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"Give me the reigns of taking care of myself with a home": Healing environments in an Indigenous-led alcohol harm reduction program

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Abstract

Background Distinct from western Managed Alcohol Programs (MAPs), Indigenous-led alcohol harm reduction programs can be defined by both 'culture as healing' and decolonized harm reduction philosophies. We sought to explore experiences of Indigenous 'family members' (participants) in an Indigenous-led alcohol harm reduction program and culturally supportive housing to identify appropriate supports according to family member perspectives, and to inform delivery of the program.

Methods Situated within an Indigenous-western research partnership, we completed semi-structured interviews with seven family members of an Indigenous-led alcohol harm reduction and culturally supportive housing program. Community-guided protocols informed relational knowledge gathering practices including semi-structured in-depth interviews, qualitative thematic analysis, collaborative interpretation of findings, and development of knowledge products.

Results Family members highlighted the importance of tailored Indigenous-led alcohol harm reduction in shifting their relationships to alcohol from survival to having choice and control of their drinking (*It's a choice I'm making right now*). The provision of varied and incremental culture-based opportunities (*Multiple pathways for connecting to culture*) facilitated engagement with culture as healing. Policies that honour respect and autonomy were identified as supportive to healing and harm reduction, countering family members' experiences in western spaces (*Give me the reigns of taking care of myself with a home*).

Conclusions An Indigenous-led alcohol harm reduction program within a model of culture as healing facilitated shifts in relationships to alcohol, providing a space where family members could explore long term goals of healing and connection to culture. Family members' experiences and recommendations offer key considerations for the design of Indigenous-led harm reduction and culture as healing models. Recommendations emphasize the provision

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of tailored alcohol harm reduction plans in parallel to multiple and accessible opportunities for connection to culture as healing in order to meet diverse participant goals and relationships to alcohol and culture.

Keywords Culture as healing, Alcohol harm reduction, Decolonized harm reduction, Indigenous health, Indigenous housing, Managed alcohol programs

Background

Substance used related harms are tied to present and past processes of colonization for Indigenous people [1–4]. Historical and present-day colonial traumas of Canada, including Residential school system and 'child welfare' policies of the nineteen-'Sixties Scoop' and today, have been shown to increase risk of substance-use related harms for Indigenous youth and adults who have been subject to these systems in childhood [5–8]. It is well documented that such colonial projects which attempted to "assimilate" generations of Indigenous people, restricted control of Indigenous community control over resources, governance, and administration of health services, have trickled down creating trauma, health inequities, and substance use harms [9–11].

While epidemiological research on alcohol consumption demonstrates that Indigenous people tend to drink less than the population average, a subset experience more significant alcohol related harms and binge use [12, 13]. In the context of colonization of Turtle Island, alcohol has been weaponized against Indigenous communities both materially and symbolically, persisting in contemporary and discriminatory myths around alcohol and Indigenous communities [14]. Namely, eugenicist and colonial science propagated biological theories of alcohol consumption among Indigenous people as part of white supremacist agendas [15]. In contrast to these narratives, evidence of the key drivers of heavy alcohol use and alcohol-related harms identified in the literature include social determinants, such as historical and lived trauma, racism, and inequitable access to education, employment, social opportunities, and safe housing [2, 12, 16–18].

In the context of homelessness, alcohol use is associated with a range of acute and chronic physical harms including liver disease, cancers, injuries, assaults, and earlier mortality [19–21]. Previous research demonstrates that people experiencing homelessness drink in heavy or more harmful patterns as an attempt to cope with precarity, displacement, and violence on the street [22–24]. For example, when beverage alcohol is not affordable, people experiencing homelessness may rely on consumption of non-beverage alcohol (NBA) to avoid acute withdrawal [22, 25] with potential severe health consequences [26, 27]. In addition, "street-based illicit drinking" is often defined by experiences of stigmatization, criminalization, unintentional injury, physical and mental health harms, violence, severe withdrawal, and exclusion from health and social services [22, 23, 28]. Criminalization and racism more severely impact Indigenous people with experiences of street based illicit drinking, noted in reports of police targeting and violence [29].

Culture-based models and Indigenous-led alcohol harm reduction

Several gaps exist for appropriate housing and alcohol use supports for Indigenous people experiencing homelessness and heavy alcohol consumption. Firstly, Euro and white-centric substance use supports (e.g. Twelve-Step programs) are often identified as inadequate and harmful [30, 31]. Indigenous-led "culture as healing" (CAH) models offer a fundamentally distinct approach rooted in Indigenous approaches to wellness and recovery. Indigenous CAH for substance use refers to the broad set of cultural healing modalities, including traditional teachings, ceremonial practices, and Elder mentorship led by Indigenous communities and cultural practitioners [32–34]. CAH models vary according to the local contexts and traditions from which they originate. However, all aim to promote holistic and strengths-based definitions of health, 'wellness', and 'healing'. There are few options for CAH for Indigenous people who are not ready or interested in becoming abstinent [35].

Alcohol harm reduction strategies are less funded when compared to strategies for illicit substance use in Canada [28], with even less attention to harm reduction approaches tailored towards Indigenous people. Gaps in harm reduction for Black, Indigenous, and People of Colour (BIPOC) are in part driven by white privilege in harm reduction [36]. Crabtree et al. [37] argue that public discourses related to alcohol and Indigeneity are implicated in this gap by "creating the sense that Indigenous alcohol use is a "special case", [hampering] efforts to create links between drug users' organizations and illicit drinkers" (p.6).

In western settings, Managed Alcohol Programs (MAPs) have been established as harm reduction programs aiming to reduce physical and social harms of heavy, chronic, and street-based illicit drinking, homelessness and/or housing instability through safer moderated alcohol administration, housing or shelter, health, and social support [32]. Participation in a MAP is associated with reductions in alcohol-related harms associated with binge drinking and withdrawal, smoother patterns of drinking, reduced emergency service use, housing stability, and reduced risk of mortality [38–42]. Qualitative

research with MAP participants illustrates that access to a stable alcohol supply, alongside housing or shelter, provide a harm reduction alternative to street-based illicit drinking, marginalization, and displacement within abstinence-based systems [23]. MAPs facilitate shifts in individual relationships to alcohol from insecurity to stability and a sense of control over drinking, while also offering a space for individuals to (re)-connect with themselves, families, and a sense of community within and outside of the MAP [54].

With over 40 MAPs established in Canada, very few are Indigenous-led and culturally based. Accounts from Indigenous participants in western MAPs and other alcohol harm reduction programs demonstrate a need for culture-based supports alongside harm reduction [42, 43]. Some Indigenous communities have also identified a specific need for Indigenous-led and culture-based MAP models [44, 45]. Importantly, there are critical differences between MAPs that include culture-based supports in the context of a western program, and Indigenous-led MAPs in which there is a foundational philosophy grounded in CAH. One example is Ambrose Place, an Indigenous-led and culturally based housing program guided by Natural Law and integrating a harm reduction approach in Treaty 6 Territory (Edmonton, Alberta). Through access to Indigenous healing and wellness traditions, ceremonies, and practices alongside MAP and culturally supportive housing, residents of Ambrose Place have reported impacts of enhanced quality of life, home and family, safer and reduced drinking [46].

Study context: Aboriginal Coalition to End Homelessness Indigenous alcohol harm reduction program

While there is some research on the impacts of Indigenous-led MAPs such as Ambrose Place [46], specific culture-based strategies alongside alcohol harm reduction [43] and more fulsome CAH models in abstinence-based settings [32], research is lacking on the implementation of broader CAH frameworks. Specifically, there is a need to develop knowledge that can guide Indigenous-led harm reduction according to the perspectives and definitions of healing for Indigenous people with experiences homelessness. This study builds from the innovative work of the Aboriginal Coalition to End Homelessness Society (ACEH), an Indigenous-led non-profit housing society in the traditional and unceded territory of the lək̓ʷəŋən speaking and WSÁNEC peoples (Victoria, BC). In 2015, the ACEH was formed with a mandate to serve the needs of Indigenous people experiencing homelessness ("Indigenous Street Family" (ISF), or "Family Members") in Victoria and across Vancouver Island, encompassing the unceded territory of the three tribal island groups of the Coast-Salish (Southern and Eastern Vancouver Island), Nuu-chah-nulth (Western Vancouver Island), and Kwakwaka'wakw territories (Northern Vancouver Island). The ACEH Dual Model of Housing Care (DMHC) is grounded in Indigenous values, perspectives, and knowledges towards pathways to healing and recovery from trauma and substance use rooted in colonialism [47]. The DMHC incorporates two pillars: (1) culturally supportive housing and (2) decolonized harm reduction, which together aim to strengthen Indigenous self-identity, family, and community through traditional foods, plants, medicines, Elder mentorship, traditional healing practices, land-based healing, and access to an alcohol harm reduction program [47].

This study aims to describe individual (referred to as 'Family Members' by the ACEH) definitions of 'culture as healing' and qualities of 'healing environments' in the ACEH Indigenous Alcohol Harm Reduction Residence Program (IAHRRP), which is situated within the ACEH Culturally Supportive House (CSH). In this paper, we describe family members' perspectives on the role of the IAHRRP in relation to alcohol and healing, as well as their perspectives on healing environments. In two related papers, we report on healing perspectives and environments related to culturally supportive housing (Brown et al., under review), and ways in which family members defined and experienced culture as healing (Hunt Jinnouchi et al., under review). Together, findings from this project aim to define and inform principles, practices, and policies that appropriately respond to the identified needs, preferences, and goals of those who take part in Indigenous-led alcohol harm reduction services and culturally supportive housing.

Methods

This project is situated within a 5-year relationship between the ACEH and researchers with the Canadian Managed Alcohol Program Study (CMAPS) at the University of Victoria. We approached this project through a participatory Indigenous research methodology, consistent with ACEH values, principles, and language. This Indigenous-western research partnership was driven by Indigenous methodological guiding principles [48–51] in the design and development of the qualitative study protocol. Guiding principles for this partnership included direct community involvement and partnership in research [49], an emphasis on relational accountability [51], collectivism and commitment to the community [49], knowledge seeking aimed towards direct action [49], and research designs determined by community driven processes and cultural protocols of decision making [48–51].

Community-defined priorities and processes have guided the establishment and ongoing journey of this partnered project. In 2016, the ACEH identified that CAH opportunities were overwhelmingly requested

by members of the Indigenous Street Family (ISF) to facilitate pathways out of homelessness [52]. Preliminary outcomes from the ACEH's culturally supportive housing pilot illustrated the importance of housing that is rooted in Indigenous context and delivery and the need for Indigenous-led approaches to harm reduction within housing. In 2018, the ACEH [45] led a MAP feasibility study with 38 members of the ISF and 20 community service providers, which validated the need for an Indigenous-led alcohol harm reduction program and highlighted important features for model design. Outputs from this project culminated with sharing at the *Wisdom of the Elders* gathering in June 2018, where leaders and traditional Knowledge Keepers of three tribal island groups and Métis Nation Victoria, local service providers, and members of the ISF reinforced a need for the IAHRRP. This laid the groundwork for situating the model within Indigenous teachings, protocols, values and principles [53].

In Spring 2020, the ACEH established the IAHRRP within the CSH. In tandem, the ACEH (co-applicant Fran Hunt Jinnouchi) in partnership with the University of Victoria Canadian Institute for Substance Use Research (CISUR) (Co-applicant Dr. Bernie Pauly), University of Calgary (NPI Dr. Katrina Milaney) and the Aboriginal Standing Committee on Homelessness (Treaty 7 Territory, Calgary AB, co-PI Katelyn Lucas) received 3-year funding from the Canadian Institutes of Health Research (CIHR) to design, develop, implement, and evaluate Indigenous-led MAPs across 2 sites in Victoria and Calgary. The CMAPS and ACEH team includes both Indigenous (Hunt-Jinnouchi, Mushquash) and non-Indigenous settler team members (Brown, Pauly, Robinson) (see: 'Authors Information' for author positioning). Community-determined processes continued to guide research design through two main routes: [1] direct engagement with a Family Members' Advisory on decision making for data collection protocols and interpretation of findings, and [2] regular meetings and discussion between the CMAPS team and ACEH leadership team, who were in turn guided by an established Elders and Knowledge Keepers Advisory. A Memorandum of Understanding (MOU) was developed to guide decision making specific to the research. This MOU was drafted according to the four principles of relational accountability (Respect, Reciprocity, Relevance, Responsibility) (Wilson, 2008). This served to identify appropriate roles and practices between the CMAPS and ACEH team members according to ACEH protocols.

Consistent with Indigenous methodologies, we used a relational knowledge gathering approach with guidance from the Family Members Advisory, Elders, Knowledge Keepers, and ACEH leadership. Preceding recruitment, Brown visited the CSH and met with previous family members to share a meal or attend a land-based outing. Up to 10–12 family members reside at the CSH. Recruitment was initiated through third party methods, including a recruitment poster in the house and staff review of the poster with individual family members. Family members who had left or transitioned from the CSH were provided recruitment materials by ACEH outreach staff. From July to December 2021, Brown conducted seven in-depth, one-on-one, semi-structured, and open-ended interviews with current and previous family members of the CSH at the CSH or the ACEH outreach office. One-on-one interviews were specifically recommended by the Family Members Advisory to preserve confidentiality regarding sensitive topics. All family members endorsed histories of chronic homelessness and heavy, daily alcohol use. Most family members who participated in an interview identified as cis men ($n=5$, cis women $n=2$), on average were 41 years old (range 24–62), and had an average tenure of 8 months in the CSH (range 5–12 months). Most family members identified with Coast Salish ancestry ($n=4$), while three other identified with another First Nation and/or Métis ancestry.

On average, interviews were one and a quarter hour and were audio recorded and transcribed verbatim by Brown. Questions focused on: experiences transitioning into the CSH; initial, present, and future goals; experiences with land-based healing; facilitators and barriers to culture-based support; perceived changes in physical, emotional, spiritual, mental wellness and connection to culture, nutrition, and other services; perceptions of alcohol in the CSH; perceptions on harm reduction, health, social, spiritual, and cultural supports; defining respectful, welcoming, and comfortable practices, supports, and relationships in the CSH and community; experiences in Indigenous-led vs. western services; benefits and challenges inside and outside the CSH; and personal definitions of wellness and success.

Initial thematic analysis was led by Brown, including reading and re-reading of transcripts, development of coding and category maps for each transcript, and generation of broad themes with associated quotes. These preliminary findings were presented back to ACEH leadership for initial interpretation. Subsequently, an infographic was drafted by Brown reflecting key themes and shared with family members for feedback. Since February 2021, findings from this project have been presented back to family members, staff, Elders, and Knowledge Keepers at ACEH gatherings and events, often as a reference point for discussion among attendees regarding ongoing CSH design and implementation and new staff orientation training. At the time of writing, the ACEH is in the process of finalizing the *Dual Model of Housing Care* (DMHC), incorporating two pillars: decolonized harm reduction and culturally supportive housing. The

DMHC is fundamentally driven by guidance from Elders and Knowledge Keepers and Indigenous worldviews, values and principles, and the wisdom of lived experience knowledge among family members who kindly shared their perspectives with us through this project and others.

Results

Three themes reflect family members' perspectives on the role of the IAHRRP and CSH in relation to alcohol, healing, and factors that promote healing environments. In *It's a choice I'm making right now*, family members outlined the importance of the IAHRRP in facilitating a relationship to alcohol based in choice rather than survival, with varying goals from abstinence to safer, more individually 'controlled' drinking. *Give me the reigns of taking care of myself with a home* describes impacts and healing environments related to collaborative practices and policies that honour autonomy, independence, and human rights. Lastly, we describe the importance of having *Multiple pathways for connection to culture, with or without alcohol*, through inclusive policies and practices that accommodate a range of relationships to alcohol and culture.

It's a choice I'm making right now

All family members described daily and heavy drinking patterns prior to entering the CSH. In the context of homelessness, many family members experienced patterns of street-based drinking with periods of binge and withdrawal. These experiences were marked with significant anxiety in securing funds for a daily alcohol supply, along with the necessity to do daily survival strategies to address withdrawal. The consistency and stability of the alcohol harm reduction program allowed for family members to reduce reliance on these survival strategies. In the following quote, a family member describes the impact of the alcohol harm reduction in shifting from survival drinking:

> *So, it's there, it's available to me. And I'm glad, I wish I had that before. If I had known this was going on like a year ago, I definitely would've been tryin' to get in here. Cause, you know I've done, I've done a lot of stuff to keep my liver and alcohol, right. And some of that I'm not proud of it, but here I am now and… and it's not hard, it's not hard anymore to get up in the morning and think where I'm going to get my next drink like that eh. […] Yeah, it takes away a lot of pressure and worry and anxiety… oh yeah not to mention that. I just get anxious. That's why I did a lot of crime. Cause I'd hate to… get to the point where there was no alcohol in my system. It'd just give me the shake and like ah "oh I've got to have it now, I've got to have it now". And then I'd go out and do crime and… now I don't have that. FM1002.*

This family member was able to meet their alcohol needs through the IAHRRP, which reduced activities necessary and often associated with survival drinking. For this family member, the alcohol harm reduction program helped to "[take] away a lot of the pressure and anxiety" he experienced on a day-to-day basis.

All family members described drinking in smoother patterns in the alcohol harm reduction program, including benefits such as reduced intoxication, reduced blackouts, and feeling in control of drinking:

> *Um… [my goal] in the end is to have my drinking controlled. Cause I don't believe I'll ever quit. And I'm not just going to do that non-drinker, right. But to have it under control some way, where I actually control, find a way to control. […] Rather than waiting to get my pay cheque and then binge, which is what I was doing. FM1006.*

Many family members described the process of using the alcohol harm reduction program to taper their alcohol use over time according to their choice and preferences. A minority of family members were specifically abstinence-oriented in their goals, although chose to take part in the IAHRRP towards this path. Importantly, the CSH was regarded as a place where everyone's goals and wishes were respected and supported, from reduced drinking, safer or less binge drinking, to abstinence:

> *For me when I was on the program it helped me look at myself in a way about my addiction, you know. And treatment, detox, you know some programs… I did look into them when I was there, at the house. And I quit drinking and then I started drinking non-alcohol beer, right, taper off the alcohol. So, and they supported me with that with the non-alcoholic beer too. So, they support you both ways, I think, right? Which is like, I thought that was really good. FM1004.*

For this family member, their goal was to reduce their drinking towards physical wellness with regards to liver function. Some family members entered the CSH with specific goals related to their drinking to either reduce their drinking or stop completely. All family members eventually voiced specific goals related to safer drinking or abstinence upon becoming familiar with the CSH and the support it provided for alcohol harm reduction.

For several family members who were aimed towards abstinence in the long term, the CSH was described as a place that provided the patience and support to pursue

abstinence when they were ready. However, this pathway was rarely described as linear. Family members who were abstinence-oriented appreciated the IAHRRP as an option for safer drinking instead of survival-based drinking. As one family member described, "it's a choice I'm making right now" (FM1003). When asked to identify strategies to support their goals and pathways towards healing if they were to leave the CSH, four of seven family members asked that they be able to return to the CSH or receive alcohol harm reduction support in their own homes. These requests illustrate the need for flexible and accessible alcohol harm reduction support according to family members' changing needs as they move forward on their pathway to healing.

Give me the reigns of taking care of myself with a home

In a supportive space with access to regulated alcohol supply, family members described new opportunities to identify and move towards their self-defined goals. As one family member describes, the CSH and IAHRRP provided an opportunity to "learn something about myself, about my drinking" (FM1004) with time and patience. The following family member highlighted that a core attraction of the house was the approach taken by staff that allowed them to "give me the reigns of taking care of myself with a home":

> *Oh, it was ah, me being on the street and drinking so much that my, I wasn't keeping up with my insulin and stuff like that and my doctor recommended that I come here instead of being on the street and… cause I was drinking quite a bit when I was on the street. Like, didn't matter. All day I'd drink, sometimes I'd drink a whole sixty-pounder for the day, for the night and then… it just caught up to me. Yeah so, [my doctor] recommended that I come here. Cause, he didn't want to get me, like fix me all up and then get me back on the street again. So, he said that there was a program here that would help me like ah, help me with my alcohol. And that would give me the ah, like the … I don't know how to explain it but give me the reigns of taking care of myself with a home. So, like… it's helped though and I've been cutting down where I barely drink anymore. FM1002.*

When family members compared their experiences in the CSH to before entering the house, several expressed differences in practices and policies that signaled more respect for their autonomy and independence. In western health and shelter spaces, family members shared experiences of paternalism and contrasted these to house practices and policies. One family member compared their experiences in the CSH versus medical detox:

> *I've been to detox and all the other programs, they're not, I don't like it because they want you to release yourself to the higher power or to god. […] Being Aboriginal, Native and Christianity, it's like water and oil. It's not for me. I don't like the way they do it, like 90 meetings in 90 days. Here, at least they talk to you like "how are you doing? What are you going through?" every time you ask for a drink. "How do you feel?" like, "is there something we can do to get you out of that funk?" There, it's just like, "well you gotta do this, you gotta do that. You gotta go to these meetings. You gotta deal with the meetings, you gotta do that." FM1003.*

In this quote, the family member contrasts several differences in his experiences between abstinence-based and Christian-rooted services and the Indigenous-led alcohol harm reduction program. They compare differences between assertive and authoritarian approaches and open-ended and collaborative approaches to staff connecting with them at the CSH. Two other family members described specific differences in medication policies and practices between their experiences in western health and shelter systems and the CSH. For one family member, simply having the trust from staff to manage their own medication, rather than having a policy to hand-in medication, signaled respect. Another family member described being 'cut off' their pain medication in detox without his knowledge or consent:

> *Well, it was horrible, I think. Well, I slept the whole seven days while I was there. And ah, while I was asleep apparently, they changed my schedule, my medication schedule. I kind of went from worse to worse. […] You know, the medication I was on was good when I went in, and when I got out, it was ruined again. It just felt like jail all over again. FM1002.*

This family member was able to receive adequate pain management upon returning to the house through his relationship with the CSH physician. In this situation and others, family members described collaborating with staff and management to amend house policies. For example, the alcohol dispensing practice was changed to avoid disagreements where family members and staff co-signed the documentation of the time alcohol was dispensed. This allowed for frank and collaborative discussion between staff and family members if there was disagreement about when a dose was given. These practices ultimately enhanced ownership and confidence in family members' healing and participation in the IAHRRP.

Multiple pathways for connection to culture, with or without alcohol: "It was nice to feel part of something"

Here, we describe family members' perspectives on accessing and engagement in CAH in relation to alcohol and the alcohol harm reduction program. Family members were varied in their interest and readiness to participate in cultural supports. In a related paper, we describe the many ways in which family members defined and participated in CAH (Hunt-Jinnouchi et al., under review).

One family member explicitly stated that they did not feel comfortable participating in some ceremonies due to ongoing drinking. For this family member, following his cultural teachings meant that participating in traditional practices could not occur with ongoing alcohol use:

> *Spirit bath. Um… sageing. But I can't do that unless I'm sober. But I'm never sober, so. You need to be at least; I believe it's three days sober. […] Um, I wanted to go. But I'd wake up and get my first couple drinks and I'd already be drunk and then it's too late to go there. […] It was understandable. I can't really understand it but… I don't know, that's apparently what you're supposed to do. […] Yeah, I was still able to go to other stuff. Walk around and… walks around um Goldstream and stuff. Other journeys and other places to go. Whale watching, that was fun […] Because it was nice to feel part of something. FM1001.*

While this family member describes feeling uncomfortable participating in certain ceremonies due to ongoing drinking, the CSH provided the space that allowed them to access culture where possible. He describes having the opportunity to 'feel part of something' as part of the culture as healing mandate of the CSH. Despite this family member's experience of drinking as a barrier to participating in the Spirit Bath, this was the only instance of family members expressing barriers to participation in cultural supports based in ongoing alcohol use.

The IAHRRP is offered alongside some 'Land-based Healing Camps': several-day culturally immersive experiences offered by the ACEH, which are grounded in the ceremonial and wellness practices of the host Elders, Knowledge Keepers, and cultural facilitators on their ancestral territories. The IAHRRP is provided on camps to promote accessibility of land-based healing opportunities for family members who otherwise would not or could not attend an abstinence-based camp. Most family members who participated or wanted to participate in camps were supportive of the provision of the alcohol harm reduction program on the land. The provision of the IAHRRP was identified as a necessary support for family members to be able to attend a camp. However, the provision of alcohol on camps was not universally supported by family members. The following family member expresses their thoughts about bringing alcohol on a land-based healing camp:

> *Yeah, I think it should be because that way everybody that's there, everybody's that doing, will learn more. Alcohol's basically a depressant and you start drinking, you're just going to forget everything and you're gonna… I find alcohol brings up a lot of stuff in the past. And… yes, a lot of people went through a lot of stuff but, if you don't want to remember that stuff don't drink. And I'm trying to forget a lot of stuff. The less I drink, the more I'll forget it. I mean sure a lot of stuff happened to me, but I don't want to remember it. And I don't need to, right [pause]. Comes up time to time… trying to forget about it. FM1003.*

Family members relationships to alcohol and their perceptions of the role of alcohol in culture as healing varied. In turn, family members had diverse goals related to connecting to culture as healing and alcohol use. In the above quote, the family member associated alcohol use with traumatic memories and felt that this detracted from their goal of learning on the land. Another family member, who acknowledged that his long-term goal would be to control rather than completely stop drinking, hoped to connect further to traditional and land-based experiences:

> *And plus, when I'm on my land, I lived with a fire. I don't cook inside. I cook outside on the fire, yeah. Different kind of life. […] I do wanna, I do wanna get in a position where I get back to my land and maybe a few head of cattle, you know. Just ah… spend my retirement life. Cause I don't intend to spend it here forever. That's what I'd like to do but… money wise, it would be tough. [pause] Yeah, yeah. […] I would say I'm getting close to that than I've ever been. At any point if I got enough funds, I could head back, build myself a small house and I'm good, like you know. That's all I need now is just ah, visit my grandchildren wherever, they're all over. FM1006.*

For some family members, reconnecting back to their territory necessitated being on a new path and way of life, which could or could not include alcohol. For family members who described immersion in their culture and communities in the past, the CSH was often described as a temporary stop on a pathway back to living according to their cultural traditions and for some, on their ancestral lands, before experiencing homelessness. The CSH was seen as a temporary stop on this pathway towards a 'different kind of life', although goals around relationships to alcohol varied across individuals with some seeing

'controlled', safer drinking as consistent with a 'traditional' life, and others looking towards abstinence. Some family members who planned to eventually transition from the CSH expressed a desire to continue to access the alcohol harm reduction program, alongside 'day' or 'outreach' culture as healing supports. These differing perspectives reflect the complexity of supporting healing environments that meet diverse needs and relationships to alcohol and culture, further illustrating the importance of supporting individual pathways to healing through tailored supports.

Discussion

This study is situated within a broader project on the design, development, and implementation of Indigenous-led alcohol harm reduction. The purpose of this collaborative study was to define 'healing environments' in Indigenous-led alcohol harm reduction and culturally supportive housing for family members as Indigenous people with lived experiences of homelessness and alcohol use. In this paper, we described family members' shifting relationships to alcohol and culture as healing through the IAHRRP, and their perspectives on healing environments that influence this relationship. In two related papers, we present findings on family members' definitions and experiences with culture as healing (Hunt Jinnouchi et al., under review) and healing environments (Brown et al., under review) in relation to culturally supportive housing and transitions into the house.

Family members described how the alcohol harm reduction program provided a stable alcohol supply where family members felt more "in control" of drinking, thereby supporting transitions from survival-based drinking and strategies. These findings are consistent with previous research that illustrates the impacts of MAPs in reducing reliance on survival strategies when alcohol is unaffordable in street-based settings and in turn creating new, more secure and stable relationships with alcohol [54]. Critically, the provision of the IAHRRP provided a new space and opportunity where family members could begin to consider longer term goals of healing and for some, engagement with culture as healing opportunities.

While similar research has described shifting relationships to alcohol among participants in western MAPs, we described these shifts within an Indigenous context of decolonized harm reduction led by the ACEH. Family members emphasized how the IAHRRP empowered their self-defined pathways to healing, inclusive of goals of abstinence to safer, more controlled drinking. Beyond the CSH, some family members planning to transition to independent housing also hoped to access ongoing alcohol harm reduction support. All family members emphasized choice and autonomy and thus control over drinking when speaking about their relationship to alcohol in the IAHRRP. These descriptions counter essentialist colonial narratives of Indigeneity, alcohol, and pathology that have often plagued research and treatment systems [14, 15, 55, 56]. Rather, from strengths-based positions, family members described reclaiming autonomy and 'taking care of myself' in contrast to their experiences of disempowerment in western detox and treatment settings. These principles have also been highlighted in previous qualitative research with regards to supporting both individual and collective community pathways to healing from the harms of alcohol and colonization [2], and with communities of people with experiences of street-based illicit drinking [25, 28]. Future programs should anticipate diversity in participant relationships to alcohol and support tailored alcohol harm reduction plans that align with shifting individual goals, including the provision of abstinence-based supports where requested.

Access to the CSH and IAHRRP provided an identity-affirming space for family members to feel respected, confident, and supported to pursue CAH opportunities. Family members had multiple pathways for connecting with culture and varied in both their goals related to culture as healing and alcohol. They expressed a range of beliefs in relation to alcohol and culture. It is notable, however, that ongoing alcohol use was only mentioned by one family member as a barrier to connection to culture. Foundational principles of inclusivity practiced in the IAHRRP and CSH, including welcoming and low barrier approaches in connecting to culture as healing, were highlighted by family members who described multiple ways of connecting to culture with or without alcohol. These findings signal the importance of offering incremental and various opportunities for connection to culture to meet varying degrees of readiness and desire to engage with culture as healing, from day trips to immersive land-based healing opportunities.

Future Indigenous alcohol harm reduction programs should consider providing multiple opportunities that allow participants to accessibly connect to culture as healing, through on-site, day, outreach, and land-based models, with recognition of diversity in individual readiness, goals, and relationships with alcohol and/or substance use. Culture as healing opportunities should be responsive to diverse beliefs among participants regarding alcohol and culture, including the provision of both alcohol-present and alcohol-free spaces and events. Practices and policies that promote multiple pathways to connect to culture are rooted in the knowledge and guidance of the ACEH Elders and Knowledge Keepers, who validated the need for an Indigenous-led MAP in 2018 so that "no one is left behind" [53]. Family member perspectives re-iterated the importance of creative and inclusive ways of welcoming people into culture as central to creating healing environments. This is consistent with the perspectives of Indigenous organizations such as the First Nations Health

Authority [57] who "calls for us to look at ways that everyone can participate in culture", with recognition of "culture as a strength – a source of resilience, a way to connect, and as medicine – it is critical for us to consider how we can include people who use substances within the work that we do by increasing access to culture" (p.2). The full breadth of ways in which family members connected to culture as healing are described in a related paper, ranging from *being in an Indigenous home* to *land-based healing* (Hunt-Jinnouchi et al., under review).

Limitations

Findings presented in this paper reflect perspectives from a small sample size of First Nation and Métis adults with experiences of homelessness. While broad themes can offer insights into the design of Indigenous-led harm reduction in other communities, we caution that these findings should be interpreted within a localized and specific urban Indigenous context and cannot be generalized to all Indigenous communities. Several factors affect generalizability of findings. The small sample size reflects a small pool of family member participants in a highly specific context of the IAHRRP and CSH, however highlights a rich data set from which to advance Indigenous-led alcohol harm reduction programs and promote decolonized harm reduction programs.

Specific Nation ancestries of family members are not reported here for confidentiality reasons. Quotes related to sacred Nation-specific practices and knowledge were excluded where possible to preserve confidentiality and to honour an MOU with the ACEH regarding publication of sacred practices in academic spheres. Further, the depth of data collected, analysis, interpretation, and presentation of findings related to culture as healing were limited per the MOU agreement involving Settler researchers. Brown is of Settler ancestry and completed data collection, analysis, and infographics, although reviews were conducted by the Advisory and both Indigenous community (Hunt Jinnouchi) and academic (Mushquash) team members at all steps of the research. While concepts related to gender did occasionally present in interviews, we did not feel that the sample included a broad enough range of gender identities (i.e., only two cis-women participated in a majority cis-male identified program) to adequately explore this topic. In our anecdotal experience as MAP researchers and culturally supportive housing providers, we recognize that gender is highly relevant to both contexts and should be specifically explored in future research.

Conclusion

In this paper, family members illustrated the role of an Indigenous-led alcohol harm reduction program in shifting their relationships to alcohol and reducing barriers to connection to culture as healing. Alongside access to a secure and safe alcohol supply, policies and practices that honour respect, autonomy, and choice were highlighted as supportive of self-defined goals around healing and alcohol. Family members countered their experiences with the IAHRRP with previous experiences of disempowerment in western spaces. Critically important was an accessible approach to culture as healing that offered multiple ways of connecting to culture-based supports, inclusive of all family members regardless of their relationship with alcohol. These broad principles can provide key insights into the design of Indigenous-led harm reduction and culture as healing models that are accessible to people with experiences of homelessness and alcohol use, although should be considered and tailored according to local community needs and contexts, guided by community leaders, Elders and Knowledge Keepers, and participants.

Abbreviations

NBA	Non-beverage alcohol
CAH	Culture as healing
BIPOC	Black, Indigenous, and People of Colour
MAPs	Managed Alcohol Programs
ACEH	Aboriginal Coalition to End Homelessness Society
DMHC	Dual Model of Housing Care
IAHRRP	Indigenous Alcohol Harm Reduction Residence Program
CMAPS	Canadian Managed Alcohol Program Study
CSH	Culturally Supportive House

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Author contributions

MB led study conceptualization, qualitative data collection and analysis, drafting, and finalization of the paper. FHJ, BP contributed to study conceptualization, development of methodological protocols, analysis, editing, and review of the paper. NC and CM were involved in study conceptualization and review and editing of all drafts of the paper. JR contributed to analysis, review, and editing of the paper. KM led the broader study conceptualization and reviewed and edited the final drafts of the paper. All authors read and approved the final manuscript.

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Data availability

The datasets are not publicly available due the small sample size and associated threats confidentiality. De-identified datasets are available from the corresponding author on reasonable request and with permission of the Aboriginal Coalition to End Homelessness Society, pursuant to a Memorandum of Understanding related to Indigenous knowledge stewardship.

Declarations

Ethics approval and consent to participate

Ethics approval was obtained from the University of Victoria Human Research Ethics Board (HREB) (Protocol (#20-0574-04).

Consent for publication
N/A.

Competing interests
It is possible that outcomes published from this study may support future funding towards ACEH programming. We declare no further competing interests or any issues relating to journal policies. We declare no further competing interests or any issues relating to journal policies.

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