol being provided in this example is white wine at 12% alcohol content.

Each Participant would require approximately 1.5 wine kits/month which would cost \$150/month/participant or \$3000/month for 20 participants.

For a 3-year pilot study the cost of wine would be approximately \$108,000 for 20 participants.

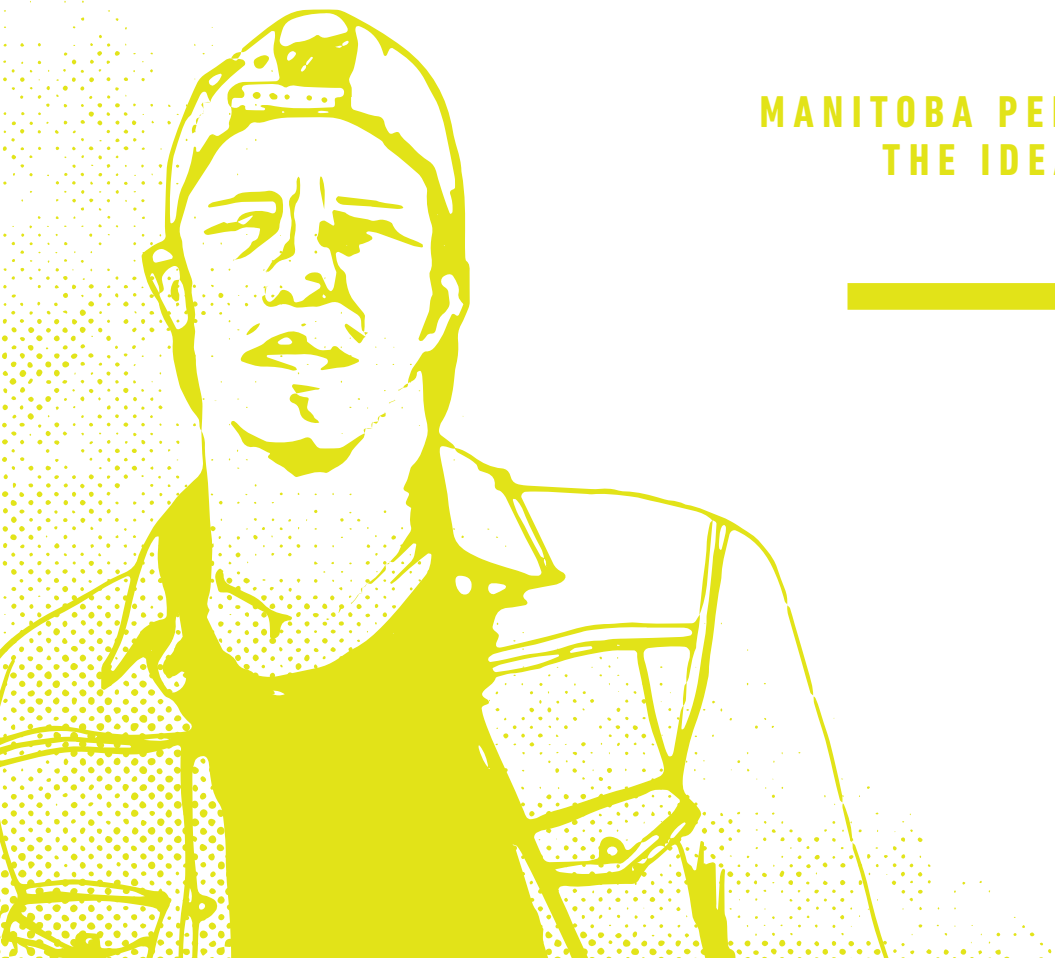
Additionally, a one-time cost of between \$8000-16 thousand dollars would be required for fermenters. Cost is dependent on size and number of fermentors required for continuous brewing.

Based on this scenario, estimated alcohol costs over three years would be \$124,000.

This estimate does not include a dispensing system or other unforeseen production costs. Likely a more reasonable estimate is closer to \$150,000 for a three-year pilot project.

**I THINK THIS
COULD TAKE A LOT
OF HOMELESS PEOPLE
OFF THE STREET, AWAY
FROM SLEEPING UNDER
A BRIDGE OR PASSING
OUT IN A CORNER.**

**MANITOBA PEERS' RESPONSE TO
THE IDEA OF A MAP IN MB.**



RECOMMENDATIONS



After 12 weeks of soliciting feedback, reviewing documents, and consulting community experts, leaders, and clinicians, the following recommendations have been developed. The goal of these recommendations is to chart a path forward that will support the community development of Managed Alcohol Programs across Manitoba.

OVERALL

Ensure that project goals are in line with current policy documents from the WRHA, MB Health, PHAC, and other RHA's –relevant to the community developing a MAP.

Drawing links between existing policies and new programming allows governments and policy makers to see how their support of new programs are in keeping with the existing policies that should be governing their decision making.

Currently, a MAP in Winnipeg is supported by the WRHA's Position Statement on Harm Reduction which states: THE WRHA IS COMMITTED TO: Supporting policies, legislation, programs, services, and actions to reduce the harms experienced by people who use drugs, trade or sell sex, and are living with HIV. These harms are disproportionately borne by structurally disadvantaged communities, making these areas foundational priorities for addressing health inequities. (Winnipeg Regional Health Authority, 2016)

Additionally, The WRHA's Health Equity Position Statement further affirms that the goal for the WRHA is to support services and innovations that focus on improving health for those most in need. (Winnipeg Regional Health Authority, 2012) A MAP's emphasis on people who are experiencing homelessness and impacted by substance use is in line with the WRHA health equity position.

Ensure that program philosophy is woven throughout all aspects of the program, from Human Resources, to work plans, to funding documents. The values and teachings that guide the program should be underscored and stated at every opportunity.

NOTE: The following are recommendations and goals connected to general timelines. The immediate goals include more specific details and explanations attached to the recommendations. The short term and long term goals have been left open-ended to create space for alternate ideas and possibilities. They are more of a road map, while the immediate goals are specific directions – how to get from point A to point B.

IMMEDIATE 0 - 12 MONTHS

Increase Peer representation on the MAP Working Group at Sunshine House.

At least 2 Peers should be a part of the working group. The Working group should be representative of the population that it seeks to serve. This means that people impacted by chronic alcohol use should be at the table.

Increase Indigenous representation on MAP Working Group at Sunshine House. A minimum of 1/3 of the committee members should be Indigenous or representing Indigenous organizations.

Because of the large population of Indigenous people living and working in Manitoba, and the disproportionate representation of Indigenous people in the population of people who are under housed or homeless in Winnipeg, and given the recommendations from the Truth and Reconciliation Commission, it is crucial to have the voices of Indigenous leadership and organizations at the table. Centering Indigenous knowledge in program development will contribute to a culturally grounded MAP.

Create a regular schedule of Working Group meetings.

The group should meet no less than every two months- this may include subcommittee groups.

Come to a consensus in the Working Group around MAP practice approaches.

This report recommends formalizing commitment to a MAP model that is Trauma Informed, Culturally Grounded, and Harm Reduction Oriented, with a commitment to a low-threshold model that feels safe and welcoming for anyone accessing MAP services.

Seek funding for a full-time MAP coordinator.

For the MAP working group to move forward, a full-time coordinator should be hired to support the work of the committee and to work on securing funding for a pilot project and/or sustainable program funding.

Host a community feast, pipe ceremony, and naming ceremony for the MAP.

Designing programming in ceremony allows it to begin in a good way and to set a positive intention to work in the best possible way with one another and with those people accessing the MAP. Welcoming spirit into the ways that we work with one another creates space to honour our ancestors and the people who have come before us who supported us in getting to this moment. Additionally, it opens our view to consider all the generations that come after us who will, hopefully, be more well because of the work that we do today.

Determine what kind of MAP is most realistic to move forward given resources and current climate.

Support was expressed by participants for both a residential model as well as a drop-in model that included housing supports. Ideally, the working group would secure funding to run both models and to evaluate each model's strengths and weaknesses as well as outcomes for people accessing the service. Practically, a decision should be made regarding what is most realistic in current climates and where the capacity exists to start a MAP.

Given community feedback and organizational support for a MAP in Winnipeg the recommendation coming from this report would be to run a pilot day program with strong housing supports for participants. This report recommends creating flexibility in the pilot design to allow for additional evaluation of a more traditional residential model should funder and organizational appetite for this model arise.

There are two other formal drop-in MAP's that are a part of the National MAP evaluation project out of the University of Victoria, one in Vancouver that is Peer run, and another in Sudbury, Ontario that is run by the Local Health Integration Network and the Canadian Mental Health Association.

Seek out partner organizations and begin negotiations on a memorandum of understanding that sets out how a formal partnership to run a MAP will work.

There was interest and support in Winnipeg for 2 or more agencies to come together to jointly run a Managed Alcohol Program. The goal here would be to create synergistic partnerships where each organization brings a different set of expertise to the table creating increased opportunities for innovation and quality program development. For example, bringing together a harm reduction/recreation oriented organization with an Indigenous wellness organization, and a housing first program might create a model that can support participants of the MAP in a way that meets the needs that they themselves identified as priorities.

Develop a general funding proposal based on this document and other documents developed by the MAP working group that can be used to apply to various funding bodies.

Begin to seek out and secure academic support and evaluation expertise for the MAP.

The Indigenous Health Section at the Department of Community Health Sciences has experience using Indigenous science to evaluate culturally grounded harm reduction programs, and the Department of Community Health Sciences has several researchers who have expertise in evaluation and using a harm reduction model for practice. Program evaluation needs to be sustainable over time and the MAP would benefit from regular program and outcome evaluation. This may include hiring an internal evaluation coordinator for the MAP that supports day to day evaluation and coordinates any external provincial or federal evaluation projects and any research partnerships with academic institutions.

Create a Peer Advisory Group separate from the Working Group to provide leadership and guidance in the development of a MAP.

This group should be paid for their time and should meet at least 6 times a year. Additionally, this group should be heavily involved in decision-making and any evaluation process that is considered/implemented.

THERE ARE TWO OTHER FORMAL DROP-IN MAP'S THAT ARE A PART OF THE NATIONAL MAP EVALUATION PROJECT OUT OF THE UNIVERSITY OF VICTORIA, ONE IN VANCOUVER THAT IS PEER RUN, AND ANOTHER IN SUDBURY, ONTARIO THAT IS RUN BY THE LOCAL HEALTH INTEGRATION NETWORK AND THE CANADIAN MENTAL HEALTH ASSOCIATION.

RECOMMENDATIONS

Create relationships with and assess support for a MAP with funders.

The Coordinator, representing the MAP Working Group and the Peer Advisory Group, should be meeting with Government representatives, private funders, and community organizations to lay the groundwork for a MAP proposal submission.

Pursue the social responsibility programs run by beverage companies and the Manitoba Liquor Control Commission.

Meet with these groups to discuss opportunities for collaboration. Specifically, this group may be interested in the pour/specific alcohol related components of the MAP.

Work with local Knowledge Keepers to learn about how to bring Indigenous knowledge into an alcohol harm reduction program. Seek out Elders and medicine people and see how they could engage with MAP participants to support healing and wellness.

Determine feasibility of Peer-led brewing.

Peer brewing is a component of a Vancouver Map as well as informal managed alcohol strategies out of Regina. If there was a way to build brewing capacity amongst peers, this could provide volunteer opportunities, skill building, and employment skills.

SHORT TERM 1-5 YEARS

- Submit Provincial, Federal and private proposals that will support the development of a Managed Alcohol Program in Winnipeg.
- Develop a communications strategy that supports the development of a MAP or MAPS in Manitoba and that clarifies any potential community concerns regarding the project overall.
- Finalize and sign any organizational memorandums of understandings.
- In collaboration with the Peer Advisory Group develop concrete and clear program policies for the project.
- Develop a training program for the MAP staff team.
- Create a detailed program model including specific programming needs, staff complement, and practice guidelines.
- Program infrastructure should be designed to meet the needs of all team members in a trauma informed way, in particular, those of peer staff.
- Create with peers and participants a Participant 'bill of rights' that can be posted openly and reviewed yearly.
- Develop care plans detailing transitions (to and from the

program) and care for participants who may need acute care(hospital) or long-term care (personal care home).

- Build on partnerships that could use existing services to manage MAP participants that may need medical stabilization prior to MAP enrolment. (Hospital, Detox, Shelter, Addictions Foundation of Manitoba, WRHA etc.)
- If the MAP begins as a pilot, seek permanent, sustainable funding for current participant caseload AND begin to seek funding for expansion opportunities should the evidence support this.
- Develop an evaluation plan that looks at social benefits, cost benefits, health benefits, and early outcomes for participants. Execute this plan alongside the pilot.
- Develop a transportation model that supports participant engagement with the MAP program. Ideally, this would include a partnership with EIA that would support participants in getting to and from the MAP.

LONG TERM 5-10 YEARS

- Transition planning for participants who have stabilized and require a different level of support.
- Engage in and create a 5-10-year strategic plan for MAPs in Manitoba
- Begin data analysis on any long-term outcome evaluation.
- Create alcohol harm reduction community of practice and/or training to support other agencies to engage people who use alcohol chronically in a way that is meaningful and possible for them.

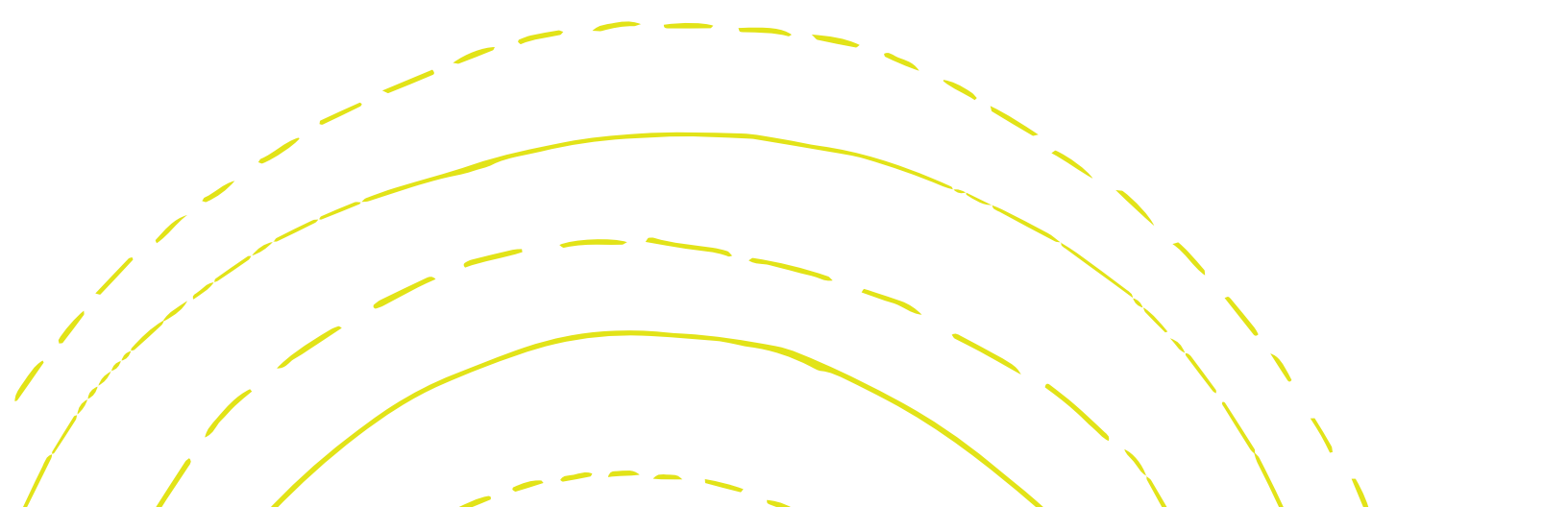
CLINICAL RECOMMENDATIONS

- The overall criteria for a participant's acceptance into a MAP should be based on
 - + desire to participate.
 - + Participant driven goals related to their participation in a MAP (i.e. housing, employment, reducing involvement in the justice system, reuniting with family, improving physical health etc.)
 - + Evidence that a MAP would contribute to stability (primarily as defined by the participant with the input of the clinical team) for the participant.
 - + Substantive history of chronic alcohol use
 - + Multiple 'treatment' attempts (residential, AA, cold Turkey, day programs).

- Housing environment
- When participants are in hospital, the hospital pharmacy takes over dispensing of alcohol along with other medications.
- Clinicians will titrate alcohol based on a goal of improved social stability and absence of signs and symptoms of alcohol withdrawal.
- The MAP will require strong pharmacological support to minimize risks of drug
- interactions at the time of the pours.
- Care plans should be developed with participants to determine the general approach to participants arriving to the MAP intoxicated. For example, some MAP's won't serve people who appear intoxicated, others provide a watered-down pour (half wine, half water). A clear plan for working with each participant if they are intoxicated and/or agitated allows clinicians to practice in a trauma informed way where the participant is never surprised by any intervention and is involved in determining clinician intervention.
- There should be no limits on the number of times participants can intake into a Managed Alcohol Program.
- Partner with an organization that can do medical stabilization without requiring total abstinence for participants who need 24-hour supervision to manage and prevent severe alcohol withdrawal.
- Each participant will review their participation with the clinical team on yearly basis to determine if their goals need to be reassessed or changed altogether.

STAFFING RECOMMENDATIONS

Staffing for a Managed Alcohol Program is varied from program to program. Here are two versions of what a staff complement could look like for a MAP in Manitoba. In both cases, the recommendation would be to plan for a mix of core staff and in-kind staffing support from partner organizations.



CADILLAC STAFF COMPLEMENT 20-50 PARTICIPANT MANAGED ALCOHOL PROGRAM

Approximately 1 Million dollars/year in program funding

POSITION	ETF	COUNT	DETAILS
Drop-in Staff	1.0	3-4	Responsible for drop in management, recreational activities, safety and security of participants.
Pour Staff/ Healthcare aides	1.0	2	Responsible for dispensing of alcohol, ordering, brewing etc.
Physician	1.0	1	Supervises the Medical component of the MAP and provides primary care to participants OR works with other primary care physicians using a shared care model.
Nurse	1.0	2	Manage day to day care and health of MAP participants. This could include wound care, immunizations, foot care, health assessments, ensuring lab work is completed, managing urgent and emergent care, facilitating care with other providers etc.
Occupational Therapist	1.0	1	Supports participants in engaging successfully in the activities of daily living.
Trauma Informed Therapist	1.0	1	Trauma specific counselling for participants as needed.
Recreational Therapist	1.0	1	Understands value of recreation in recovery and develops programming that supports the work of the MAP team and provides recreational opportunities for participants that can support their goals.
Program Manager	1.0	1	Provides management for entire team, responsible for evaluation, program model fidelity, etc.
Clinical Team Lead	1.0	1	Manages clinical supervision for the team. Supports day to day practice of the team. Responsible for participant Intake.
Indigenous Health Coordinator	1.0	1	Supports participants in their road to recovery through engagement and reengagement in cultural activities, ceremony, and teachings. Brings in Knowledge Keepers to share with participants. Supports the team to enhance and build on their capacity to provide culturally grounded care.
Social Worker with emphasis on drug and alcohol counselling	1.0	1	Works within systems to facilitate participant wellness. Provide drug and alcohol counselling to participants.
Reception/Admin Support	1.0	1	Supports day to day management of the MAP.
Housing Worker	1.0	1	Finds housing, supports participants to maintain housing.

RECOMMENDATIONS

MINIMUM STAFF COMPLEMENT 20-50 PARTICIPANT MANAGED ALCOHOL PROGRAM

Approximately 600 Thousand dollars/year in program funding

POSITION	ETF	COUNT	DETAILS
Drop-in Staff	1.0	4	Responsible for the pour, drop in management, recreational activities, safety and security of participants
Physician	0.5	1	Supervises the Medical component of the MAP.
Nurse	1.0	2	Manage day to day care and health of MAP participants. This could include wound care, immunizations, foot care, health assessments, ensuring lab work is completed, managing urgent and emergent care, facilitating care with other providers etc.
Recreation Coordinator	1.0	1	Understands value of recreation in recovery and develops programming that supports the work of the MAP team and provides recreational opportunities for participants that can support their goals.
Program Manager	1.0	1	Provides management for entire team, responsible for evaluation, program model fidelity, etc.
Clinical Team Lead	1.0	1	Manages clinical supervision for the team. Supports day to day practice of the team. Responsible for participant Intake.
Indigenous Health Coordinator	1.0	1	Supports participants in their road to recovery through engagement and reengagement in cultural activities, ceremony, and teachings. Brings in Knowledge Keepers to share with participants. Supports the team to enhance and build on their capacity to provide culturally grounded care.
Social Worker with emphasis on drug and alcohol counselling	1.0	1	Works within systems (Health, Justice, EIA, CFS etc.) to facilitate participant wellness. Provide drug and alcohol counselling to participants.

NEXT STEPS

In the very short term, priority should be placed on applying for and securing funding to hire a MAP coordinator to facilitate and manage the working groups efforts to move forward with a Managed Alcohol Program for Manitoba.

In addition, the MAP Working Group should work on a communications strategy that creates a united stance and could allow the group to begin speaking about managed alcohol in a specific and targeted way to build support for the project overall. This document should serve as a foundational document for presentations and discussions about managed alcohol in Manitoba.

CONCLUSIONS

MAP's are just about people preparing for regular life.

– PEER PARTICIPANT

Managed Alcohol Programs provide care and support to a population of people who are severely underserved in current health and social service programs. They are often made to fit into services that just don't address their needs. This can lead to people feeling like they are unsuccessful or unable to attain their goals, when, in fact, the programs have not been designed with their specific needs in mind. Who people are has often been ignored and, instead the focus has been placed entirely on their use of alcohol. Alcohol harm reduction, specifically Managed Alcohol Programs are designed with people who are impacted by chronic and sometimes problematic substance use in mind. MAP's create room for people to live by offering a more stable relationship with alcohol. They honour the strengths and gifts that people carry and create the stabilization that people require to explore, reconnect, and engage with themselves and their community in a new way.

This feasibility report has begun the process of engaging with local community to talk about MAP'S. The goal was to get feedback from various sources and have that feedback inform the current recommendations. It is by no means an end point, but rather a beginning. A starting point for the community to move forward from. Managed Alcohol Programs are supported across the country and, locally, by participants, frontline providers, managers and policy makers. There are many ways to develop a managed alcohol program for Manitoba, and the hope is that the interest, feedback, and support will contribute to a community mobilization that sees improved services for people experiencing homelessness and who are impacted by chronic alcohol use.

**MY PEOPLE KNOW
WHEN A PLACE IS
SAFE FOR THEM.
MAKE THIS SAFE.**

INTERVIEW PARTICIPANT



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APPENDIX A

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EXTRA THANKS TO:

The women at the Mothering Project

The drop in participants at Sunshine House

Residents of the Bell Hotel

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