



Commentary

On the outside looking in: Finding a place for managed alcohol programs in the harm reduction movement

Andrew Ivsins^{a,*}, Bernie Pauly^{a,b}, Meaghan Brown^a, Joshua Evans^c, Erin Gray^d, Rebecca Schiff^e, Bonnie Krysovaty^a, Kate Vallance^a, Tim Stockwell^a

^a Canadian Institute for Substance Use Research, University of Victoria, Technology Enterprise Facility Room 273, 2300 McKenzie Ave, Victoria, BC, V8P 5C2, Canada

^b School of Nursing, University of Victoria, HSD Building A402A, Victoria, BC, V8P 5C2, Canada

^c Department of Earth and Atmospheric Sciences, University of Alberta, 1-26 Earth Sciences Building, Edmonton, AB, T6G 2E9, Canada

^d School of Social Work, MacEwan University, 9-505 Robbins Building, Box 1796, 10700-104 Avenue, Edmonton, AB, T5J 2P2, Canada

^e Department of Health Sciences, Lakehead University, 955 Oliver Road, Thunder Bay, ON, P7B 5E1, Canada

ARTICLE INFO

Keywords:

Managed alcohol program
Harm reduction
Alcohol
Alcohol use disorder
Enabling places
Homelessness
Alcohol harm reduction

ABSTRACT

Alcohol policy in North America is dominated by moderation and abstinence-based modalities that focus on controlling population-level alcohol consumption and modifying individual consumption patterns to prevent and reduce alcohol-related harms. However, conventional alcohol policies and interventions do not adequately address harms associated with high-risk drinking among individuals experiencing severe alcohol use disorder (AUD) and structural vulnerability such as poverty and homelessness. In this commentary we address this gap in alcohol harm reduction, and highlight the lack of, and distinct need for, alcohol-specific harm reduction for people experiencing structural vulnerability and severe AUD. These individuals, doubly impacted by structural oppression and severe AUD, engage in various high-risk drinking practices that contribute to a unique set of harms that conventional abstinence-based treatments and interventions fail to adequately attend to. Managed alcohol programs (MAPs) have been established to address these multiple intersecting harms, and though gaining momentum across Canada, have had a hard time finding their place within the harm reduction movement. We illustrate how MAPs play a crucial role in the harm reduction movement in their ability to not only address high-risk drinking practices among structurally marginalized individuals, but to respond to harms associated with broader structural inequities such as poverty and homelessness.

Introduction

“...we always felt like we were, sort of, the red-headed stepchild of the harm reduction movement, in a way, at the time, because, again, we said, well, you know, yes it is a legal substance. But just because it’s legal doesn’t mean that, you know, the same techniques and tools don’t have a chance of being successful for the group we’re working with.” (Managed Alcohol Program site manager)

In 2006, the International Journal of Drug Policy published a special issue titled “Harm reduction and its application to alcohol policy” (Volume 17, Issue 4, July 2006). The issue includes an impressive collection of work from scholars across the globe discussing harm reduction as an approach to tackling alcohol-related problems. Notably absent from this special issue is attention to the application of harm reduction to alcohol use among people doubly impacted by severe alcohol use disorder (AUD) and socio-structural oppression and

marginalization. The reason for this absence is not clear, though we might surmise that, at the time, there was limited awareness of the unique needs of this population, with few treatment options available for the management of severe AUD beyond abstinence. As Measham (2006) noted in the special issue, in comparison to “safer use” initiatives concerning illicit substances, “safer drinking” initiatives have not yet been fully developed, in particular concerning individuals with severe AUD. In this commentary, we aim to further the conversation started in that special issue and illustrate both how far we have come, and at the same time how much more can be done, in addressing severe AUD among structurally vulnerable populations in Canada. We draw attention to a gap in alcohol harm reduction for people impacted by structural disadvantage and marginalization related to poverty, homelessness, colonization, and capitalism, and discuss the important role of managed alcohol programs (MAPs), increasingly being implemented across Canada, in addressing severe AUD among people experiencing

* Corresponding author.

E-mail address: aivsins@gmail.com (A. Ivsins).

<https://doi.org/10.1016/j.drugpo.2019.02.004>

structural vulnerability.

We begin with a brief discussion of alcohol use and harm, and the norms that govern its use. We then discuss the regulation of alcohol in Canada, the various policies and interventions in place to combat alcohol-related harms, and the role of harm reduction in alcohol policy. We highlight the lack of attention to harms related to alcohol use among structurally vulnerable populations, and elaborate on drinking patterns and associated social and health issues experienced by structurally vulnerable people with severe AUD. The commentary concludes with an account of MAPs in Canada – a unique intervention aimed at reducing the harms experienced by individuals with severe AUD and impacted by structural vulnerability.

Alcohol use, harms, and interventions

Alcohol is one of the most harmful psychoactive substances, second only to tobacco, as a major risk factor for injury, morbidity, and mortality (Rehm & Imtiaz, 2016; Rehm et al., 2009; World Health Organization, 2018). While alcohol is consumed in some capacity in most countries across the globe, prevalence varies widely, with larger per capita consumption in higher-income countries generally than lower-income countries (World Health Organization, 2014). Not surprisingly, alcohol attributed morbidity and mortality, and alcohol-use disorders, are generally higher among those countries that consume more alcohol (Rehm et al., 2009). There is an estimated 6.8% of adults in Canada, compared to 4.9% of adults worldwide, burdened with alcohol use disorders (Gowing et al., 2015; World Health Organization, 2014). Strikingly, the prevalence of alcohol dependence among homeless male populations has been estimated to be almost 40% (Fazel, Khosla, Doll, & Geddes, 2008; Fazel, Geddes, & Kushel, 2014). Individuals with severe AUD and who are experiencing structural vulnerability are impacted by a variety of factors associated with socio-structural inequities, and are at increased risk of harms of substance use.

While alcohol in Canada is regulated by various government policies that control its production, distribution and consumption, alcohol use is largely influenced by various socio-cultural norms that shape how and when alcohol is consumed. These norms are largely rooted in discourses of pleasure, leisure, and moderation such that controlled consumption is acceptable in certain spaces (e.g., restaurants, home, sporting events) while excessive intoxication is generally frowned upon except under certain circumstances and in particular contexts (e.g., among college/university students, within the night time economy) where social norms allow for, or even encourage, increased consumption and more “risky” behaviours (Borsari & Carey, 2001; Measham, 2004; Thurnell-Read, 2017). Violation of these social norms of moderation results in punitive sanctioning (e.g., fines, imprisonment), labelling (e.g., drunkard, alcoholic, lush), stigma/discrimination and social marginalization. Individuals who experience severe AUD and additional structural vulnerability are more likely to be perceived as violating prescribed drinking norms, and are also more likely to experience higher prevalence of alcohol-related morbidity and mortality. For example, structurally vulnerable individuals with severe AUD are often limited to drinking in public, consume cheap alcohol (e.g., cooking wine, sherry) or non-beverage alcohol (e.g., mouthwash, hand-sanitizer), engage in heavy drinking episodes, and exhibit extreme intoxication, all of which increase vulnerability to alcohol-related harms (Larimer et al., 2009; McCormack, Hoffman, Norman, Goldfrank, & Norman, 2015; Stockwell, Williams, & Pauly, 2012). Physical and social harms of street-based alcohol use are amplified in the context of homelessness, including risks of violence, theft, and exploitation.

A variety of measures have been implemented in Canada to decrease the burden of alcohol related morbidity and mortality, including alcohol policies that control the production, sale, and consumption of alcoholic beverages (e.g., minimum pricing, age restrictions), education campaigns promoting alcohol and safety (e.g., designated driver and

responsible drinking campaigns), a host of detox and withdrawal management services, and abstinence based treatment and peer support programs (e.g., Alcoholics Anonymous, out-patient and residential treatment centres, counselling services) (Giesbrecht et al., 2016). Although implementation is not always consistent, comprehensive or entirely effective, these measures are aimed at controlling population-level alcohol consumption or modifying individual consumption patterns associated with both problematic and non-problematic use in an effort to reduce alcohol-related harms (Giesbrecht et al., 2016). These approaches such as impaired-driving legislation, controlling access to alcohol, and regulating the production and distribution of alcohol, are general population measures that do not sufficiently address harms associated with high-risk drinking among those with severe AUD and other barriers. While alternatives to abstinence-based treatment and support groups such as ‘moderation management’ exist in some countries like Canada and the United States, they tend to be geared towards individuals experiencing mild to moderate alcohol use disorder and who are not impacted by structural vulnerability (Humphreys & Klaw, 2001; Kosok, 2006; Witkiewitz & Alan Marlatt, 2006). As such, individuals who are doubly impacted by structural vulnerability and severe AUD are often literally left out in the cold. This group does not adequately benefit from (or indeed necessarily want to access), and may in fact be negatively impacted by unintended consequences of, mainstream alcohol policy and popular abstinence-based treatment options (Grazioli, Collins, Daepfen, & Larimer, 2015; Wenzel et al., 2001). For these reasons we draw attention to harm reduction interventions specifically tailored to those impacted by severe AUD and structural marginalization. We suggest there is a need for tailored interventions for this sub population that specifically endeavor to reduce the adverse consequences of substance use without requiring abstinence (even when in treatment).

Alcohol harm reduction

While the roots of harm reduction can be traced back to the early 20th century, broader uptake of harm reduction interventions such as sterile needle/syringe distribution gained popularity in the early 1990s, spurred on by an HIV epidemic among people who inject drugs, and as a response to zero tolerance approaches to illicit drug use (Ball, 2007; Jarlais, 1995). Principles of harm reduction include the acceptance of psychoactive substance use and a focus on reducing harms (Single, 1995). The focus of harm reduction initiatives has often been to address biomedical harms such as bloodborne diseases associated with illicit drug use by focusing on specific technologies and/or modes of consumption. Examples include needle exchange programs, crack pipe and other drug paraphernalia distribution, and safer use initiatives such as supervised consumption/injection facilities.

Alcohol sits in a unique position in the harm reduction world. Where illicit drug harm reduction tends to focus more on *meso*- and *micro*-level interventions, alcohol use and the attempted reduction of related harm is guided by widespread and established alcohol policy aimed at the broader general public. Herein lies the shortcoming of current alcohol harm reduction; by focusing on broad, macro/population-level policies intended to encourage moderation, much alcohol harm reduction is unable to address forms of drinking that would benefit instead from tailored safer-use interventions targeting structurally vulnerable groups of people who drink. Individuals whose drinking patterns do not fit with prescribed drinking norms are less likely to benefit from such macro policies, and may even be negatively impacted by current alcohol policy measures (d’Abbs, 2015; Lee et al., 2018). As a number of papers in the 2006 IJDP special issue demonstrate, while much alcohol harm reduction concerns specific groups of people who engage in riskier or potentially harmful drinking practices, these measures clearly reflect a focus on youth, young adults, college/university students, and those participating in the night time economy. Few of the measures discussed focus on people with severe AUD, and in

the case of moderation management modalities, may be inaccessible to people with severe AUD and intersecting structural vulnerabilities. In fact, other than conventional counselling and treatment services, there are few interventions in Canada for people experiencing severe AUD and structural vulnerability, aside from a limited number of managed alcohol programs and alcohol-tolerant “housing first” models (Collins, Clifasefi et al., 2012; Collins, Malone et al., 2012; Pauly et al., 2018; Podymow, Turnbull, Coyle, Yetisir, & Wells, 2006). However, these initiatives often receive limited attention within alcohol harm reduction policy. Missing from current alcohol harm reduction initiatives are comprehensive interventions that address harms of drinking that deviate from social norms, and those on the margins of society, such as people experiencing severe AUD and structural vulnerability.

In many ways, people experiencing severe AUD and structural vulnerability more closely resemble other structurally disadvantaged people who use drugs (in terms of their experiences of structural oppression, broader of use, and disproportionate drug use-related harms) than the broader drinking public for whom most alcohol policy is intended (Crabtree et al., 2018). As such, these measures targeting the broader drinking public are not necessarily effective for people whose drinking patterns deviate from the norm, and who do not respond to conventional treatments/measures which are rooted in discourses of responsibility and moderation or abstinence. Contexts of use, the impact of socio-structural factors on consumption practices, and experiences of stigma/discrimination, homelessness/unstable housing, racism and poverty all need to be taken into consideration when designing and implementing harm reduction interventions for people experiencing severe AUD and structural vulnerability. The problems associated with alcohol do not come from consumption alone, nor from policies controlling consumption, but also from broader historical and socio-cultural/structural/environmental factors (Measham, 2006). Importantly, harm reduction for people experiencing severe AUD and structural vulnerability should have the capability to not only address harms directly related to substance use practices, but harms associated with broader structural inequalities such as poverty and homelessness. Managed alcohol programs (MAPs) are one such intervention.

Managed alcohol programs

Increasingly common in Canada, managed alcohol programs are a non-abstinence-based intervention intended to address the varied and intersecting harms that impact people experiencing severe AUD and structural vulnerability. Until recently (and in some cases still today) MAPs tended to operate “under the radar” to avoid public controversy. As such, MAPs have historically not been part of the broader harm reduction conversation and do not have as strong a foothold in the harm reduction movement as, say, needle/syringe exchange programs. However, with the growing awareness of and attention to MAPs (see for example the Special Issue on MAPs in the journal *Drug and Alcohol Review*: April 2018; Volume 37, Issue S1), this is changing and MAPs are increasingly understood and accepted as an important harm reduction measure.

While specific eligibility criteria vary across sites, typical criteria include consumption of non-beverage alcohol (NBA), frequent contact with police and first responders, frequent visits to hospital emergency departments, a history of heavy drinking in public, and unsuccessful attempts at abstinence. Specifically, MAPs seek to reduce acute (e.g., seizures, injury) and chronic (e.g. liver disease) harms related to unsafe alcohol consumption patterns such as street-based drinking, high-intensity binge drinking, drinking in isolation, and drinking NBA such as mouthwash, hand sanitizer, cooking wine, and rubbing alcohol, while also addressing harms related to structural vulnerability such as homelessness, violence, and cycling through social and health services. While MAPs vary in terms of structure and programming (for an overview of MAPs in Canada see: Pauly et al., 2018), they all share the common goal of reducing alcohol use harms through managing people’s

alcohol consumption, often alongside other social and health supports. Alcohol harm reduction within MAPs is accomplished in various ways such as administering regular measured doses of alcohol throughout the day in a safe environment as an alternative to street-based and isolated drinking, providing alcohol for purchase at minimal cost (e.g., through on-site alcohol brewing programs), and exchanging NBA for beverage alcohol. A key element of these programs is offering people experiencing severe AUD a non-abstinence-based means of reducing harms associated with high risk/intensity patterns of alcohol consumption. This concept is not unfamiliar, as we witness the expansion of injectable and oral opioid assisted treatments to treat severe opioid use disorders (Oviedo-Joekes et al., 2017; Palis et al., 2017).

A core component of MAPs is also addressing harms related to structural vulnerability and oppression. Indeed, alcohol use related harms are compounded by experiences of structural inequities and vulnerability such as homelessness/unstable housing, violence, cycling through social and health services (e.g., shelters, hospital/emergency room visits) and frequent interaction with law enforcement (D’Amore, Hung, Chiang, & Goldfrank, 2008; Roy et al., 2016). To address harms related to social inequity most MAPs in Canada provide some form of housing support (e.g. emergency shelter, transitional, supported or permanent housing), provide food service (one to three meals a day), contain on-site or embedded primary care and clinical support, and offer additional social, health and cultural supports (Pauly et al., 2018). A useful way to understand MAPs and their place in the harm reduction world is to position them within the risk environment framework, which suggests that intersecting physical, social, economic and policy environments produce and shape substance use and related harms (Rhodes, 2009). The risk environment framework has been effectively applied to understand and attend to various forms of substance use and risk behaviours, including public injecting (Rhodes et al., 2006), crack pipe and needle sharing practices (Ivsins, Roth, Benoit, & Fischer, 2013; Rhodes et al., 2003), and risky drinking behaviours among university students (Wilkinson & Ivsins, 2017). For people experiencing severe AUD and structural vulnerability, housing instability may necessitate drinking in public, which encourages binge drinking as a way to avoid interactions with law enforcement (otherwise potentially resulting in detainment or arrest, and the confiscation of alcohol). This in turn heightens levels of intoxication which increase chances of injury and/or violence. Similarly, the use of NBA has been shown to be shaped by both policy and social environments, whereby liquor store policies impede the purchase of legal alcohol, and social situations encourage pooling resources and sharing low-cost alcohol (British Columbia Centre for Disease Control, 2013).

When viewed through a risk environment lens, MAPs can be understood as a safer environment intervention (SEI) in that they address multiple harms stemming from multiple intersecting environments, without requiring abstinence (McNeil & Small, 2014; Rhodes et al., 2006). A qualitative synthesis of SEIs for people who inject drugs found SEIs mitigated drug-use related harms by providing alternative spaces away from street-based drug scenes, enabling safer drug use practices, and facilitating access to social and health resources (McNeil & Small, 2014). In essence, SEIs move people out of or away from environments that produce risk and harm, and into environments that better enable safety and wellbeing. MAPs function in the same way by providing safer places to consume alcohol, enable and encourage safer alcohol consumption practices, and often offer additional types of socio-cultural programming and assistance including access to healthcare services, help securing housing, support groups, and leisure activities. Key here is a recognition that SEIs involve more than modifying harmful drug and alcohol consumption patterns, but attending to variously intertwined broader forces that shape drug use-related harm. By removing structurally vulnerable individuals with severe AUD from risky environments (e.g., drinking in public, social situations of sharing NBA, sleeping on the street), MAPs attend to not only harms related to unsafe drinking practices, but those associated with structural disadvantage

and marginalization. Recent research on MAPs is promising, demonstrating not only positive changes in patterns of alcohol consumption and a reduction in acute and social alcohol-related harms, but their benefit as safe and supportive environments (Evans, Semogas, Smalley, & Lohfeld, 2015; Pauly et al., 2016; Stockwell et al., 2018; Vallance et al., 2016). For example, a recent study of six MAPs in Canada that compared MAP residents to a control group found that, compared to the control group, long-term MAP residents drank less NBA, consumed fewer standard drinks per day, and were less likely to report alcohol-related harms over the previous 30 days (Stockwell et al., 2018). However, longer term disease risk remains a concern, and we are still investigating the role of MAPs in relation to chronic and long-term alcohol related outcomes and health.

Conclusion

Recent work has drawn attention to the unique harms experienced by structurally marginalized people with severe AUD (Collins et al., 2018; Crabtree et al., 2018; Holtyn et al., 2017). This work highlights the need to address not only risky drinking practices, but intersecting socio-cultural and contextual factors implicit in experiences of structural and everyday violence and oppression. While most harm reduction measures specifically target methods and technologies of drug consumption, adequately attending to the risks and harms experienced by structurally vulnerable people who drink/use drugs also requires addressing underlying socio-cultural issues (Pauly, 2008). It is crucial in this respect to address forms of structural and everyday violence and oppression that contribute to, and augment, these risks and harms for both other drugs and for alcohol.

Crabtree et al. (2018) suggest that the harms experienced by “illicit drinkers”, and the harm reduction strategies they employ, closely resemble those of other “illicit” substances. Yet as the so called “red-headed stepchild” of the family, managed alcohol programs have struggled to find their place in the harm reduction movement. This may be due in part to the unusual position of alcohol as a legal psychoactive substance, and the previously limited (but growing) awareness of the diverse needs of structurally vulnerable individuals experiencing severe AUD. The intersection of severe alcohol use and structural vulnerability (e.g., homelessness, poverty, discrimination) contributes to multiple, often entangled, social and health inequities. There is a clear need for wider implementation of harm reduction measures that adequately address these issues. The safer environment interventions and enabling places frameworks provide useful platforms from which to conceptualize how alcohol-specific harm reduction measures might attend to various environments, context and places known to shape and produce risk and harm (Duff, 2011; Evans et al., 2015; McNeil & Small, 2014).

Conventional alcohol policies configured around population-level interventions are dominated by moderation and abstinence-based modalities in which a reduction or cessation of alcohol use is the outcome of interest. While moderation or abstinence may be viewed as an ideal means to avoiding alcohol related harm, in practice such strategies are often not ideal for individuals experiencing severe AUD and structural vulnerability. Although protective against longer term morbidity and mortality outcomes, moderation/abstinence-based policies and interventions may not demonstrably reduce, and may actually promote, shorter-term alcohol related harm among individuals experiencing severe AUD and structural vulnerability. By shifting the environments of consumption, moving structurally vulnerable individuals experiencing severe AUD from harmful environments into places that facilitate and enable safety and wellbeing, MAPs are an example of a harm reduction measure capable of addressing multiple intersecting harms. It is by opening up spaces of healing, safety, and wellbeing, without requiring abstinence, that harm reduction measures can most successfully benefit structurally marginalized individuals experiencing severe AUD.

Funding

This research was funded by grants from the Canadian Institutes of Health Research by way of a Partnerships for Health Systems Improvement (PHSI) grant (application # 293577), the Michael Smith Foundation for Health Research, Shelter House (Thunder Bay, Ontario) and Vancouver Coastal Health.

Conflict of interest statement

The authors have no actual or potential conflict of interest to declare.

References

- Ball, A. L. (2007). HIV, injecting drug use and harm reduction: A public health response. *Addiction*, 102(5), 684–690. <https://doi.org/10.1111/j.1360-0443.2007.01761.x>.
- Borsari, B., & Carey, K. B. (2001). Peer influences on college drinking: A review of the research. *Journal of Substance Abuse*, 13(4), 391–424. [https://doi.org/10.1016/S0899-3289\(01\)00098-0](https://doi.org/10.1016/S0899-3289(01)00098-0).
- Collins, S. E., Taylor, E., Jones, C., Haelsig, L., Grazioli, V. S., Mackelprang, J. L., ... Clifasefi, S. L. (2018). Content analysis of advantages and disadvantages of drinking among individuals with the lived experience of homelessness and alcohol use disorders. *Substance Use & Misuse*, 53(1), 16–25. <https://doi.org/10.1080/10826084.2017.1322406>.
- Collins, S. E., Clifasefi, S. L., Dana, E. A., Andrasik, M. P., Stahl, N., Kirouac, M., ... Malone, D. K. (2012). Where harm reduction meets housing first: Exploring alcohol's role in a project-based housing first setting. *The International Journal of Drug Policy*, 23(2), 111–119. <https://doi.org/10.1016/j.drugpo.2011.07.010>.
- Collins, S. E., Malone, D. K., Clifasefi, S. L., Ginzler, J. A., Garner, M. D., Burlingham, B., ... Larimer, M. E. (2012). Project-based housing first for chronically homeless individuals with alcohol problems: Within-subjects analyses of 2-year alcohol trajectories. *American Journal of Public Health*, 102(3), 511–519. <https://doi.org/10.2105/AJPH.2011.300403>.
- Crabtree, A., Latham, N., Morgan, R., Pauly, B., Bungay, V., & Buxton, J. A. (2018). Perceived harms and harm reduction strategies among people who drink non-beverage alcohol: Community-based qualitative research in Vancouver, Canada. *International Journal of Drug Policy*, 59, 85–93. <https://doi.org/10.1016/j.drugpo.2018.06.020>.
- d'Abbs, P. (2015). Widening the gap: The gulf between policy rhetoric and implementation reality in addressing alcohol problems among Indigenous Australians. *Drug and Alcohol Review*, 34(5), 461–466.
- D'Amore, J., Hung, O., Chiang, W., & Goldfrank, L. (2008). The epidemiology of the homeless population and its impact on an urban emergency department. *Academic Emergency Medicine*, 8(11), 1051–1055. <https://doi.org/10.1111/j.1553-2712.2001.tb01114.x>.
- Duff, C. (2011). Networks, resources and agencies: On the character and production of enabling places. *Health & Place*, 17(1), 149–156. <https://doi.org/10.1016/j.healthplace.2010.09.012>.
- Evans, J., Semogas, D., Smalley, J. G., & Lohfeld, L. (2015). “This place has given me a reason to care”: Understanding ‘managed alcohol programs’ as enabling places in Canada. *Health & Place*, 33(Supplement C), 118–124. <https://doi.org/10.1016/j.healthplace.2015.02.011>.
- Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high-income countries: Descriptive epidemiology, health consequences, and clinical and policy recommendations. *Lancet*, 384(9953), 1529–1540. [https://doi.org/10.1016/S0140-6736\(14\)61132-6](https://doi.org/10.1016/S0140-6736(14)61132-6).
- Fazel, S., Khosla, V., Doll, H., & Geddes, J. (2008). The prevalence of mental disorders among the homeless in Western countries: Systematic review and meta-regression analysis. *PLoS Medicine*, 5(12), e225. <https://doi.org/10.1371/journal.pmed.0050225>.
- Giesbrecht, N., Wettlaufer, A., Simpson, S., April, N., Asbridge, M., Cukier, S., ... Vallance, K. (2016). Strategies to reduce alcohol-related harms and costs in Canada: A comparison of provincial policies. *The International Journal of Alcohol and Drug Research*, 5(2), 33–45. <https://doi.org/10.7895/ijadr.v5i2.221>.
- Gowing, L. R., Ali, R. L., Allsop, S., Marsden, J., Turf, E. E., West, R., ... Witton, J. (2015). Global statistics on addictive behaviours: 2014 status report. *Addiction*, 110(6), 904–919. <https://doi.org/10.1111/add.12899>.
- Grazioli, V. S., Collins, S. E., Daepfen, J.-B., & Larimer, M. E. (2015). Perceptions of twelve-step mutual-help groups and their associations with motivation, treatment attendance and alcohol outcomes among chronically homeless individuals with alcohol problems. *The International Journal of Drug Policy*, 26(5), 468–474. <https://doi.org/10.1016/j.drugpo.2014.10.009>.
- Holtyn, A. F., Jarvis, B. P., Subramaniam, S., Wong, C. J., Fingerhood, M., Bigelow, G. E., ... Silverman, K. (2017). An intensive assessment of alcohol use and emergency department utilization in homeless alcohol-dependent adults. *Drug and Alcohol Dependence*, 178, 28–31. <https://doi.org/10.1016/j.drugalcdep.2017.04.025>.
- Humphreys, K., & Klaw, E. (2001). Can targeting nondependent problem drinkers and providing internet-based services expand access to assistance for alcohol problems? A study of the moderation management self-help/mutual aid organization. *Journal of Studies on Alcohol*, 62(4), 528–532. <https://doi.org/10.15288/jsa.2001.62.528>.

- Ivsins, A., Roth, E., Benoit, C., & Fischer, B. (2013). Crack pipe sharing in context: How sociostructural factors shape risk practices among noninjection drug users. *Contemporary Drug Problems*, 40(4), 481–503. <https://doi.org/10.1177/009145091304000403>.
- Jarlais, D. C. D. (1995). Harm reduction—A framework for incorporating science into drug policy. *American Journal of Public Health*, 85(1), 10.
- Kosok, A. (2006). The Moderation Management programme in 2004: What type of drinker seeks controlled drinking? *The International Journal of Drug Policy*, 17(4), 295–303. <https://doi.org/10.1016/j.drugpo.2006.03.003>.
- Larimer, M. E., Malone, D. K., Garner, M. D., Atkins, D. C., Burlingham, B., Lonczak, H. S., ... Marlatt, G. A. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *JAMA*, 301(13), 1349–1357. <https://doi.org/10.1001/jama.2009.414>.
- Lee, J. P., Pagano, A., Moore, R. S., Tilsen, N., Henderson, J. A., Shell, A. I., ... Gruenewald, P. (2018). Impacts of alcohol availability on Tribal lands where alcohol is prohibited: A community-partnered qualitative investigation. *The International Journal of Drug Policy*, 54, 77–86.
- McCormack, R. P., Hoffman, L. F., Norman, M., Goldfrank, L. R., & Norman, E. M. (2015). Voices of homeless alcoholics who frequent Bellevue hospital: A qualitative study. *Annals of Emergency Medicine*, 65(2), 178–186. <https://doi.org/10.1016/j.annemergmed.2014.05.025>.
- McNeil, R., & Small, W. (2014). 'Safer environment interventions': A qualitative synthesis of the experiences and perceptions of people who inject drugs. *Social Science & Medicine*, 106, 151–158. <https://doi.org/10.1016/j.socscimed.2014.01.051>.
- Measham, F. (2004). Play space: Historical and socio-cultural reflections on drugs, licensed leisure locations, commercialisation and control. *The International Journal of Drug Policy*, 15(5–6), 337–345. <https://doi.org/10.1016/j.drugpo.2004.08.002>.
- Measham, F. (2006). The new policy mix: Alcohol, harm minimisation, and determined drunkenness in contemporary society. *The International Journal of Drug Policy*, 17(4), 258–268. <https://doi.org/10.1016/j.drugpo.2006.02.013>.
- Oviedo-Joekes, E., Brissette, S., MacDonald, S., Guh, D., Marchand, K., Jutha, S., ... Schechter, M. T. (2017). Safety profile of injectable hydromorphone and diacetylmorphine for long-term severe opioid use disorder. *Drug and Alcohol Dependence*, 176, 55–62. <https://doi.org/10.1016/j.drugalcdep.2017.02.021>.
- Palis, H., Marchand, K., Guh, D., Brissette, S., Lock, K., MacDonald, S., ... Oviedo-Joekes, E. (2017). Men's and women's response to treatment and perceptions of outcomes in a randomized controlled trial of injectable opioid assisted treatment for severe opioid use disorder. *Substance Abuse Treatment, Prevention, and Policy*, 12(1), 25. <https://doi.org/10.1186/s13011-017-0110-9>.
- Pauly, B. (2008). Harm reduction through a social justice lens. *The International Journal of Drug Policy*, 19(1), 4–10. <https://doi.org/10.1016/j.drugpo.2007.11.005>.
- Pauly, B., Vallance, K., Wettlaufer, A., Chow, C., Brown, R., Evans, J., ... Stockwell, T. (2018). Community managed alcohol programs in Canada: Overview of key dimensions and implementation. *Drug and Alcohol Review*, 37(Suppl. 1), S132–S139. <https://doi.org/10.1111/dar.12681>.
- Pauly, B., Gray, E., Perkin, K., Chow, C., Vallance, K., Kryswaty, B., ... Stockwell, T. (2016). Finding safety: A pilot study of managed alcohol program participants' perceptions of housing and quality of life. *Harm Reduction Journal*, 13(1), 15. <https://doi.org/10.1186/s12954-016-0102-5>.
- Podymow, T., Turnbull, J., Coyle, D., Yetisir, E., & Wells, G. (2006). Shelter-based managed alcohol administration to chronically homeless people addicted to alcohol. *CMAJ*, 174(1), 45–49. <https://doi.org/10.1503/cmaj.1041350>.
- Rehm, J., & Imtiaz, S. (2016). A narrative review of alcohol consumption as a risk factor for global burden of disease. *Substance Abuse Treatment, Prevention, and Policy*, 11(1), 37. <https://doi.org/10.1186/s13011-016-0081-2>.
- Rehm, J., Mathers, C., Popova, S., Thavorncharoensap, M., Teerawattananon, Y., & Patra, J. (2009). Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. *Lancet*, 373(9682), 2223–2233. [https://doi.org/10.1016/S0140-6736\(09\)60746-7](https://doi.org/10.1016/S0140-6736(09)60746-7).
- Rhodes, T. (2009). Risk environments and drug harms: A social science for harm reduction approach. *The International Journal of Drug Policy*, 20(3), 193–201. <https://doi.org/10.1016/j.drugpo.2008.10.003>.
- Rhodes, T., Kimber, J., Small, W., Fitzgerald, J., Kerr, T., Hickman, M., ... Holloway, G. (2006). Public injecting and the need for 'safer environment interventions' in the reduction of drug-related harm. *Addiction*, 101(10), 1384–1393. <https://doi.org/10.1111/j.1360-0443.2006.01556.x>.
- Rhodes, T., Mikhailova, L., Sarang, A., Lowndes, C. M., Rylkov, A., Khutorskoy, M., ... Renton, A. (2003). Situational factors influencing drug injecting, risk reduction and syringe exchange in Togliatti City, Russian Federation: A qualitative study of micro risk environment. *Social Science & Medicine*, 57(1), 39–54. [https://doi.org/10.1016/S0277-9536\(02\)00521-X](https://doi.org/10.1016/S0277-9536(02)00521-X).
- Roy, L., Crocker, A. G., Nicholls, T. L., Latimer, E., Gozdzik, A., O'Campo, P., ... Rae, J. (2016). Profiles of criminal justice system involvement of mentally ill homeless adults. *International Journal of Law and Psychiatry*, 45, 75–88. <https://doi.org/10.1016/j.ijlp.2016.02.013>.
- Single, E. (1995). Defining harm reduction. *Drug and Alcohol Review*, 14(3), 287–290. <https://doi.org/10.1080/09595239500185371>.
- Stockwell, T., Pauly, B. B., Chow, C., Erickson, R. A., Kryswaty, B., Roemer, A., ... Zhao, J. (2018). Does managing the consumption of people with severe alcohol dependence reduce harm? A comparison of participants in six Canadian managed alcohol programs with locally recruited controls. *Drug and Alcohol Review*, 37(S1), S159–S166. <https://doi.org/10.1111/dar.12618>.
- Stockwell, T., Williams, N., & Pauly, B. (2012). Working and waiting: Homeless drinkers responses to less affordable alcohol. *Drug and Alcohol Review*, 31(6), 823–824. <https://doi.org/10.1111/j.1465-3362.2012.00422.x>.
- Thurnell-Read, T. (2017). "Did you ever hear of police being called to a beer festival?" Discourses of merriment, moderation and "civilized" drinking amongst real ale enthusiasts. *The Sociological Review*, 65(1), 83–99. <https://doi.org/10.1111/1467-954X.12361>.
- Vallance, K., Stockwell, T., Pauly, B., Chow, C., Gray, E., Kryswaty, B., ... Zhao, J. (2016). Do managed alcohol programs change patterns of alcohol consumption and reduce related harm? A pilot study. *Harm Reduction Journal*, 13(1), 13. <https://doi.org/10.1186/s12954-016-0103-4>.
- Wenzel, S. L., Audrey Burnam, M., Koegel, P., Morton, S. C., Miu, A., Jinnett, K. J., & Greer Sullivan, J. (2001). Access to inpatient or residential substance abuse treatment among homeless adults with alcohol or other drug use disorders. *Medical Care*, 39(11), 1158.
- Wilkinson, B., & Ivsins, A. (2017). Animal house: University risk environments and the regulation of students' alcohol use. *The International Journal of Drug Policy*, 47, 18–25. <https://doi.org/10.1016/j.drugpo.2017.06.002>.
- Witkiewitz, K., & Alan Marlatt, G. (2006). Overview of harm reduction treatments for alcohol problems. *The International Journal of Drug Policy*, 17(4), 285–294. <https://doi.org/10.1016/j.drugpo.2006.03.005>.
- World Health Organization (2018). *Global status report on alcohol and health 2018* Geneva: World Health Organization.
- World Health Organization (2014). *Global status report on alcohol and health 2014* Retrieved August 23, 2017, from http://www.who.int/substance_abuse/publications/global_alcohol_report/en/.