Shelter From the Norm: Refining Our Understanding of Alcohol Use Disorder, Homelessness, and Harm Reduction

Opinion Editorial

Joseph C. Salter, M.Sc. Global Health, Faculty of Health Sciences, McMaster University

Alcohol is a major contributor to numerous health conditions, resulting in 3 million deaths worldwide each year.[1] Current estimates indicate that 283 million people suffer from alcohol use disorder (AUD), the DSM-V term for alcohol addiction.[1] Despite its indiscriminate global reach, AUD receives surprisingly little attention from health professionals and policymakers.

The process of addiction, though convoluted and idiosyncratic, does retain a degree of predictability. Factors, such as trauma and mental health disorders, consistently underpin AUD.[2-5] For many who experience addiction, the social fabric that defines our humanity unravels around them.[6] Over time, AUD gets buried beneath layers of marginalization and discrimination, which reinforces the drinking behaviour and traps individuals in a vicious cycle.[7,8] Not surprisingly, AUD is deeply intertwined with homelessness. Alcohol use is deeply ingrained in street culture, offering an escape from the hardships of life on the streets, though it often comes at the expense of basic necessities.[9] In high-income countries, people with severe AUD are twice as likely to be unsheltered and account for approximately 33% of the population that experiences homelessness.[10,11]

In Canada, like most countries, funding flounders in a quagmire of politics and bureaucracy, with best practice displaced by misunderstanding. Society often ostracizes people with AUD and reduces their humanity to mere labels, such as 'drunks' and 'alcoholics', that rob them of their self-worth and agency.[12] Flawed assumptions and beliefs surrounding addiction result in an uncoordinated, fractured care system that fails to provide people suffering from AUD—especially those who are homeless—with the supports they need. Greater public awareness, coupled with educated debate, is essential for achieving practical and systemic change.

Highlighted below are 4 ideas pertaining to addiction, in general, and AUD, in particular, that must be reconceptualized. A brief discussion of harm reduction follows to embody this ideological transition.

I. Remodeling Addiction

The prevailing theory for AUD in the medical community is the brain disease model of addiction (BDMA), which emphasizes its neurobiological elements.[13] Notwithstanding the meaningful contributions of biomedicine, the BDMA tends to isolate addiction from its environment.[14] For example, a 2016 publication in the *New England Journal of Medicine*[15] cites the central role of major neurophysiological pathways in addiction (e.g. emotional and reward circuits) as support for the BDMA; however, critical analysis reveals an inattention to socioeconomic factors, which are minimally discussed and only considered insofar as they impact the structure and function of the brain. Short-sightedness leads to misdirected funding and investment in unnecessary medical research; many addiction-related issues can be sufficiently addressed by social workers and therapists.

Furthermore, proponents of the BDMA often suggest that medicalizing addiction reduces stigma.[15] In actuality, the 'lazy and weak-minded addict' stereotype stems more from political affiliation, news sources, and humanitarian values than beliefs about addiction.[16] Pathologizing addiction may well render the individual powerless because it discards central concepts like *choice* and *responsibility*, while justifying medical paternalism.[14,17] Holistic models that view addiction as a self-regulatory deficiency or a self-sustaining developmental process offer more coherence of disparate factors, thereby enabling interdisciplinary research and interventions that target the roots of AUD.[17]

II. Challenging Abstinence-based Approaches

For decades, abstinence has been the leading treatment approach for AUD. Abstinence may be ideal from a medical perspective but is not always

attainable or desirable for patients, especially considering the prominent role of alcohol in society and culture. The "pass or fail" nature of abstinence-based treatment can even create psychosocial barriers, where patients feel negatively judged, despondent, and helpless, distancing them from care systems.[18,19]

Research fails to demonstrate the superiority of abstinence-based methods compared to non-abstinence methods.[20,21] Non-abstinence goals, such as reduced drinking, shift the focus from the *act of drinking* to the *relationship* the individual has with alcohol. Recognizing this integral relationship will expand avenues for long-lasting psychosocial intervention.

III. Redefining Recovery

Viewing recovery as a *state* of abstinence is unhelpful because patient motivations, patient objectives, and definitions of 'recovery' change over time. In fact, recovery is perceived as a process: learning more about oneself, identifying best practices, and adjusting to a new lifestyle.[22] Therefore, treatment plans must be both flexible and all-encompassing in order to adapt to unfolding needs. Unfortunately, the existing care system in Canada is structurally rigid and functionally restrictive.

IV. Contextualizing Addiction

Context plays an important role in AUD, beyond psychological conditioning. Discriminatory policies, social norms, public discourse, and economic conditions place some individuals at a higher risk for using drugs.[23] In homeless shelters, zero-tolerance policies toward alcohol use are rooted in abstinence-based ideology. These outdated policies create barriers that deprive people with AUD of shelter—leaving them vulnerable to exploitation and injury on the streets—defeating the very purpose of homeless shelters. In this light, society plays a role in creating and perpetuating harmful conditions.

Welcoming Harm Reduction

Alcohol-based harm reduction (HR) is a public health initiative that aims to: (i) change patterns of alcohol use; (ii) improve types of alcohol consumed; (iii) minimize harms in the environment of consumption; and (iv) reduce social harms (e.g. car accidents) and service costs.[22] Accordingly, the philosophy of HR situates the individual within their environment. Low-barrier shelters called managed alcohol programs (MAPs) or 'wet shelters' are appearing in most major Canadian cities. Based upon the principles and practices of HR, MAPs offer daily doses of beverage alcohol—in place of rubbing alcohol, mouthwash, hand sanitizer, and aerosols—provided in a safe environment with support staff available.

HR is quite controversial because many believe this approach enables alcohol consumption and encourages continued use; however, there are key differences between *encouraging* and *accepting* alcohol use. By providing a facility for people who experience severe AUD and homelessness, MAPs offer somewhere to rest, re-establish social ties, and reconnect with the wider health system.[24,25] Accepting individuals for who they are mitigates dehumanization and builds trust, paving the way for their recovery.

As always, there is a caveat. Even if organizations adopt HR principles, discordance between administrative policies and front-line practices creates barriers.[22] For example, at shelters that purportedly tolerate alcohol use, staff may ignore or reprimand alcohol consumption, which perpetuates feelings of neglect among people with AUD.[26,27] These barriers should be addressed through staff training and inclusive policy-making at all levels.

Conclusion

Appropriate systems-level changes will never materialize without effecting ideological change in the political, medical, and public arenas. In order to progress, we should challenge our understanding of addiction, consider alternatives to abstinence, and broaden our definition of recovery. By recognizing the role of the environment, we can look beyond the 'morality of the alcoholic' into the realm of evidence; HR represents an evidence-based change in philosophy from one of disdain to one of acceptance.

Instead of eroding our sense of justice and fragmenting our collective vision for a more equitable future, it is time we realign our expectations to give people with AUD the respect and dignity they deserve.

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What's so Special About Nisa Homes? A Case Study of Community-Based Shelters in Canada

Research Article

Nour Al-Nasser, MSc McMaster Global Health Program, Punjabi Community Health Services Placement

Abstract

While domestic violence occurs in all communities, and across all race and class lines, this study examines the barriers Muslim women face when accessing the mainstream Canadian shelter system and the ways in which Nisa Homes, a community-based shelter for Muslim women, facilitates access and impacts Muslim women's lives and wellbeing. This study utilizes key informant interviews and focus group discussion with Nisa Homes staff and current and past Nisa Homes residents to produce its findings. As an outcome of this data, this study explores the gaps in the Canadian shelter system and how barriers can be overcome by exploring the innovative ways in which Nisa Homes provides services to Muslim women.