Community Programming in Mental Health Care Planning: A Case Study at the Drinkers Lounge in Vancouver, BC

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Abstract

The Drinkers Lounge is an innovative harm reduction drop-in centre for drinkers in the Downtown Eastside (DTES) of Vancouver. Drinkers in this community are arguably the most street-entrenched population in the DTES because they are barred from almost every public space in Vancouver (Maynard 2019). Many of the drinkers are Indigenous, which means they experience racism in addition to the discrimination and the stigma that is associated with living in poverty and drinking. Most services for drinkers and other substance users are informed by biomedical and neoliberal ideology, which pathologizes individuals and commonly takes an abstinence approach to care. The Drinkers Lounge focuses instead on the social determinants that lead to substance use, such as a history of personal trauma, ongoing discrimination, and colonial and neoliberal policy. Rather than focusing on abstinence, they offer a range of supports to the drinkers to improve their health and well-being in many aspects of their lives. For the Drinkers Lounge to connect this population to these supports and services, they have had to create an innovative and radical space that is welcoming to the most marginalized members of the community. They have done this by embodying three main principles: (1) a focus on meaningful community building, (2) valuing the lived expertise of the community members, and (3) considering Indigenous approaches to care. This model has many perceived benefits and is widely credited as lifesaving by community members. Nevertheless, the Drinkers Lounge continues to struggle for survival and sustainable funding.

Foreword

This major research paper was completed as a requirement of the Master in Environmental Studies (MES) program at York University. My area of concentration was Health Equity Planning.

My personal experience engaging with mental health resources in the past has led me to believe that the Canadian model of mental health care is limited in several ways. Biomedical and clinical models of mental health care do offer people some support, but real recovery and stability tend to come from a variety of resources and community supports that fall outside of these models, which only some people are privileged enough to have. For me, recovery was also about understanding the circumstances and systemic conditions that led to my mental distress, rather than seeing myself as a biologically flawed or ill.

I began the MES program hoping to learn more about how to effectively plan for more equitable mental health services that could better support people who are experiencing intersecting layers of systemic oppression. Throughout my research, I began to see that the most effective changes to these systems often came from radical grassroots groups and organizations who resisted the status quo. I understood that these groups and individuals have a wealth of lived experience, expertise, and knowledge, and are actively resisting the way we understand mental health. It is for this reason that I was drawn to the Drinkers Lounge, where community members are actively challenging mainstream mental health care services by creating a model that better fits their priorities and needs. This community co-operative challenges the dominant neoliberal and biomedical ideologies that inform how we design health care, by creating a model that prioritizes social determinants of mental health, in addition to individual medical needs. Conducting this research at the Drinkers Lounge helped me to realize the following objectives from my MES Plan of Study: (1) to develop an understanding of the social

determinants that are affecting the health of people living in Canada and the processes that are contributing to health inequities, (2) to explore critiques of biomedical models of health, and (3) to explore alternative health frameworks and the ways in which people resist oppressive models of health. Through this research I have been able to take an in-depth look at what this community is facing, how they resist biomedical frameworks, and what kind of model they have created.

Another objective that I identified in my Plan of Study was to learn how to use planning as a strategy and tool to improve health outcomes and health equity in Canada. This research has helped me to achieve this by allowing me to explore how this model has succeeded and what challenges arise when planning for these types of services. I was also able to explore what principles are necessary for these types of services to succeed. It is apparent that planning for equitable health is not just about the services that are offered, but about challenging our hierarchies of knowledge, questioning our priorities and values, and approaching care in a more communal way. It is about prioritizing community and diverse types of knowledge, and making space for various types of healing. It is about creating flexible services that make room for community expertise in each distinct community. Through this project, the Drinkers Lounge has shown that there are ways that our communities can move away from health inequities and instead move towards social justice, healing, and health.

Acknowledgments

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I would like to dedicate this project to Tommy, Jamie, and all the other members that have passed away in the Drinkers Lounge community.

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Glossary of Abbreviations

PHS - PHS Community Services Society (Formerly known as Portland Hotel Society)

CMAP - Community Managed Alcohol Program

MAP - Managed Alcohol Program

DTES - Downtown Eastside

CAMH - Centre for Addiction and Mental Health

OCAP - Ownership, Control, Access, and Possession

VANDU - Vancouver Area Network of Drug Users

VCH - Vancouver Coastal Health

DURC - Drug Users Resource Centre

BCCDS – British-Columbia Centre for Disease Control

AA - Alcoholics Anonymous

SRO - Single Room Occupancy

OPS - Overdose Prevention Society

Chapter I:

Introduction and Literature Review

I conducted the research for this paper at the Drinkers Lounge, a harm reduction project in Vancouver, BC. The Drinkers Lounge is a drop-in centre and a Community Managed Alcohol Program (CMAP) in the Downtown Eastside (DTES) neighbourhood. The Drinkers Lounge is an innovative program that considers community and social supports to be crucial health care interventions for drinkers[1].

I begin this paper with an introduction to the Drinkers Lounge drop-in centre, followed by a literature review that challenges clinical models of mental health care and explores the effectiveness of social supports for drinkers. The second chapter will describe the methodology I used to carry out this research at the Drinkers Lounge. The Findings chapter will explore how the participants understand addiction and drinking, what specific supports the Drinkers Lounge offers, what principles have made this model a success, and the challenges the Drinkers Lounge is facing. The concluding chapter will be a summary and discussion of these findings.

My research will offer additional ethnographic data that explores the mechanism of effectiveness of community-based managed alcohol models. I will explore how and why this model works, and how it can be used to plan for health equity throughout Canadian health care services.

The Centre

The Drinkers Lounge is a small drop-in centre (the centre) in the Downtown Eastside (DTES) of Vancouver, run under the non-profit harm reduction organization, PHS Community

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[1] **Drinkers**: I use this term first because it is how the members of the Drinkers Lounge identify themselves. I also use the term ‘drinker’ rather than terms like ‘alcoholic,’ ‘person with severe alcohol use disorder,’ or ‘person with severe alcohol dependence’ because of their biomedical connotations, because of the stigma associated with these terms, and because of their potential to categorize people who are moving through cycles of dependence, moderate drinking, and sobriety.

Services Society (PHS)[2]. While the centre is open to anyone, the target population are those who live in, and around, Oppenheimer Park. Oppenheimer Park is the home of a small tent city and is a central meeting space for those who identify as Indigenous and who drink alcohol, including illicit alcohol[3], in a street-entrenched culture (Maynard 2019).

The centre is open Monday to Friday for four hours a day (10:00 AM to 2:00 PM) and is a place for drinkers to sit, socialize, watch TV, and participate in the different supports and programming that are offered throughout the week. On Tuesdays, the group gathers for a weekly meeting of drinkers, which anyone is welcome to join. To become a member of the Drinkers Lounge, a person must attend three of these meetings. The membership of the Drinkers Lounge has reached as many as 250 people and continues to grow. Currently about 40 members visit the centre on daily basis.

A Community Managed Alcohol Program (CMAP) also operates out of this space. The program works by giving members the opportunity to pay a monthly membership fee of $50.00 to $150.00 and receive one to three bottles of wine or beer a day. These fees contribute to buying the equipment and supplies the members need to brew the alcohol themselves. The members who are not able to pay the monthly fee are able to "buy in" during two specified times throughout the day, and pay a small fee for a single bottle of wine or beer. Members who are experiencing severe withdrawal may also receive a small cup of alcohol for $0.75 fee.

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[2] **PHS Community Services Society**: This organization was formally named the Portland Hotel Society.

[3] **Illicit alcohol**: This term refers to non-beverage alcohol, such as rubbing alcohol, mouthwash, hand sanitizer, aftershave, lighter fluid, and so on. The phrase 'illicit drinking' refers to the consumption of beverage or non-beverage alcohol in stigmatized and criminalized ways, such as public consumption by homeless drinkers (Maynard 2019). This term is the descriptor of choice for the drinkers as it emphasizes the criminalization and social marginalization they experience because of their use of alcohol (Maynard 2019).

However, this program is unlike other Managed Alcohol Programs (MAP) across Canada in that it has an explicit focus on community building and is the only MAP program in Canada led by "peers."[4] The CMAP operates through a "Brew Co-op" that is run by the members. Once a person becomes a member, they become part of the Brew Co-op and are eligible to works shifts brewing alcohol for a $3.00 stipend per shift. If a person is interested, they can eventually begin apprenticing to become a "brewmaster." The brewmasters take on additional responsibilities and also take on a leadership role in the community. They are paid $25.00 per shift.

Members are also eligible to work other small jobs throughout the day, such as cleaning, buying supplies, or "Hydration runs," where two members form an outreach team and take water, juice, or hot chocolate to the Oppenheimer park to hydrate other drinkers in the community. They are also paid a $3.00 stipend for these shifts.

An additional service is the illicit exchange program, which gives people the option to come in with their illicit alcohol, such as hand sanitizer and rubbing alcohol, and trade it for beverage alcohol.

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[4] **Peers**: Also sometimes referred to as consumers/survivors, this term refers to people with lived experience in their community, including experiences with substance use, addiction, and mental health issues. PHS runs several peer-run initiatives and projects in the DTES, including overdose prevention sites, outreach teams, advocate teams, and clean-up teams, among others. Within the PHS, abstinence is not required for a peer to work, and people can maintain their use while they work, as long as they are able to the job. The jobs are designed to be flexible, and additional workers will often "fish" for shifts if someone does not show up. This means that there is no risk of losing your job if you are too unwell to work your shift. Because of this, this work is not traditional employment and is not unionized (though union values are adopted, such as seniority). The peer workers are considered volunteers and are paid an honorarium or stipend for their work. These payments range from $3 per shift to $17 per hour. This model allows people who are unable to keep traditional work to find stability and increased quality of life through stable access to meaningful work, money, and support. In addition, many members of the DTES community find peer-led services more accessible because they are run by people that know the community, have had similar experiences, and do not respond negatively to their behaviour.

Literature Review

Managed Alcohol Programs

Research has increasingly shown the effectiveness of MAPs as a harm reduction strategy that improves the health and well-being of street-entrenched drinkers (Nielsen et al. 2018, 19). MAPs mainly improve health by reducing the consumption of illicit alcohol (19). Illicit alcohol is an accessible alternative for drinkers because it is low cost, high in alcohol content, and widely available. However, the chronic ingestion of illicit alcohol leads to organ damage and toxic effects on the gastro and nervous system (7). It can also lead to dangerous symptoms, such as gastric pain, nausea, vomiting, convulsions, seizures, comas, and cardiac or respiratory arrest (7). Over time it may also lead to poorer cognitive performance, vision loss, memory deficits, and higher chances of mental distress[5] (8).

Nielsen, Novotna, Berenyi, and Olson (2018, 18-20), in a literature review of existing research on MAPs, found that these programs consistently reduced alcohol use and improved health outcomes. However, they also had numerous other benefits, such as providing a safe space for people to drink off the streets, and offering an accepting environment that enables recovery, healing, and reconnection (18-20). By helping people to stabilize a range of problems, the MAPs allow people to find the time, energy, and resources that are necessary to engage in the construction of a valued identity, place, and create meaning and purpose in their life (Kidd, Kirkpatrick, and George 2011, 102).

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[5] **Mental distress:** I use this term in place of the term ‘mental illness’ because of the biomedical implications and stigma associated with the latter.

One of the main benefits listed by participants in these programs, is that they feel safe and part of a supportive environment (Evans et al. 2015, 119). This reduces feelings of isolation and disconnection from social networks (Nielsen et al. 2018, 22). MAPs have been shown to provide a microenvironment characterized by respect and trust, a sense of home, and "feeling like family" (Pauly et al. 2016, 10).

Despite these benefits, studies associated with these programs rarely explore the experiential dimensions and how MAPs actually work to improve health outcomes (Evans et al. 2015, 119). Researchers have called for increased research to understand how health outcomes are improved through the creation of spaces where people can find enabling resources, such as a sense of belonging, social support, and an understanding of the self (123-124).

The Social Determinants of Mental Health

Dominant Canadian biomedical[6] ideology tends to discuss health and addictions as a problem that is isolated to individuals rather than a societal issue (The Global Commission on Drug Policy 2017, 23). In contrast, a social determinants of health approach understands a person's living conditions to be the primary factors that shape their health (Raphael and Mikkonen 2010, 7). Raphael and Mikkonen (2010, 7) argue that health outcomes in Canada are largely shaped by how income and wealth are distributed, as well as additional factors such as

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[6] **Biomedical Model of Health:** The biomedical modal is the dominant model used in medicine in Canada. It is a scientific model that assumes disease to be fully accounted for by biological deviations from the norm, and leaves no room for the social, psychological, and behavioural dimensions of illness (Engel 1977, 130). This model assumes that mental disorders, such as substance use, are biologically-based brain diseases, caused by biological abnormalities located in the brain (Deacon 2013, 847).

employment, housing, education, and discrimination. They assert that health is shaped by the decisions that governments make in a range of different public policy domains (7).

Research has increasingly shown that substance use is often a response and a coping strategy to deal with difficult life circumstances such as trauma, anxiety, stress, and abuse (Brown et al. 2018, 91). These experiences are often the consequence of systemic processes of colonization, economic processes of capitalism, and policies of exclusion that discriminate on the basis of gender, sex, and race (91). The harms of illicit drinking, such as violence, theft, and being taken advantage of are not specific to people who use alcohol, but flow from the lack of access to safe and dignified housing, negative relationships with police, and a lack of economic opportunity (91). Illicit drinkers are often the most socially marginalized people in the DTES (Maynard 2019), which further intensifies the harms associated with illicit drinking.

Crabtree et al. (2018, 91) found that for illicit drinkers, the harms of being poor and marginalized were of greater concern than the harms specific to illicit drinking. In the DTES community, homelessness[7] in particular, is a major barrier to health and quality of life. Members of the Drinkers Lounge experience long periods of homelessness and unstable housing, which only exacerbates their health challenges (Maynard 2019, 2). The Centre for Addiction and Mental Health (CAMH) and the Empowerment Council (2016, 2) argue that safe, affordable and well-maintained housing is imperative to physical and mental health and a significant part of

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[7] **Homelessness:** Because of the housing crisis in Vancouver, many people at the Drinkers Lounge have been without a home in the recent past, have insecure or inadequate housing, or currently do not have a home. As the Canadian Observatory on Homelessness explains, "Most people do not choose to be homeless, and the experience is generally negative, unpleasant, unhealthy, unsafe, stressful and distressing. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination" (Gaetz et al. 2012).

Some of the members live in tents in Oppenhiemer Park. These tents are regularly moved or removed by the city, despite the large community of people living there. One community member, at a 2019 action in Oppenheimer Park, pointed to the fact that this park and all of Vancouver is on the unceded territory of the of the Coast Salish Peoples, including the territories of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and Səl̓ílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations, and that the Indigenous people living in Oppenheimer Park are not "homeless" but "houseless."

recovery and wellness for people with mental health and addictions issues. Despite common conceptions, homelessness is more likely to cause mental health and addictions problems, rather than those being the cause of homelessness (2).

Illicit drinkers, who are already economically marginalized, are also socially marginalized. They are disproportionately barred from shelters, clinics, housing projects, community centres, grocery stores and other public spaces, resulting in their being arguably the most street-entrenched demographic in the DTES (Maynard 2019). This social marginalization means that illicit drinkers are less able to access health care services than other populations, which only furthers their health issues. Scholars have argued that while our health care system is one of the best in the world, it contains deeply structured hierarchies based on gender, class, and race (George et al. 2015, 13633). Yee and Shahsiah (2006, 4) found that many racialized communities have negative experiences of race-based discrimination within the Canadian mental health care system. Many racialized people felt misunderstood, alienated, stigmatized, helpless, afraid, confused, and isolated, and regretted seeking mental health services, particularly psychiatric and hospital-based services (4).

Because of this, some scholars have been advocating for an intersectional[8] social justice analysis of recovery in mental health care that understands the oppression and dimensions of power within the mental health care system (Morrow and Weisser 2012, 28). Public health departments need to focus on the structural causes of poverty, how social and economic conditions affect health, and how economic inequality creates health problems which are

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[8] **Intersectionality:** Intersectionality is a concept that emphasizes the various ways in which race, gender, and other factors interact and shape peoples' experiences (Crenshaw 1991). Crenshaw explains that the discrimination Black women face cannot be captured by looking at race or gender separately, because the traditional boundaries of these discriminations cannot capture their experiences (1991). Instead, social inequality is better understood as many interlocking axes of social division that work together (Malcoe and Morrow 2017). Intersectionality foregrounds lived experience, and relies on peoples' own descriptions and understandings of their lives (10-11).

disproportionately distributed across the population (Raphael 2000, 200). To address health inequities, the social determinants of health need to be recognized, and they need to be linked to government policies, like poverty reduction, income security, and accessible employment (CAMH and Empowerment Council 2016, 4).

On a smaller scale, health care interventions need to address and reduce the systemic barriers that are experienced by street-entrenched drinkers. The Drinkers Lounge is one example of a program that is offering radically low-barrier access to care.

Biomedicalism and Neoliberalism

Despite all the research that mental health is tied to social inequities, the social determinants of mental health continue to be marginalized in research, policy, and services (Morrow 2013, 323). Most mental health services and supports continue to approach care from a biomedical and neoliberal understanding of mental health rather than a sociomedical one.

The dominant way of understanding mental distress in Canada is through the lens of neurobiology (Morrow and Weisser 2012, 30). Biomedicalism, the dominant ideology in mental health, frames all forms of emotional suffering as (neuro)biological disorders among individuals, while often ignoring any evidence that considers power relations or social contexts (Malcoe and Morrow 2017, 5-6). Addiction is understood through a disease model, which defines addiction through an individual's biological makeup. This model of addiction, which links addiction to mental illness, has been used to try and alleviate the stigma associated with addiction. However, because it is rooted in human pathology, it often only further stigmatizes people and leaves them vulnerable to exclusion and marginalization (Heather et al. 2018, 250).

The well-known "Rat Park" experiment also helps deconstruct the idea that addiction is tied to a neurobiological dependence on a substance. Experiments in the twentieth century showed that when rats in cages were offered pure water and opiate-laced water, the rats would choose to drink the opiate water to the point of overdose. This reflected the idea that drugs are powerfully addictive substances that need to be highly restricted through prohibitionist policies. However, in the 1970s, researchers looked at the experiment from a different perspective. Rather than placing the rat in an isolated cage, they constructed an environment called "Rat Park," where the rats lived collectively, surrounded by activities that they enjoy. In this context, the rats drank much less opioid water and their use never resulted in an overdose (The Global Commission on Drug Policy 2017, 23). The study challenges the idea that drugs themselves are dangerous and challenges the government's "war on drugs" approach to addiction. Instead it emphasizes the environment in which drug users live.

Neoliberal worldviews support biomedical ideology as they also promote an individualistic understanding of complex social problems, and emphasize individual responsibility in addressing them (Morrow 2013, 327). This hegemonic discourse is maintained through the medical, pharmaceutical, legal, and criminal justice systems, as they construe social problems as the fault and responsibility of individuals (Malcoe and Morrow 2017, 9). Neoliberal governments can be reluctant to acknowledge the social production of disease and take responsibility for health outcomes because of the expensive and rising costs of medical services (Crawford 1977, 663). The ideology of victim blaming allows the public to be dubious of a universal right to health care and feel that tax money would be wasted on people who they perceive to lack motivation and lead a poor lifestyle (669). Blaming individuals justifies a shift of cost back to them without addressing larger structural barriers (670). However, this approach

also ignores the fact that neoliberal policy has led to massive spending cuts to social welfare services, which has further exacerbated mental health problems (Morrow 2013, 323).

The continued dominance of biomedical and neoliberal paradigms favours psychiatry over social care in mental health (Morrow 2013, 323), which is supported by the pharmaceutical industry (20). Many people are further stigmatized by the scholarship surrounding mental illness that creates diagnoses and labels, that are themselves a form of inequity, and a result of sanism[9] (29). Literature is increasingly showing how groups of people, like women, racialized people, and people living in poverty are disproportionately pathologized for their mental distress (30).

Throughout history and today, psychiatry and diagnostic practices have been used as a form of social control and are often used to construct the abnormal, racialized, other (Malcoe and Morrow 2017, 11). People who experience emotional distress or mental difference are feared, stigmatized, criminalized, and brutalized. It is often socially acceptable for them to be treated as non-persons (3). Indigenous people who experience severe emotional suffering due to state violence, are often diagnosed as having mental health and addictions issues (4). China Mills (2017, 89) has explored how psychiatrization has been used as a tool and form of colonialism. She writes that psychiatry is a technology exported to colonized lands and used as a tool to legitimize colonial oppression in the name of scientific progress. Psychiatry frames ideas of superiority, cultural priorities, and can force people to accept these new cognitive categories. These reconfigure resistance to colonialism as individual pathology or madness and erase alternative ways of knowing, being, and doing (87). In this way, meaningful experiences and resistance are depoliticized, cast as biological symptoms of a mental illness, and psychiatry and medicine are called on as a remedy (92).

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[9] **Sanism:** The irrational prejudice towards people who experience mental distress or those who are perceived to be mentally disabled. This concept challenges what broad set of values are associated with the idea of sanity and is used to reclaim the idea of madness as a positive and productive entity (Malcoe and Morrow 2017, 10).

Morrow and Weisser (2012, 28) argue that moving forward, mental health frameworks need to acknowledge biomedicalism and neoliberal policy regimes. This includes an awareness of the dimensions of power that exist in mental health policy that are created by biomedicalism, racialization, sanism, ageism, and heterosexism (28). Central to any discussion about recovery needs to be the recognition of profound discrimination towards psychiatrized people and the social and structural barriers that impede recovery (28).

Deinstitutionalization

Over the past 40 years, a community mental health movement has emerged in Canada. Deinstitutionalization was a movement that began in the 1950s and peaked in the 1970s to return people to their independent lives by replacing custodial mental health care models with psycho-social rehabilitation models (Morrow and Jamer 2008). As a result, psychiatric hospitals and facilities have been closed across the country in order to move towards community models of care. While moving away from this model was a vast improvement, the government has failed to provide community supports like housing and income to people leaving these institutions (2008). Deinstitutionalization policy was also not accompanied by increased funding to community supports or alternative community-based living, which has led to homelessness, poverty, and addictions (Morrow, Dagg, and Pederson 2008, 1). At the same time, this situation is exacerbated by neoliberal discourses of austerity in Canada since the 1990s, which favours reduced government support and economic regulation (3). Neoliberal policies have included a general retrenchment of social welfare supports and disability pensions and a divestment of federal funding from housing, which has resulted in an increase of poverty and homelessness (3). Yet

this growth of homelessness was blamed on the de-institutionalization of individuals rather than these neoliberal policies (4).

In addition, because people were no longer institutionalized, homelessness has become more visible among people experiencing mental distress (Morrow, Dagg, and Pederson 2008, 5). This increase in homelessness, poverty, and mental distress, and its visibility has led to a lot of public fear and misrepresentations about mental illness (1). Often mental distress is now perceived to be the cause of homelessness, and biomedical definitions of mental illness are used for people who are experiencing poverty and homelessness (3). Because of this misinformed discourse, governments have faced political pressure to re-institutionalize (1).

Morrow, Dagg, and Pederson (2008, 2) argue that institutionalization has not disappeared but has switched locations, as people with mental illness are criminalized and moved to correctional facilities. Drug prohibition policy in Canada and the "war on drugs" has been used as further justification for police intervention in certain communities. However, research has shown that prohibition policies originated as a form of social control, specifically targeting racialized and marginalized communities (Gordon 2006, 63). The government has selectively prohibited drugs because of their associations with these communities, rather than any evidence that they are more physically dangerous (63). In addition, police enforcement of these laws is disproportionately targeted at racialized and working-class individuals and communities (68).

Boyd and Kerr (2015, 418) expand on this by demonstrating how the Canadian police, especially in Vancouver, BC, have been at the forefront of the discourse and regulation around mental health regulation. By exploring several Vancouver Police Department reports, they found that narratives of violence and danger among people labelled as mentally ill were consistency emphasized (427). This has led to a huge expansion of the criminal justice system and increased contact between people experiencing mental distress and the police (418). This process has

created a popular myth linking mental health and violence, despite the fact that as a group, people with mental health concerns are not more violent than other people (428). The authors argue that the police have emphasized this dangerousness to legitimize interventions and institutionalization, even when no violent behaviour has occurred (427). They argue that due to this structural discrimination, the dominant discourse is shifting away from health and community supports, and instead supporting re-institutionalization as a solution (429).

Grassroots Movements and Peer Workers

To address this lack of support from the government, grassroots movements of ex-patients and their allies have responded to the gaps left by deinstitutionalization. For example, the Mental Patients Association (MPA), which was created in 1971 in Vancouver, BC, influenced mental health services by putting patients in charge of their own services (Boschma, Davies, and Morrow 2014, 2). As psychiatric medical models began to be questioned, professionals and patients negotiated new understandings of expertise in mental health work and peer-support workers became important leaders in community organizations (9). These groups pressed for non-professionals to be hired into the system and modelled new ways of community living (20).

The work of grassroots activists has brought to question the evidence-based policy discourses that are dominant in health policy. These discourses privilege particular methods and ways of knowing, and create a knowledge and evidence hierarchy that posits scientific knowledge as more objective and truthful than other knowledges (Lancaster et al. 2017, 61). This epistemological tension diminishes what can be known through embodied, lived experience, and

values scientific evidence based definitions (65). As a result, emotion is devalued and lived experience and passion are constituted as the antithesis of clear and systemic reasoning (65).

Mad studies[10] have been an important part of challenging this hierarchy of knowledge. Mad frameworks, like intersectional and post-colonial frameworks, understand mental health through its intersection with social inequities, such as racism, classism, genderism, and colonialism (Josewski 2017, 63). They assert that sanism and psychiatrization are structural forms of discrimination based on hegemonic assumptions about rationality, normality, and madness, which systematically pathologizes, stigmatizes, discriminates against people with mental illness diagnoses (63). Mad activism has emerged as a way to embrace madness as a legitimate state of being, and psychiatrized people as legitimate knowers with knowledge (70). These frameworks heavily rely on the perspective of people with lived experiences of mental health diagnoses (63).

However, as peer-based models expand in Canadian health care, it is important to ensure that these models ethically engage people with lived experience in mental health care through partnerships as opposed to tokenism (Josewski 2017). The peer-work movement has slowly become absorbed into dominant mental health practices and clinical recovery models that compliment pathological approaches to madness (334-335). This inclusion does little to disrupt structural violence and allows the dominant powers to proceed to modify and manage madness (336). While this peer labour produces feelings of hope, optimism, and empowerment in individuals, it risks ignoring the sociopolitical order that subjugates many people (336).

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[10] **Mad studies:** This has emerged as a field of study mostly led mostly by people with lived experience of psychiatrization. The field undertakes a radical critique of psychiatry, disrupts strictly biomedical understanding of mental health, and focuses on the structural causes of mental distress such as sexism, violence, racism, and poverty. (Morrow 2017, 36).

In addition, some researchers criticize the peer model because of the implicit binary of ‘professional’ and ‘amateur’ can position the consumer voice as lesser (Lancaster et al. 2017, 64). The term ‘peer’ often differentiates them from professionals, despite them being paid for their expertise, experience, and work (Fabris 2013, 133). These discourses have the potential to further marginalise voices and shape who may legitimately speak when developing policy (Lancaster et al. 2017, 61).

In addition, academic researchers regularly undervalue the lived experience of peer workers. Crabtree et al. (2018, 85) argue that there exists a gap in the research that prioritize the experiences and perspective of drinkers. Little research focuses specifically on illicit drinkers own perceptions of the alcohol related harms they experience and how they could be best addressed (86). As a result, many other alcohol harm-reduction strategies are not well targeted to the poor and marginalized illicit drinkers who participated in this research (90).

For these reasons it is crucial that the lived experience of people with lived experience is taken seriously and respected as expertise by health care workers, researchers, funders, and other institutions of power. Communities with lived experience will need to be at the forefront of leading a recovery movement and developing new structures and ways of organizing that challenge biomedicalism and rebalance the biomedical and social needs of people (Morrow and Weisser 2012, 39).

Community Leadership

In response to individualistic approaches to health and addictions, grassroots activists have also maintained that community needs to be at the centre of healing and health.

One response to this was the recovery paradigm, which emerged from psychiatric survivors' movements to disrupt biomedical dominance in favour of social and structural understandings of mental distress (Morrow 2013, 323). This model focuses less on the reversal of individual pathology and emphasizes instead that wellbeing is an intrinsically social process that is embedded in local communities (Heather et al. 2018, 250). This social identity approach challenges biological determinism by asserting that recovery from drug use is reliant on social networks, mutual aid and peer-supported pathways (250).

However, recovery, which has now been widely adopted in Canadian mental health policy, has since been framed individualistically as a personal journey, with little wider analysis of social and structural relations of power (Morrow 2013, 325). Despite its roots, it now plays into biomedical mental illness narratives and individualistic discourses of broken brains, chemical imbalances, and self-management (323).

To resist these overarching narratives of individual transformation, community organizations have begun to develop ways of building community, and increasing evidence shows that people are healthier when they have these community connections (Block 2018, 182). Still, these collaborative forms of health care are often called "alternative" medicine and are not accessible to everyone (182). They remain an anomaly in the system because they confront the dominance of the expert model and do not deliver large profits to institutions (183).

Peter Block (2018, 41) challenges our reliance on professional expertise by explaining that our love of leaders stems from a deeply patriarchal and colonial agenda. He argues instead that each citizen should be seen as an active agent that needs to be accountable to others (41). Part of this means shifting out models of care so that we treat people as if they have the ability and responsibility to change society, rather than being passive citizens (61). Services that embody this and put the community in charge, give people a sense of belonging and pride and

can be extremely healing (51-53). He advocates for creating structures that bring citizens together to self-organize and identify and solve our own issues (79). Moving away from a growing dependence on "experts" and choosing to more widely distribute ownership and accountability will allow us to avoid imbalances of power and resources (174-175).

One way Block argues that we can do this is to focus on gifts, rather than deficiencies (12). He argues that defining and analyzing suffering communities as a set of problems to be solved is only treating the symptoms of a fragmented community (33-35). While most social services are organized around what is missing and broken in people, they should instead focus on bringing the gifts of those on the margins to the centre (13).

Block emphasizes that building effective community is always a custom job. Local people need to be the ones to decide what is needed for their specific community (5). It is important to recognize that this change happens slowly and happens on small grassroots levels, not from large scale models that have clear outcomes and are imposed from the top (26).

Decolonizing Health Care

Part of this customizing of health care for each community means acknowledging that Canadian and Eurocentric ideas of health are not the only way of understanding health and may not be the most effective approach for many people. Morrow and Weisser (2012, 38) explain that some cultures value collectivity over individuality, and individual notions of recovery may not resonate with people from non-dominant ethno-racial groups. While most research sees health as the absence of disease, many Indigenous people have a more holistic idea of health that incorporates the social determinants of health (Clark et al. 2017, 167). The biomedical psychiatric paradigms that inform mental health services and policy tend to suppress diverse

understandings of human distress and feelings, and erase culturally appropriate ways of coping with challenges (Ibrahim 2017, 125). Thus, when decolonizing mental health, it is crucial to ask Indigenous people how they understand their own mental health (Clark et al. 2017, 167).

Focusing on mental health as an individual health problem also prevents and obscures a critical and historically situated focus on the social problems that contribute to mental health issues in in the context of neocolonialism (Clark et al. 2017, 168). Decolonizing mental health research and practice means resisting narratives of disease put forth through neocolonial research paradigms and instead considering past and current forms of colonization (169).

Clark et al. (2017, 168) argue for a radical re-visioning of the theoretical and practical approaches to intervention and training in Indigenous mental health in Canada. They argue that Western models have failed to work as an intervention for Indigenous mental health and trauma, despite cultural competency, evidence-based practice, and trauma-informed care (168). Mental health programming that is based in "Western" value systems only works to further colonize Indigenous bodies and identities (183). More models are needed for research and practice that are based on a diversity of traditions, beliefs, and knowledges (183).

Returning to Indigenous spirituality has proven to be a path to healing for many communities (Johnson 2016, 123). When addressing addiction, it is important that traditional Indigenous cultural viewpoints beyond mainstream models of medicine and wellness are considered. For many, this means considering not only the body, but the mind, emotions, and spirit (Nielsen et al. 2018, 22).

Planning for Health Equity

Marina Morrow (2017, 36) argues that the most productive way forward for mental health advocates who are pushing for social change and social justice in mental health are frameworks that allow for a structural, rather than individual focused, analysis of social factors, such as poverty, violence, colonialism, racism, and gender, and their intersections with mental distress. Analytical frameworks such as intersectionality, decolonial theory, and Mad studies are all useful because they centre how relations of power are structured and how they impact people's experience of the mental health system (47). It is the research strategies that emerge from these fields that have the potential to challenge dominant epistemologies, discourses, and normative thinking (Malcoe and Morrow 2017, 22).

In terms of health care, Morrow, Dagg, and Pederson (2008, 4) advocate for a mental health system that considers medical and social understanding of mental health rather than relying on a purely reductionist biomedical paradigm. This would involve a continuum of care model that recognizes housing and other social welfare as key to managing and recovering from mental illness (2).

Health care also needs to meet the needs of diverse groups of people (Tuck et al. 2016, 8). Care cannot be generalized because of the intersections and fluidity of identity and social location of both patients and practitioners (9). Population-based flexible services need to be developed, which can only happen when local groups are involved in the planning processes (Hansson et al 2010, 5).

Chapter II:

Methodology

I conducted the research for this paper between February and May of 2019. In the Summer of 2018, I worked as an auxiliary staff member at the Drinkers Lounge and got to know the members and staff. During my time there, it became clear that the program was extremely effective and vital to the community. However, it was struggling to stay open due to inadequate funding. I approached the manager who I had been working with and discussed carrying out my research at the Drinkers Lounge. She has worked closely with the members for several years and has strong relationships with them. She felt that the members would be happy to be involved.

Over the next four months, I returned to Toronto to write my proposal. This proposal was supported and approved by three PHS staff members: the manager of the Drinkers Lounge, the PHS Community Engagement senior manager, and the PHS program director for Indigenous Health Services. The proposal was also approved by the York University Office of Research Ethics Human Participants Review Committee, with additional approval to work with Indigenous research participants.

In February 2019, I conducted two interviews with the Drinkers Lounge staff members and 16 interviews with the members of the program. These interviews varied in length from 15 minutes to one hour, depending on their responses to the questions. The questions that guided my research were, '*How does building a supportive community for drinkers at the Drinkers Lounge and Brewer's Co-op function as a health and mental health intervention? How do stakeholders describe, perceive, and experience this health promotion model?'*

Because most of the members of the Drinkers Lounge are Indigenous, I felt it was important to draw on Indigenous methodologies for my research. My approach was informed in a large part by the graduate seminar 'Reshaping Research with Indigenous Peoples' taught by Dr. Deborah McGregor at York University. In *Indigenous Methodologies: Characteristics, Conversations and Contexts*, the central textbook for the class, Margaret Kovach outlines several

Indigenous methodologies that were critical to my research framework. With this background, I was able to take steps to conduct my research in a non-extractive[11] way that was critical of the colonial knowledge belief systems that guide traditional academic research practices (Kovach 2009).

The Interviews

During the interviews I used a narrative research methodology, which allowed me to focus on the stories of a small group of people (Creswell 2007, 54). Kovach (2009, 96) discusses storytelling as a powerful methodological tool in which story functions as both a method and a meaning that crosses cultural divides and provides contextualized knowledge. She explains that story is a decolonizing action that gives voice to the misinterpreted and marginalized and values interpretative knowing (97). Storytelling is a method that is not fragmented by the structured interview process. It can elevate research from an extractive exercise serving the fragmentation of knowledge to a holistic endeavor that situates research firmly within a relationship (98).

I conducted conversational interviews based on the themes that had come up during my literature review and adapted them to themes that came up frequently during the interviews. I had a full list of questions prepared if I needed them, but followed the lead of the participant and encouraged them to tell their story in a less structured fashion. I attempted to follow the flow of their stories rather than fracture the conversation with specific questions. I asked questions about their stories and shared in conversation and experiences when they asked me about myself, to

[11] **Extractive Research:** Positivist ethnographic research has a tendency to view knowledge as something that is to be extracted from an individual or a group in fragments, rather than seeing this knowledge sharing as a reciprocal process (Kovach 2009). Extractive research approaches tend to leave the people that have been studied disenfranchised from the knowledge they have shared (Kovach 2009).

create a more reciprocal interaction. In this paper I have included the voices and stories of those who I interviewed as much as possible.

As a white settler, self-location was key to my research. This helped me examine the purpose and motive behind my work and to be aware of the power dynamics between the participants and myself as a researcher (Kovach 2009, 112). Kovach (2009, 33) explains that decolonizing and anti-oppressive methodologies demand a critical reflexive lens and the political examination of location and privilege. For this reason, throughout my research, I committed to continually reflecting on my motivations behind my decisions. With each decision I made, I attempted to prioritize the participants, their well-being, and their experience before the research project itself.

This was particularly important for me throughout the interviewing process. It became clear during these interviews that the participants were readily willing to share emotional stories and experiences from their lives. I quickly realized that my role as an interviewer was not neutral, and I needed to play a role in supporting them through this process. I made the decision to prioritize their experience rather than the data I was trying to obtain. As Kovach (2009, 66) explains, decolonial research needs to focus on the process of the research rather than on the product or outcome of the research. Seeking information should not be extractive, but reciprocal, and there exists a responsibility to maintain good relations (57).

Many of the participants shared stories of trauma in their lives. While I wanted to create a space for these stories, I did not want to focus on them exclusively. Some authors argue that the peer-work movement has led to the commodification of the stories of marginalized people who are repeatedly asked to share their personal stories, which are paraded as narratives of recovery (Costa et al. 89). Some have begun to call the proliferation of this type of storytelling in the mental health sector as “pornographic” because people are asked to share very intimate details of

their life and trauma, often without compensation, while others passively watch and consume the stories of trauma or even profit from the collaboration (Costa et al. 2012).

To avoid this type of storytelling during the interviews, I did not specifically ask people to share stories of trauma. I found that the best way to do this was to start the interviews by asking, *'Could you please introduce yourself and tell me any of your story you want to share.'* I found this left room for people to share their stories of trauma if they wanted to but I did not create any expectation for it.

This also allowed people to define themselves in a way that they chose from the beginning. 'Deficit Discourse' is a common disempowering narrative that represents Indigenous people in terms of deficiencies and failures (The Lowitja Institute 2018). For many people, their trauma and past experiences were an important part of their story and they wanted to share that with me. However, I did not want people to feel that they needed to be defined through these experiences.

When participants were telling stories that were causing them to become increasingly emotional, I would leave room for them to tell them and express their emotions. However, I would then steer the next questions to their healing process, or how the Drinkers Lounge has helped support them through these things.

Dr. Carmen Logie (2019) also explains how intersectional analyses often focus on complex structures of marginalization, and as researchers, we often get the answers we ask for when we ask about trauma. We often think of intersecting identities in terms of oppression, but she asserts that we need to remember the potential in those identities. How people exist, persist, and navigate oppression is an equally important part of intersectionality. Researchers need to also ask participants about resilience and strength. In particular, she explains that reciprocity and solidarity are intersecting factors that are key to the survival of marginalized groups, despite the

structural barriers they face (Logie 2019).

For this reason, during the interview, I tried to shift the narrative from one of victimization to one of empowerment to create a more positive experience for the participants. I felt that creating a positive experience for the participants should be the primary goal of the research, and the written output should be secondary. In my questions, I tried to focus on the capacities of the members rather than the oppression they experience. I made it clear at the beginning of the interview that I consider them to be experts in their field and that the work they were doing was extremely valuable. I also framed the questions around their skills and knowledge, rather than their struggles.

Partnership

In order to do the research in reciprocal way, I wanted to partner with the Drinkers Lounge members to create the research process. My research was guided by the principles of Ownership, Control, Access, and Possession (OCAP), which is one way to ensure that a community maintains control of the data that is collected during a research project, can make decisions about it, can assert ownership of it, and access it (Schnarch 2004, 80). In addition, they maintain the right to review the process and frameworks (81).

In order to implement these principles, I began the process by going to the Drinkers Lounge for their Tuesday meeting. I introduced myself, explained why I was there, and explained what I had hoped to achieve. I explained that I thought they had a wealth of knowledge and expertise and I wanted to help them share their work more widely. The response was overwhelmingly positive and at least half of the members there expressed that they wanted to volunteer to do an interview. However, in my proposal I had planned to have a panel of three members that would oversee my work and help me design the research process. Despite the

enthusiasm people expressed for the project, the members did not express much interest in helping with the design of the research. Because of the under-resourced nature of the community and the centre, people were reluctant to make any commitments beyond a one-hour interview. In future projects, it will be important to have additional resources to work more closely with the members in designing the research and work to build their capacity to carry out similar projects.

However, to ensure they maintained control and ownership of the data, I explained to each participant that the data and stories that I collected was still theirs and they were free to contact me and make changes to their interviews at any time. During the consent process, I asked them if they would like a copy of their transcript, a copy of my paper, and if they would like to contribute their transcript for future research. For those that agreed, I returned their transcripts to them and made a document of all the transcripts to be kept by the Drinkers Lounge staff and used at their own discretion. To protect their identities in the future, I removed their names from these transcripts. Lastly, I will create a condensed report of the findings for them to use for their own purposes. In September 2019, I will bring this report to them and continue to work with them to use the findings in future projects.

Working with Drinkers

A further consideration for my research was how to work with marginalized drinkers in an ethical and equitable way. I was concerned that the incentive payment of $15 would pressure some members, many of whom are homeless and living in poverty, to participate or share information they did not want to share. For this reason I explained before each interview that they were not expected to share anything they did not want to, that they could leave the interview at any time, that they could refuse to answer any questions, but they would still be paid. Because the payment was not contingent on their participation, one member was paid and did not return

for the interview, and two participants responded with one-word answers, giving me very little data. However, I simply made room for this in the process and my expenses and considered it to be a contribution to the community. By expecting this from the beginning I was able to avoid coercing anyone to share something they did not want to.

Most members seemed comfortable and excited to share their story and talk about the Drinkers Lounge. Only two members were reluctant to talk during the interviews. I continued to ask them questions but did not probe them for longer answers, did not express disappointment, and paid them and thanked them for their time. I made sure not to go in with any expectations of politeness, gratitude, or what I perceived to be normative behaviour. Only one member expressed frustration towards me as a researcher. However, when I made space for his complaints and received them as valuable data, he then became more willing to share his experiences with me and participate in the process.

Another consideration was how to receive consent from participants that were drinking during the interview process. In my proposal, I planned to ask three simple questions of the participants before they started the interview to ensure they were not too inebriated to consent. However, in practice, asking these questions felt problematic and condescending. I felt that it was not my place as an outside researcher to be evaluating the mental capacity of the participants in order for them to be included in the project (and be paid). I felt that asking these questions would reinforce a hierarchy of knowledge, one that I challenge in my paper, where a settler researcher is perceived as more cognitively reliable or capable than the community members. For many of the participants, drinking is part of their daily life and does not take away from the fact that they have knowledge and wisdom to share, and are very capable of making this decision themselves. I felt that asking these questions would be more targeted at appeasing the University ethics board rather than ethical considerations for the participants themselves.

Instead, I decided to address this concern by returning their transcripts to them and allowing them to make any changes to them that they wanted at any time, should they want to remove something they had said. In addition, I rarely refer to the participants by name throughout the findings to further maintain their privacy and not put anyone at unnecessary risk.

Data Analysis

After completing the interviews, I began by transcribing them into written documents. I used a transcription software program to create the first draft of the transcripts. I then listened to the audio of each interview to fill in the remaining parts and make any necessary corrections. As I listened to the interviews I created a list of themes that repeatedly came up in the stories. At the end of the transcription process, I divided these themes into five categories and relevant subcategories. The five main themes were: Descriptions of the Drinkers Lounge and the members, experiences and understandings of addiction, the Drinkers Lounge philosophy and model of care, the supports the Drinkers Lounge offers, and funding issues. Three other pertinent themes repeatedly came up during the interviews, which I categorized under 'Governance and Guiding Principles.' These were Community, Peer Leadership, and Decolonizing Health. After establishing these categories, I used the transcription software to code the data. I read through each interview and categorized quotations under each theme and subtheme. After coding the data in this way, I read the collection of quotations under each category and subcategory and summarized them in writing to create the 'Findings' section of my paper. I also included quotations that best captured the findings of each category.

Because of the amount of interviews, I was left with document of considerable length. I decided to turn the 'Supports' section into visual graphics to more efficiently demonstrate all the services the Drinkers Lounge offers. Though many of the categories overlapped and related to

each other, I did my best to avoid repetition by organizing each finding into its most fitting category.

To analyze the data I drew on an intersectional social justice methodology (Morrow and Weisser 2012). This methodology emphasizes the ways in which the mental health system stigmatizes and discriminates against people experiencing mental distress (38). For my analysis, this meant recognizing the profound discrimination and interlocking forms of oppression that the drinkers experience, such as racism, sexism, sanism, etc. (28). It also meant expanding beyond the specific barriers the drinkers face, and moving beyond individualistic framings of mental health, by turning to a social and structural inequity framing that explores the various social, political, and economic processes through which people experience oppression and privilege (28). This analysis needs to acknowledge the various dimensions of power that exist in the mental health system, such as biomedicalism, racialization, sanism, sexism, ageism, heterosexism, etc., and consider how this power is distributed (38). However, to move away from framing the social location of drinkers solely in terms of oppression, I made sure to focus the intersectional analysis on the resilience and strength of this particular community (Logie 2019).

One consideration that this brought up during the development of my proposal was how to collect the demographic data I needed for an intersectional analysis. At first I felt that I needed to ask demographic questions at the beginning of each interview. However, my experience working in the community made me reluctant to ask such direct questions about personal things like housing, work, and health. I felt this would come off as intrusive and invasive from an outside researcher who they may not necessarily trust. This concern was echoed in a collaborative community research project on harm reduction strategies for people who drink non-beverage alcohol (Crabtree et al. 2018). At the community town hall meetings where the data

was collected, the Vancouver Area Network of Drug Users (VANDU) leadership asked that demographic information not be collected as they felt it would hinder participation and engender mistrust of the research project. Instead they reported on the general characteristics of the participants to provide context to interpret their statements (Crabtree et al. 2018). With this affirmation, I decided to prioritize the experience of the participants rather than attempt to make my data set appear more quantitative. Instead, the demographic data that I outline below was voluntarily offered to me through the stories that the participants shared. This allowed them to share the information that they wanted when they were comfortable doing so, which was sometimes later on in the interview.

This technique also allowed people to define themselves how they wanted rather than being forced to define themselves through the pre-existing categories I had decided on. For example, one participant explained that she identified as white, because she was raised by a white family, despite being born Indigenous, which was a category I had not considered beforehand. By doing this, I was able to capture stories that reflected the intersectional experiences of the participants but in a way that was more representative of their reality. As a result, my data has led to more nuanced and accurate findings.

Chapter III:

Findings

Part I: Background

The Participants

I conducted at total of 18 interviews at the Drinkers Lounge: two staff members and 16 members of the Drinkers Lounge and Brew Co-op. First, I interviewed Michelle, the lead PHS staff member at the Drinkers Lounge, who has been working with the Drinkers Lounge since 2014. When I began my research, Michelle had left her role and was replaced by Petr, who I also interviewed. Michelle was re-hired part way through my research in May of 2019. I will refer to the PHS staff members by their names or as 'staff.'

Of the 16 members that I interviewed, three wished to remain anonymous and will be referred to as Member A, B, and C. Each member I interviewed was currently a drinker or had been a drinker in the recent past. They were all currently part of the MAP or had been at some point in the recent past. I will refer to these participants by their names or as 'members.'

Most of the participants worked or had worked in the past as brewers for the Brewer's Co-op. Two participants, Tyler and Rachel, were the main brewmasters and had taken on primary leadership roles. Two participants indicated that they were apprenticing to be brewmasters.

The members I interviewed were approximately between the ages of 20 and 60. Five of the members and one staff member identified as women and 12 members and one staff identified as men. The Drinkers Lounge caters to a younger crowd (between the age of 20 and 35), but the participants in my research were mostly over 30. This could be because the older members had been part of the Drinkers Lounge for longer, visited the centre on a more regular basis, and were able to talk about the long-term effects it has had on their lives.

Of the members I interviewed, thirteen were Indigenous, one identified as white, having been born Indigenous but raised by a white family, two identified as white, and one had immigrated from Vietnam as a child. Both staff members identified as white. The members of the Drinkers Lounge, including the participants, came from reserves, cities, and towns across Canada.

The History

The Drinkers Lounge originated at the Drug Users Resource Centre (DURC), a drop-in centre that was funded by Vancouver Coastal Health (VCH). It was a thriving community space where 1500 people a day could see the doctor, socialize, watch movies, sleep, get food, find various supports, and have the opportunity to work a shift and make three dollars. DURC was almost entirely run by peers who worked as administrators, cleaners, facilitators, advocacy workers, and monitors, among other roles. This work offered many people stability because they knew they would not be fired if they were not able to be there, as there were always other people available to fill in. Thorough this work, about $4000.00 a week went back into the community. In return, the community respected and felt a sense of ownership of DURC.

The Drinkers Lounge emerged out of the ‘Life Skills’ programming at DURC. DURC was centrally located just across from Oppenheim Park, where the drinker community was already intact and where many of them lived or spent their time. Many of them began to come in for the different services and programming that were being offered for drug users. This was one of the only places that would not kick drinkers out for being drunk and disruptive. As the drinkers became part of the DURC membership, it became clear to the staff and members that the drinkers had different needs and that no other support services were being offered in the city.

In response to this, a member there began to develop the Brew Co-op. It began as group of about 15 people brewing one or two wine kits a month, but quickly exploded into brewing five days a week.

Unfortunately, in 2016, the health authority transferred DURC's funding to a different organization and DURC was shut down. After its closure, it became clear that the programming for drinkers would not be transferred to another location and the drinkers would lose their supports. Eventually, the BC Centre for Disease Control (BCCDC) agreed to fund the program for one year, and the Drinkers Lounge opened at its own location two blocks away. Despite this, the drinkers still lost many of the additional supports they were receiving at DURC. The staff explained that due to this lack of supports, in the two years since losing DURC, about 30 Drinkers Lounge members have passed away.

Part II: Understanding Substance Use

The Social Determinants of Mental Health

While many services treat drinking and alcoholism as a solely biomedical issue, almost none of the participants described substance use as originating from mental illness or any sort of biological disorder. Instead, the members and staff recognized the social and systemic factors that affect the health and mental health of the members and lead to excessive drinking. While some participants used the terminology of addiction and alcoholism, all of them attributed their drinking to emotional pain that stemmed from profoundly negative experiences in their lives. In addition to their personal stories, the participants identified various systemic barriers to health

and social services, such as discrimination, stigma, erasure, and a widespread expectation of abstinence in order to receive care.

Michelle explained that after working in this community for many years, she believes the issues at play are more social health problems than physical health problems (though physical health is affected). While she agrees that it is important to acknowledge individual mental health, focusing only on this overlooks the systemic and societal issues at play. She explains that an onus on individuals leads to the narrative that people need to "pull themselves up by their bootstraps." However, many of the members are unable to do this because of a myriad of factors, including a lack of socioeconomic opportunities and traumatic experiences.

"I think if you're not mentally ill in this world, then you're mentally ill [laughs]. Like if you can get through this world without drugs and alcohol, then you are living in a different world." – Michelle

Traumatic Experiences

The participants of this study overwhelmingly connected their drinking to some form of emotional pain stemming from past and ongoing traumatic experiences. Almost all the members had experienced an immense amount of abuse, pain, and loss in their lives. Several members explained that drinking was a way to bring out happiness in people instead of feeling all the pain in their lives.

Several of the participants had left their home because of abusive parents or family members. Several described experiencing sexual, physical, and mental abuse as a child. One participant explained that many of the members were from reserves and had left to try to escape

this pain. She herself stated that she did not want to quit drinking because of the things that had happened in her life, which brought her too much pain, such as being sexually and physically abused.

“For me, the doctor said, ‘Do you want to go to detox?’ and I'm like, ‘Nope. Not at the moment.’ Because there's several things that have happened in my life that are not right: being raped and being hit. There is a lot of pain. There's all our emotions” – Rachel E.

Many of the participants described being isolated from their families for various reasons. Some had fled abuse, some had gone through the foster care system, some had been cut off from their family, and some no longer had family members that were alive.

One participant described being part of the 60s Scoop, growing up in a foster home, and losing eight of his eleven siblings. He connected his drinking to not being able to get over his grief from the recent loss of his wife. A second participant linked his drinking to a depression he went through after the loss of his two sisters and a brother last year. He had also spent 18 years in foster care, and 20 years in jail, further isolating him from his family.

One participant explained that all the people in her community are also continually grieving the loss of so many lives in the Downtown East Side (DTES), people who she considered family. Many of the members described losing close friends and people who were parental figures or like family to them.

“But deep inside they're crying. Deeply. You know, when you feel too much pain in your life-- and I mean like over, what, 14 years of your life… It’s like, am I crying for myself or am I crying for somebody else?” - Harley

A few of the members indicated that they had been drinking from a very young age. One had been drinking since the age of twelve and said he has had a drinking problem since. One said he had been drinking and using drugs since the age of nine in an attempt to not “feel the pain.” Another had gone through a tough upbringing and explained that his PTSD had driven him to alcoholism at the age of seven.

“So I got introduced by my brother and my mother, who has different addictions, but my hardest struggle is alcohol. I had my first drink when I was seven years old. It was a screwdriver, vodka and orange juice.” – Stanley Jr.

In addition, many of the members understood the history and trauma that Indigenous people face and how this affects them. In the interviews, two members connected their struggles to colonial government policies. A third member expressed being frustrated that alcohol had been introduced to Indigenous peoples to begin with.

Discrimination

In addition to the traumatic past and ongoing events that affect the health and mental health of the members, the participants indicated that they face additional stigma and discrimination that prevents them from accessing services that would help improve their physical and mental health. One participant explained that when people are homeless and have nowhere to go, it is a lot easier to get into a cycle of drinking, and that having more services would help this.

Drinkers

The participants described being stigmatized and discriminated against for being drinkers in their daily lives. This discrimination is elevated for people who are street entrenched and drinking in public, especially when those people are Indigenous.

In public, people shame drinkers for drinking even though they themselves drink, because of the additional harms they face, like poverty and homelessness. The members explained that when people see them in a public space, they immediately call the cops. The drinkers described being yelled at or people making rude comments about them as they pass, like calling them "good for nothing." Some members described how this discrimination also comes from people who use drugs. Despite facing the same harms as people who use drugs in the DTES, they are often even more stigmatized. This discrimination and judgment towards drinkers only further marginalized the drinkers and prevented them from accessing certain spaces.

For many of the participants, the Drinkers Lounge is the only agency where they are allowed in when they are drunk and where they do not feel like they are being looked at funny. Michelle explained that one of the reasons that there are so few services accessible to drinkers is that they are difficult and complex people to serve. Most medical professionals or service providers are not aware of how to deal with their behaviours as it is often very personal to their own personality, trauma, and situation. However, rather than banning them from services, she advocates for creating relationships with them, so that workers are aware of their behaviours, patterns, and needs. While this process is intensive and takes time and energy, it prevents their behaviour from being criminalized.

Michelle also explained that people get preoccupied by the fact that the drinkers are making their own alcohol. Despite the popularity of drinking and craft brewing in Vancouver, people continue to be morally opposed to alcohol programming that is not abstinence based. These moral abstinence arguments prevent even a small centre like the Drinkers Lounge from being funded, which is dangerous for the community.

"To have them come into a place where if you're a huge angry Indigenous man who's drunk and have the reaction be 'Oh, you want a hug?' instead of 'Get the fuck out of here,' that makes a huge difference." – Michelle

Medical Professionals

Some participants explained that they are refused medical services when they are drinking. For many people, they drink every day, so this means they are never able to access services. In addition, the times when people are drinking may be the times when they are most in need of services.

Another common complaint was that doctors refuse the members painkillers because mixing them with alcohol can be harmful to the liver. However, the members described having serious broken bones after being attacked and falling down a set of stairs, for example, and not being given Tylenol or aspirin. This means they must then rely on alcohol for pain management.

Another reoccurring complaint was that doctors and hospitals shame drinkers and continually tell them that they need to quit drinking when they are there for other health services. This meant that drinkers were less likely to seek these services in the future.

When accessing emergency services for withdrawal, the members had mixed experiences. Some hospitals would treat them well, put you them an IV to avoid a seizure, and allow them to spend the night. Other hospitals would not treat them as a priority and rush them out after giving them Ativan.

Police

Many participants explained that police rarely try to build trusting relationships and it is common for them to escalate conflicts unnecessarily. Many had had negative experiences with the police or had experienced harassment.

One member explained how the police keep approaching him because of his history and reputation, despite the work he has done to heal and manage his anger and become calmer. He described how the day before the interview, he was attacked, stabbed in the arm, and robbed by a group of people, but when the police arrived, they assumed he had started the conflict and arrested him. Another member was paying for alcohol at a liquor store, but the staff assumed he was trying to steal and threatened him with a baseball bat. He explained that even the courts had noticed a difference in his behaviour in recent years, but despite this, he is continually treated like a criminal. A third members had been handcuffed by police despite having a broken arm. Lastly, another member described the police coming to arrest her in front of her friend for driving with an expired driver's license.

Often the drinkers are discriminated against even more than drug users. While drug users are able to use openly in the DTES, drinkers have to hide their alcohol or the police will come pour it out and potentially arrest them and take them to the "drunk tank."[12]

Michelle explained how for the drinkers, fear and anger is pathologized and criminalized, especially among younger Indigenous people, who are often questioned just crossing the street. She explained that often when young men are brawling, they are fine, and not hurting anyone. Yet the police treat them as violent criminals and send them to jail rather than getting them the support they need. She explained that sometimes people do need to go to the drunk tank to cool off for their own safety and the safety of others, but more health interventions are needed to replace these criminal interventions.

"It's history really. They keep bugging me. Even new cops bug you because of your older reputation, right? You might've been a badass a couple of years ago, but when you're calm and back in the neighborhood, they still have a record of us. So they think, 'I gotta keep on this guy. He may seem nice, or this and that. He might manipulate you and seem like a good guy, but he's not'.... In these situations they are like, 'You're probably one of the ones who started it,' but meanwhile we're the ones who kind of got in the middle and ended it" – Stanley Jr.

Racism

Some of the participants explained that the discrimination targeted at drinkers is amplified if they are Indigenous. One member shared how people would walk by and say things

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[12] **Drunk Tank:** A jail cell where intoxicated people are held until they are sober

like "Look at that Native person on the bench, drunk all day, every day." Some described how people immediately assume they are drinkers because they are Indigenous. Again, Michelle explained that many Indigenous members are targeted by police. She described how young Indigenous men in particular have to deal with dangerous lifestyles and the justice system on a larger scale. While they are often just more scared or angry because of their traumatic life experiences, they are pathologized and criminalized on a larger scale.

Gender

When I began the interview process, I had assumed that the women I talked to in the DTES would face additional discrimination, harms, and oppression because of their gender. However, the female participants I spoke to did not mirror this view. Most participants seemed to feel that their DTES community was a safe space for women. The participants explained that the DTES community is tight knit, and women can find safety within it. One member explained that people are always watching and willing to help you.

Michelle explained that while women do have autonomy, systemic oppression can make things particularly difficult for women. For instance, some women do have to make choices to stay in potentially abusive relationships in order to have housing, or because it is safer for them than being alone. However, it is important to respect women who make the choices that are best for them. While the women I spoke to were aware of the dangers that women face in the DTES, they were resilient and knew how to protect themselves.

The participants also relayed that the men in their community are also hurting and at risk. Michelle explained that while men in general are safer and more privileged in our society, there is very little support for the men in this community. Even white men in the DTES are living in

extreme poverty, are underprivileged, and in need of support. She has also found that even for men that have been abusive towards others, what they need is more supports and to be held accountable by their community, rather than be criminalized.

All of the members that I interviewed identified as cisgender men and women. Below I will address the gap in programming and services for LGBTQ+ people in this community.

Victimization

While the participants pointed to direct correlations between their trauma and their drinking, Michelle made clear the danger of reducing them to this trauma. While their history needs to be acknowledged and supported in this setting, healing involves focusing on their agency and abilities, and respecting their self-determination. While they have a lot of trauma in their lives and face oppressive circumstances, they are also extremely resilient. They have the ability and capacity to make their own choices and break negative cycles. She believes it is necessary to explore the line between understanding their past and reinforcing personal agency and responsibility.

Part III: An Alternative to Biomedical Clinical Care Models

A Harm Reduction Model

Many services in Vancouver, especially those targeted at drinkers, are abstinence-based, making them inaccessible to anyone who cannot or does not want to quit drinking. As a result, Drinkers are further marginalized and unable to access health and social supports.

In contrast, at the Drinkers Lounge there is no expectation of sobriety or abstinence. The program recognizes that people fluctuate between drinking and sobriety depending on what else is happening in their lives, and know that expecting people to remain sober is not always realistic. In addition, recovery for some people may simply be to reduce their drinking to a manageable level, like having a beer or wine with dinner.

Instead of removing alcohol from their lives, the goal at the Drinkers Lounge is to reduce the harms associated with drinking and to improve the supports in people's lives. By having a space where abstinence is not required and where drinking is not judged, drinkers are connected to crucial health supports and services.

In Michelle's experience, the solution to problematic substance use is not abstinence, but connection. People need to replace and fill-up their lives with good things to help mitigate their need to use substances. She explained that is impossible to know what exactly will give someone the best chance of reducing their drinking and that we need to focus instead on making sure that they are healthy and happy.

"We have one guy who is 45, has been drinking for 20 years, and is incredibly sick, but he used to live on the street and drink Listerine every day. Now he's housed and has medical treatment and is drinking his two wines a day that he gets from MAP, and for him that is success. He doesn't want to stop drinking but he probably would be dead if he wasn't here and didn't have this housing. To someone else that would seem extreme, but that is his success story from where he was to where he is now. He has friends now. He used to be super isolated and only had his partner, but his partner was one of the first people who passed away when DURC closed. I think he probably would have died after his partner passed away because it was all he had. But the community just sort of swooped around and supported him." – Michelle

Experiences of Biomedical Services

Many of the participants had tried various models of care for drinkers like Alcoholics Anonymous (AA), detox centres, and treatment centres. Many of the participants avoided these, particularly AA, because they felt like many of them were too judgemental.

Michelle explained that clinical services are less effective for this community because they force expectations on people. They require that patients move towards certain goals, like sobriety, and when they reach the goal they are immediately discharged. This goal of "fixing" people and then getting them out of treatment creates a back and forth fluctuation for drinkers where they are sober for periods but then start drinking again due to a lack of support in their lives during a traumatic event.

Some people had positive experiences with detox and treatment when they felt they were ready to quit drinking. The main problem was that there are so few options. It is a very long wait for a spot, and if they miss their appointment, the wait increases. This wait again means that people easily fall back into cycles of drinking, particularly if they are homeless and have nowhere to go. The participants expressed that there is a need for more wet shelters and more alcohol treatment and detox centres, especially ones that are in the neighbourhood.

While these types of mainstream services can be effective and removing alcohol from someone's life, drop-in centres like the Drinkers Lounge are an important way them to receive continual support.

Part IV: The Drinkers Lounge Supports

The Drinkers Lounge offers a range of supports to its members. I have divided them into the following four categories, though many of them overlap and relate to each other. The following four figures illustrate the various supports and services the Drinkers Lounge offers.

"Because we're able to offer this service where people really like the alcohol, we're also able to connect them with all sorts of other types of care, whatever they need. We try to accommodate whatever people are missing in their lives, whether it's housing or identification or work." – Petr

The Managed Alcohol Program

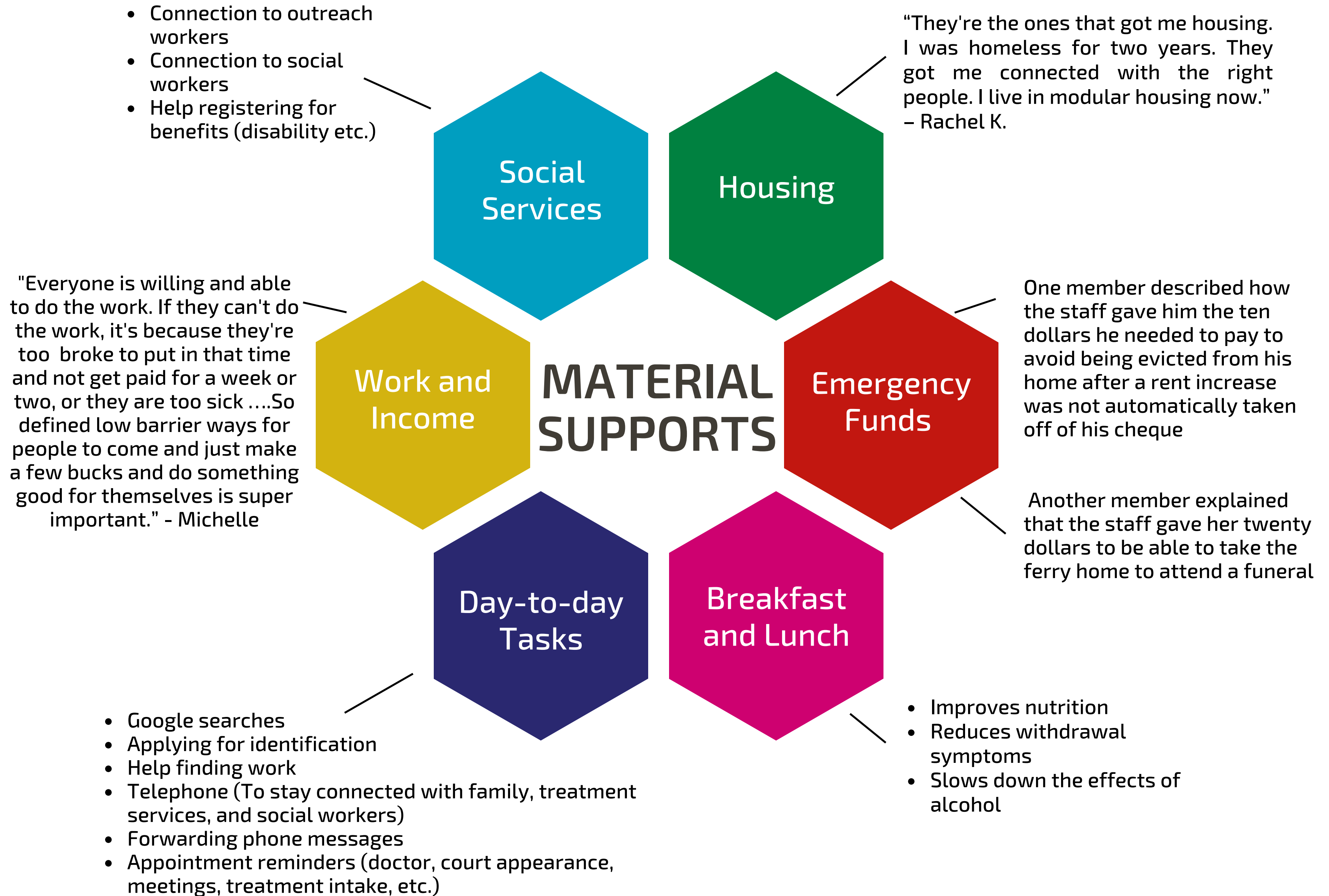
For many of the members, the MAP had been a significant support to them. Having access to affordable beverage alcohol had the following effects on the members.

Figure I: The Managed Alcohol Program

Material Supports

The Drinkers Lounge offers basic material supports that are lacking in the lives of the drinkers. Offering these improves their health, creates stability in their lives, and supports them in maintaining this stability. The following figure illustrates some of these basic supports.

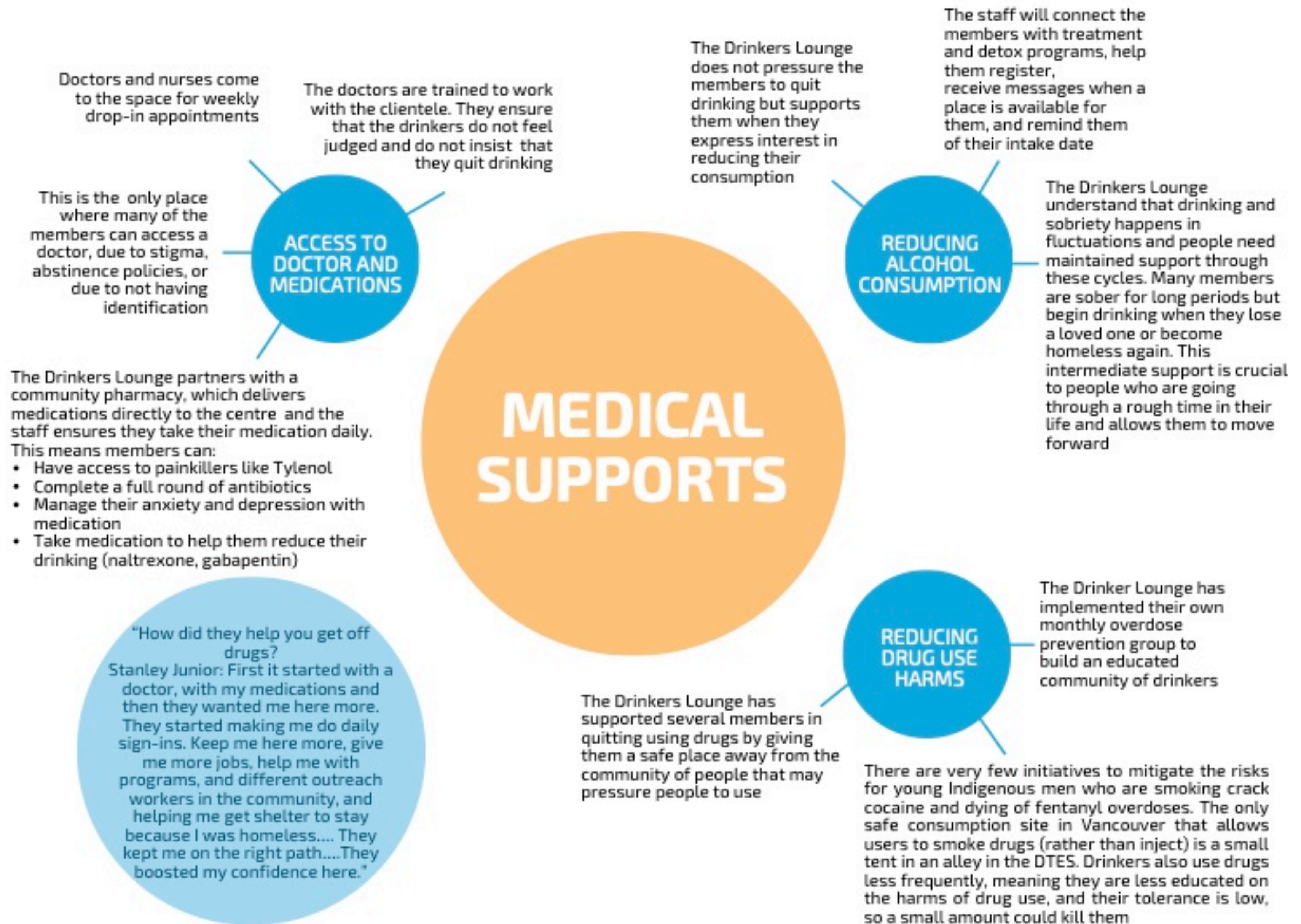
Figure II: Material Supports



Medical Supports

The Drinkers Lounge offers various medical supports to drinkers who are not comfortable or able to seek them at other locations due to the barriers described above. By bringing medical supports to a community space where the members feel comfortable and safe, and which they visit on a regular basis, the members are able to receive the following medical services.

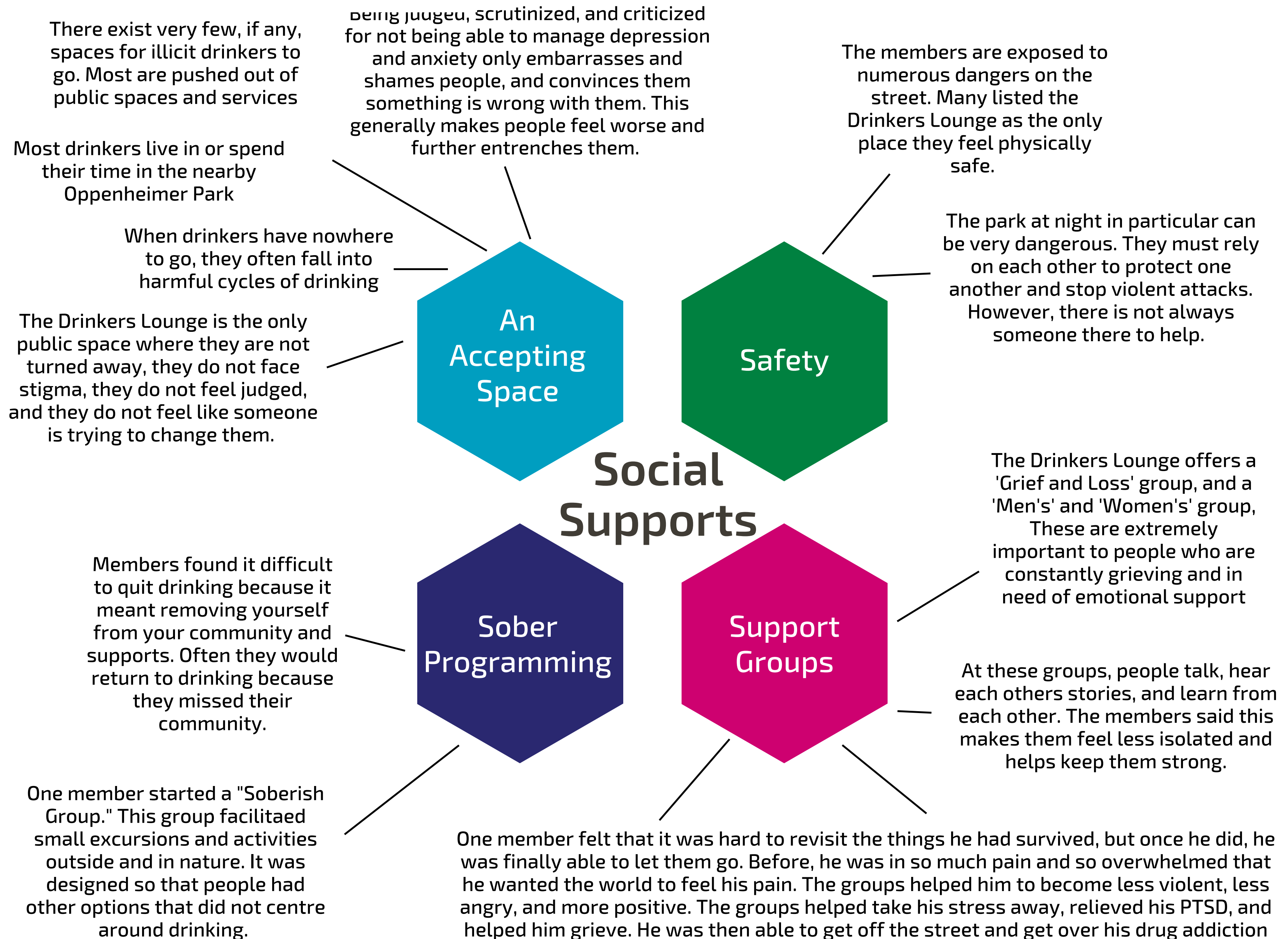
Figure III: Medical Supports



Social Supports

The following social supports are an extremely important part of how the Drinkers Lounge has been able to improve the quality of life of the drinkers. Several of the members explained that the Drinkers Lounge had been an important stepping stone for them in their lives. One member explained that once they become a part of the community and become more comfortable, they are able to become more open, less negative, and start moving forward in their lives.

Figure IV: Social Supports



Part V: Governance and Guiding Principles

The success of this program depends on it being a low-barrier and accessible space that people want to return to on a regular basis. During the interviews I identified three reoccurring principles and styles of governance that enable this centre to succeed. These principles are what distinguishes the Drinkers Lounge from other models of care and were the major contributors to healing and health amongst the members.

Community

"And it teaches a new way, teaches them how to belong, how to feel accepted and function. Because everyone here is an outcast. None of their families are there for them and none of them, they don't feel cared for or loved. But here they feel accepted and like family." - Stanley Jr.

The innovative community building aspect of the Drinkers Lounge model is what sets this model apart from other MAPs across Canada. This community is created through the Brew Co-op, the weekly meetings, the support groups, and the inclusivity of the space. The participants overwhelmingly listed their community as the main reason they keep returning to the Drinkers Lounge and a huge source of positive change and improved health in their lives. It was an extremely valuable way to reduce the isolation that many of them experience and increase the supports in their lives. As Michelle explained, this connection to other people is often a better solution to problematic substance use than abstinence is.

Almost every participant described the Drinkers Lounge as the only place where they felt

that they belonged and the only place that felt like home. Many participants described the people at the Drinkers Lounge as their family.

For many of the members, the Drinkers Lounge was an important space of positivity. One member described this community as one where they pick each other up, help each other go forward, and build themselves up, rather than breaking themselves down. Many of the participants described trying to support each other and make each other happy.

A big source of support for people was being around people that were going through the same things as them and having someone to talk to. The group allows them to express their grief and their loss and feel a sense of strength from the group.

This kind of support was extremely valuable to people who had recently lost people in their life. For some people, they feel this community has saved their life in these moments.

"It's more positive. We stick together. We all laugh. We all stick together when there's tough times. Like when we lose someone in the group, it's when we pull together. It's what we need to do, you know? These guys in here are more my family than my own family. In my real family, I'm the black sheep." – Senior

The staff also played a crucial role in this community building process. It was clear that building genuine compassionate relationships with the members is the only way staff are able to support them. Michelle explained that these relationships are easy to build if you are open and trusting towards the drinkers, because they are such open and welcoming people. She explained that by building relationships of trust, support, and empathy, it is possible to be a little harder on people and encourage them to achieve their goals.

Michelle emphasized that this can be a difficult balance. Building relationships is

extremely important so that the staff know when a member needs to be loved and supported and when they need to be held accountable. One member echoed that sometimes they need staff that are strict, enforce the rules, and keep the place safe, and sometimes they need staff that make people feel loved, accepted, and wanted.

Talking to participants during a staff changeover made it clear how important this staff role was in community building. When staff members do not create meaningful relationships with the members and take on a more authoritarian role, the community feels this lack of support and begins to feel discouraged.

"And their love. Get good hugs and every once in a while, [whispers] 'Hey, are you okay?' It's always good to have somebody say that to you: 'Are you okay?' 'Yeah, I'm okay a little bit.' - Harley

Peer Leadership

A fundamental part of the CMAP model is that it is operated by peer workers. While there are usually two PHS staff members in a managerial and supervisory position, the rest of the centre, particularly the brew co-op, is run by peers. As I mentioned above, some members also take on leadership and managerial roles. Because of their lived experience, the members are often more equipped to support each other than staff members are.

The participants explained that the Drinkers Lounge and brew co-op are self-governed to an extent and run by the community. While the role of PHS staff is important, this ethic of a partnership with the community members, rather than a hierarchy of roles, is pivotal to the success of the model.

Expertise

Having lived in the community for so many years, the members of the Drinkers Lounge have lived experience that can translate to an expert knowledge of community needs and of what interventions are needed to improve their health. Because they are the ones that access the services, they know how to design and run the site in a way that adapts the services to local needs.

In addition to a knowledge of what services are needed, the members have an intimate knowledge of each individual. Many of them have grown up together and can inform the staff how to best work with them.

"If you set up something that you think is going to work for someone else, that's probably not going to work. People here know what they want and they're not slow." – Tyler

Having people receive care from their fellow community members is a key component to offering low barrier-services. Often people are much less reluctant to seek help when it is coming from their friends and trusted community rather than an authority figure or a medical professional. For many people, their negative experiences in clinical settings deter them from seeking care. Michelle explained that even within services that are attempting to be low-barrier, there may still be a perception of "us versus them." For this reason, the community is better able to keep each other accountable than the staff.

"I notice when one of my members, when I smell rubbing [alcohol] on them. I say, 'What's up' They say, 'Yeah, I took a few sips here and there' and I'm like, 'Smarten your ass up' [laughs]." – Rachel E.

Often the peers' expert knowledge of the community comes from the fact that the members are the ones that have already been doing this work in their community. When the centre closes and the staff go home, the members continue to do this type of harm reduction work unpaid. Several of the members explained that their role at the Drinkers Lounge did not stop when they left, and was, in reality, a full-time job for them. The members I spoke to described giving people clothes, helping them get ID, waiting with them until a shelter opens, or even inviting them into their homes to sleep.

"I've got a lot of heart for other people that don't have nothing, you know, like not even a place to sleep. I would bring them home to my place. I say, 'You can't sleep out in the cold right now. You can come to my room, you can sleep on my bed.' I've got this white love seat, leather, and I sleep on that. So I can bring someone out from the cold. Like tonight, she's going to be cold. If I found someone out there tonight, I would bring them home and I say, 'Come and have a coffee. Go lay down and sleep on my bed.' - Alvin

One strategy the members used outside of the centre to keep each other safe was to form groups that would unofficially guard Oppenheimer park. They would break up fights, de-escalate situations, and actively try to keep everyone calm and in a good mood.

This experience with de-escalation in the community is one of the most important skills at the Drinkers Lounge. When fights do occur within the centre, which is not uncommon for

people who are drinking, the members are able to de-escalate situations in ways that other service providers cannot. Often it is the members who know best how to respond to someone who is angry because they are friends, they have had similar experiences, and they know how to talk to them an equal. Service providers who do not have the training necessary to work with drinkers, often responds negatively and defensively, which tends to escalate the situation and results in the refusal of services to the drinker. Michelle explained that at the Drinkers Lounge, when someone is aggressive, angry, yelling, or having an emotional outburst, rather than immediately telling them to leave, the respond with support and love, which often de-escalates the situation much quicker. People who continue to fight will be sent for a nap on the cot or are sent out for a walk. However, they are always welcomed back, which encourages them to take responsibility for their behaviour in a supportive environment, rather that furthering their isolation.

"Could we not find another way to support them and reduce this risk to themselves and others instead of just sending them to jail and them being treated as violent criminals? I think a lot more support is needed." - Michelle

Impact

Not only are the community members the best candidates for this work, but the participants explained that the work itself has a positive impact on their health and lives.

Many of the members described how the work was helping them develop valuable skills. Firstly, they have developed an expertise in brewing craft alcohol. Secondly, they developed

skills in community work and outreach. The members enjoyed this outreach work and expressed a desire to continue doing this work.

For some members, the flexibility of the work gave them confidence that they could successfully do work that they are proud of. The model also actively creates opportunities for people to seek more responsibilities and opportunities when they are ready. This allows people to do things at their own pace and still feel validated and successful.

For many members, this work provided them with pride and meaning in their lives, which gave them hope for the future and improved their overall wellbeing.

"I remember things, even outside of the Drinkers Lounge, you could use those skills anywhere. Whatever they teach you, it's awesome." - Maxine

Empowerment

The members explained that once people are supported and given the opportunity to use their skills, they open up and reveal their talents. Understanding that the community has the skills, the ability, the agency to be effective community workers is an essential part of the program. Rather than treating the drinkers as victims, Michelle explains that the people in the community are extremely resilient and have figured out how to survive.

Despite their abilities, the PHS staff recognizes that leadership roles need to be low-barrier. These roles need additional time and care because, despite their skills, some peers do need some guidance with boundaries and anger management. It is also important to realize that they do not have the same pay as the PHS staff members, they are not unionized, and they do not have the same stability in their lives.

However, the role of staff should be to support the members in taking on these leadership roles. When the staff do not respect this collective type of leadership and simply use the peers in a tokenistic way, the members sense this, which jeopardizes the strength of the program. During the time of the interviews, when new staff members had been hired, the members told me that they no longer felt trusted and respected by the staff to be a real part of decision-making processes. The established community leaders were beginning to feel frustration and resentment. During this time, some members stopped coming to the Drinkers Lounge on a regular basis, which can dangerous for them and the community.

When the members are respected as leaders and are given the tools to design and run the services themselves, they develop respect and ownership of it. This is critical to its success and their continued commitment to it.

"Because they're capable. I feel like some funders think, 'Oh, they're making their own booze, you're getting the booze for them.' But we're not just giving them booze. They're making it themselves. They're brewing it themselves. They're taking the initiative to be healthy…They're actually contributing to a healthier community and a healthier society. The more they heal themselves, the more they're healing the fucking world. Which is so cheesy, but it's true." – Michelle

Decolonizing Health

Because the majority of the members at the Drinkers Lounge are Indigenous, it is imperative to recognize that the way we design out healthcare services has the potential to

contribute to systemic oppression. The Drinkers Lounge has begun to create a model of care that is more accessible to Indigenous community members and will better meet their needs.

Indigenous Cultural Supports

Almost every participant explained that the Indigenous cultural practices at the Drinkers Lounge were an integral part of their health and healing. Because the staff at the Drinkers Lounge are non-Indigenous, the centre relies heavily on outside organizations to offer these Indigenous cultural supports. The Drinkers Lounge is connected with Culture Saves Lives, an Indigenous organization that offers cultural supports to people in the DTES. Members of the organization regularly came to the Drinkers Lounge to lead support groups, conduct smudges, drumming, and singing circles, and to offer other cultural supports.

Many of the members described the spiritual healing effect that these practices had on them. The music and smudges made them feel cleansed and gave them a sense of relief. The drums were repeatedly described to me as a heartbeat, that gave the members a sense of connection and helped them to "feel alive."

The practices also helped the members to feel connected to where they were from. As one member explained, many Indigenous people are running from their reserves and arriving in Vancouver and are in need a safe place to feel welcome, find support, and reconnect to their culture.

One member explained that the cultural practices help him to feel better and get out of his drug addiction. Getting back in touch with his culture led to him becoming more positive in his life. Many of the members explained that connecting with their culture helped them to take steps towards recovery.

"It got me connected back to my roots, in a way that I knew. I just started getting back in touch with my Native culture. I used to do that stuff when I was younger from my grandpa before he passed on…I'd get picked up by my grandpa and go back to my home reserve where I'm from. I'd learn his songs, learn how to drum and sing. Then I learned how to do all those dances." – Stanley Jr.

"I don't want to die drunk. You know I got nine grandkids. I want to teach them to-- I can carve and do woodcarving and I can make silver and gold jewelry. I can Indian sing and dance and I want to teach my grandkids…I sing and dance and play. My late Dad was a medicine man and a cultural teacher. All the songs and dances that were on my reserve, they belonged to my late Dad. He used to think I never listened, but I did. I learned every one of his songs and dancing. [Staff] wants me to sing one time here." – Senior

Indigenous Leadership

Both the staff members and some Drinkers Lounge members expressed the need for Indigenous staff members to work at the Drinkers Lounge. Both staff members were grateful for the opportunity to work with this community but were well aware of their privilege and the need for more Indigenous representation. Michelle said that while she had built some great relationships, she thinks Indigenous role models allow people to look more easily at the staff, relate to them, and see how they might want to do this kind of work someday. She explained that Culture Saves Lives is important because they are, for the most part, young Indigenous men who have been through a lot of the same things. This kind of mentorship and normalization allows

members to see people like them who have gotten to a good place and are taking on leadership roles. Tyler also emphasized the need for Indigenous elders and councillors, because the members sometimes cannot open up to white people. He explained that Indigenous knowledge in these situations does not compare with the book smarts that comes with education.

Flexibility

Because the Drinkers Lounge is open to everyone, the group is home to a wide diversity of people. While the majority of the members are Indigenous, they still come from a wide variety of Indigenous communities across Turtle Island. While some participants felt that this created some problems, in general, the participants explained that they all learned to get along and share their culture with one another. As a result, the Drinkers Lounge has become home to a diverse and inclusive community and a unique urban Indigenous culture.

"Who cares what tribe you're from. We're all one family here. We get along like that. We don't care if you're Cree, Haida Gwaii, or Blackfoot, Stigfoot, or whatever foot [laughs]. That's why I get along with people." - Alvin

One point of some contention that was brought up by the participants is whether or not people should be able to participate in Indigenous cultural practices when they have been drinking or using drugs. Some Indigenous people believe that people need to abstain from substance use to participate. However, the Culture Saves Lives facilitators have a harm reduction focus and aim to promote healing by sharing these practices with anyone who wishes to participate, whether or not they are using. While some people disagreed on this point, the

members seemed to have some flexibility around it. Most of the members believed that everyone should be allowed to be present for these practices, even if they believed that they should not participate directly. This flexibility was critical for the drinkers who needed this kind of healing to recover.

“I like how here they accept you even if you're under the influence because-- Like back in the day you weren't supposed to smoke weed. You weren't supposed to drink or nothing to be involved in it. But I like the exception here, because cultural healing is the only thing that is going to heal you really.” – Stanley Jr.

Part VI: Funding Constraints and Challenges

Overall, the participants relayed to me that Drinkers Lounge programming was extremely successful, essential, and life-saving service. However, the lack of funding has kept the future of the centre precarious and has prevented and program from meeting all the needs of the members. While these types of community health interventions can be extremely effective, they are not the ones that are consistently funded, and are often targeted for closure. Almost all of the problems with the Drinkers Lounge model were due to the lack of resources and the strain that this put on the centre. Both the staff and members were aware and concerned about the lack of funding the program was getting and were actively trying to fundraise and secure funding.

“So that is why it frustrates me so much that the Drinkers Lounge doesn't have the support and the funding. I see it as just the beginning, the tiniest thing. But we're getting hung up on having people make their own alcohol so that they are making healthier choices and actually

empowering themselves and working together. And this is a city where there's about 65 microbreweries, which is ironically contributing to gentrification and distancing these folks more from their community. If we can't get behind our morality and get over that one little thing and fund this, then there's just so much else that needs to be done. It's just so frustrating" – Michelle

Issues Due to Inadequate Funding

Staffing Shortages

For the PHS staff at the Drinkers Lounge, the life-saving work they are doing at the Drinkers Lounge is extremely challenging and time consuming, especially because they are understaffed and under-supported and forced to learn a lot on their own.

Currently, there are only two staff members that work at the Drinkers Lounge in one day, who are dealing with dozens of people and drop-in visits. When I began my interviews, two of the long-time staff had resigned because of this lack of resources and the burn out they experience. This staff turnaround leads to challenging transitions that harm the members of the Drinkers Lounge the most, as they lose someone who was the foundation of their stability.

In addition, the participants identified the need for more peer leaders, especially Indigenous leaders. They explained that they are more equipped to deal with conflicts, burn out less easily, and require less training because they are used to the culture and community.

"That is one of the reasons I had to quit because I was fighting so hard. I know this program is important and I know it is more dangerous to not have it, but if we're not going to get the support

to grow and expand and support people, then it's going to get dangerous to stay stagnant at this place. We are identifying needs and we need to support people in a better way. It just got exhausting. I love them so much and that's why I'll never fully leave, but I just need to step aside so I can actually have the energy to do things for people, and try to make things happen in other realms." *– Michelle*

Fighting

The most common complaint that the members identified was the fighting that occurs within the Drinkers Lounge space. For some of the members, especially young men, their trauma comes out as aggression, and criminalization only worsens their trauma.

While these conflicts are sometimes used as evidence that the Drinkers Lounge is unsafe, the participants made it clear that fights like these are more dangerous and harmful outside of the space. Despite complaining about these fights, the members never wanted the police to be called. The Drinkers Lounge gives them an opportunity to de-escalate fighting and support their friends without police intervention. Often when conflicts occurred, the best response is to give them support or offer them a space to sleep and calm down.

While the members can usually de-escalate these conflicts and offer the necessary support themselves, there is sometimes not enough members and staff present to manage an aggressive person. It is in these situations where members are asked to leave, or the police are called. Many of the members were frustrated by this and worried about their friends, but also understood that when only one staff member is there, that they may feel the need to call the police for the wellbeing of themselves and others.

It was clear throughout these interviews that the centre was in need of more resources and staff to de-escalate personal conflicts without criminalizing their behaviour. The members also requested more conflict resolution training.

Limited Hours

Almost all of the participants expressed a need for the centre to be open for longer than four hours a day. For some, the weekends, when the centre was closed, were also a difficult time. Not only do they become more isolated but they often experience severe withdrawal. Several of the participants explained that on the weekends they resorted to stealing alcohol or drinking illicit alcohol again. Many participants identified the need for a 24-hour drop-in centre that was open seven days a week to avoid returning to these harmful cycles.

Undervaluing Peers

A few members and staff felt that the members were underpaid for their work at the Drinkers Lounge. As Petr explained, a three-dollar stipend for their work is extremely low, even compared to other peer roles in the DTES. The amount they receive does not reflect the value of the lived expertise that they bring to the work which is critical to the success of the centre.

Need for Expansion

Most of the programming at the Drinkers Lounge, such as the support groups, the cultural programming, and the soberish group, have precarious funding. Some of the groups are only available when they are able to receive funding, and some have already been discontinued.

The centre itself is in need of more space and programming to address the growing size of the group. The Brew Co-op works in the same space as the drop-in centre, which can make it difficult for them to do their work when it is too busy. One member explained that when it gets too crowded and people are bumping into each other, they are more likely to get into arguments.

In terms of supports, many of the participants explained that while the Drinkers Lounge was extremely valuable, it was only the beginning of what the community needed. The members requested additional things like showers, clothing, a washer and dryer, and forms available to help people get identification. There are many needs that were met at DURC that are no longer being met.

The members identified that there was a significant need for additional programming at the Drinkers Lounge for people coming out of treatment and detox centres. They explained that once people make a choice to quit drinking, they no longer have the same support. They are by themselves in treatment and become isolated as they lose their connection with the drinking community. This is especially harmful because once they leave treatment, they are faced with overwhelming emotions and are in need of the support of a community. The members had several suggestions for what this programming could look like, such as a space at the Drinkers Lounge that offered programming for sober members, art groups, or additional Indigenous programming.

The members also emphasized the need for more cultural supports. They appreciated the cultural programming but wanted it to be increased and to be a more central focus. Tyler described a friendship centre or a cultural based model where people could rebuild their skills,

with a focus on their own culture.

Another gap in Drinkers Lounge model is that there is no programming or supports for trans, non-binary, two-spirit, or other LGBTQ+ people. While the staff and most members aim to be inclusive and do not allow for homophobic and derogatory comments, the programming generally caters to straight, cis-gendered people, who fall within the male/female gender binary. Petr noted the need to extend their programming to be more inclusive of the various members of the community. He explained that there is no trans people coming to the Drinkers Lounge which means they need to work on making a space and services that are more welcoming to them.

Reasons for Inadequate Funding

Since the creation of the Drinkers Lounge, the health authority and other potential funding bodies have been consistently reluctant to fund it. This has continually frustrated the staff and members because there are no other services that are meeting the needs of this population.

Part of the reason funders may be reluctant to fund these programs is the stigma associated with drinkers. Michelle explained that no one has been able to give her an answer about why they do not want to fund the program, and they are constantly left in a limbo of not being shut down, but also not getting funding.

In addition, funding authorities often have their own ideas of what treatment should look like, and the Drinkers Lounge does not fit into these conventional models. People who have very little knowledge of drinkers and street-entrenched lifestyles often perceive these spaces to be overly chaotic spaces, rather than safe ones. Despite health authorities in Canada attempting to

move towards community interventions in health care, in reality, funders who do not understand the principles behind these models, do not prioritize funding towards them.

"There's no money and there just isn't this kind of program so there's no pre-existing funding stream for it. All alcohol programming is for moderate alcoholism or for abstinence. Sort of like AA (Alcoholics Anonymous) 12 step. There are a lot of managed alcohol programs across Canada and they're all amazing and a lot of them are doing a really good job and a really celebrated, but they're all having the same issue where they're just having a hard time being funded because they need the stats that are proving that people are recovering. There's just too much focus on stats and outcomes instead of really getting to know people and finding out what they need. I think that community interventions just don't get big funding." – Michelle

Part of the problem, as Michelle explained, is that funding authorities rarely come out to see what the Drinkers Lounge does. For funders, there is generally a focus on statistics and outcomes that can rarely capture personal stories. The best proof that people are recovering is to talk to the people, who are willing to talk about what they need and how the program benefits them. As a result, community interventions that are extremely effective but do not have the resources to provide statistics are not funded.

"In the Second Generation (Health) Strategy with VCH (Vancouver Coastal Health) they said that within five years they were going to implement low-barrier managed alcohol programming. They haven't even gotten started on that yet. From what I've heard, they're going to have an internal board to try to find out what people need, but we're right here. Whether or not you agree with what we're doing, come and find out and meet the people." – Michelle

In addition, Michelle felt that health authorities often try to reduce and compound services for one community in order to check a box, rather than meeting their actual diverse needs. When DURC closed in 2016, the health authority tried to effectively package the many needs of the community into one service by transferring DURC's funding to another organization. This organization was meant to take on the programming and services that DURC offered, in addition to their own. In reality, very few of these supports transferred to the new space and many people in the community were harmed.

Effect of Closures

Michelle explained that when DURC closed in 2016, people lost access to many of the services that they depended on, some lost their jobs, and some lost their homes. She maintained that it is destabilizing for anyone to lose a place that they go to every single day, where they know people, where they know they can go, and where they know they can get work. She estimated that this isolation and loss of services led to the death of several of the drinkers.

Since the closure, the staff and members have struggled to resume the services that DURC supplied the community but are still extremely limited in what they can do. As the Drinkers Lounge faces a similar fate as DURC if they cannot find additional funding, the staff worry how many more people they would lose. When asked what would happen if the Drinkers Lounge closed, Michelle responded:

"Oh my God. I don't know. I mean, what did they do before, you know? People are resilient and they're going to figure it out, but I think that people will die and I think that people will lose their

housing, and I think that people will return to drinking illicit alcohol and more people will be on the street and more people will be in jail. So to take that away would be devastating." – Michelle

In the five months since these interviews, two of the participants have already passed away. The services the Drinkers Lounge offer are the bare minimum of what the community needs. They are in desperate need of secure funding, and increased funding to expand.

Chapter IV:

Summary and Discussion

Reducing Illicit Alcohol Consumption

The above findings confirm what researchers have been saying about the benefits of MAP programs in Canada. The Drinkers Lounge MAP program was effective in reducing the consumption of illicit alcohol, as was explained in previous studies (Nielsen et al. 2018, 19). Many of the members had experienced the physical harms and dangers associated with drinking, such as those discussed by Nielsen et al (2018, 7). Every member interviewed was able to successfully reduce these symptoms, avoid withdrawal, and stabilize their drinking over time. It should be noted, however, that when the Drinkers Lounge is closed on the weekends, members are often forced to return to illicit drinking and are again exposed to the associated harms.

Improving Access to Medical Care

The range of supports that the Drinkers Lounge offers sets it apart from other MAP programs across Canada. As Yee and Shahsiah (2006, 4) described, some of the members experience race-based discrimination within the Canadian mental health care system that acted as a barrier to them receiving service. Additionally, medical health professionals are often not trained to understand or deal with the challenging behaviour associated with drinking. Consequently, members are disproportionately barred from clinics and other health care services (Maynard 2019). The Drinkers Lounge successfully connected the members with health care services that they would otherwise not receive by bringing a doctor and medication to the space where the drinkers already congregate. To ensure that the drinkers engage with these services,

this care needs to be flexible, non-judgmental, and not require abstinence. Through regular access to this care, they were able to stabilize their drinking and their health.

In addition, the Drinkers Lounge functioned as a place where members could become connected with treatment and detox centres (if and) when they did feel they had reached a place where they wanted to quit drinking. By bringing these services to the Drinkers Lounge, the members were connected with additional medical supports that they otherwise would not know how to or would not be able to access.

Other Material Supports

The medical supports at the Drinkers Lounge are only one part of the continuum of care that improves health outcomes for the members. The centre also offers a range of other tangible supports for the members that are needed to improve their quality of life. These include access to housing, food, work, and other social services supports. It is crucial that these supports are flexible and can meet a variety of needs. For example, one member was able to access the $10 he needed to avoid eviction and homelessness. As the literature explained, homelessness can lead to worsened mental health and addictions problems, and housing is imperative to the physical and mental health and a significant part of recovery (CAMH and Empowerment Council 2016, 2). The members confirmed that these connections to housing, work, income, and other basic needs are crucial to their health are an integral piece of the Drinkers Lounge health care model.

Social Supports

In addition to the above basic health supports, the Drinkers Lounge differentiates itself from other MAP programs by having an explicit focus on community and social supports. These supports dramatically improve the mental health of some of the members, but also improve their physical health. The improved stability and support in their lives allows them to begin to heal emotionally and reduce the harms associated with drinking. For some, this support also means that they are capable of reducing their consumption of alcohol for the first time. The following are the social supports that the members outlined and how these led to improved health and quality of life.

Safety

Nielsen, Novotna, Berenyi, and Olson (2018, 19) explain that many homeless drinkers sleep in unsafe locations where they are at risk of assault and are continually on edge. The Drinkers Lounge offers a safe place to drink that was away from the sometimes violent and unsafe locations where members spend their time. While fighting was still an issue inside of the Drinkers Lounge, it was much more controlled than other spaces and the members felt a sense of safety. While it may seem trivial, the calmness associated with having a space to feel safe, calm, and comfortable for a few hours throughout the day was an important part of bringing stability to peoples' lives and reducing the constant stress associated with a street-entrenched lifestyle.

Decriminalization

As the literature explained, Canadian police in Vancouver linked mental distress with narratives of violence and danger, increasing their contact with police and the criminal justice

system, despite them no being more violent (Morrow, Dagg and Pederson 2008, 418-427). The drinkers and staff confirmed that because of the behaviours associated with drinking and the stigma associated with it, they had increased encounters with police, who would often escalate situations and blame drinkers who were attempting to deescalate the conflict.

In addition, because there is no public space for them to consume alcohol, drinkers who do not have housing were often criminalized for drinking itself. As the literature explains, the harms of illicit drinking are not specific to people who use alcohol, but flow from the lack of access to housing, lack of economic opportunities, and a negative relationship with police (Brown et al. 2018, 91). By offering a safe space where alcohol is accessible, where drinking and the behaviours associated with it are not criminalized, and where people are able to receive the supports they need, members are able to prevent unnecessary encounters with police and the criminal justice system.

Acceptance

Nielsen, Novotna, Berenyi, and Olson (2018, 18-20) found that one of the main benefits of MAPs was the creation of an accepting environment because it enabled recovery, healing, and reconnection. As Maynard (2019) explains, drinkers are disproportionately barred from shelters, clinics, housing projects, community centres, grocery stores and even public spaces, resulting in their being arguably the most street-entrenched demographic in the DTES. The drinkers in this study confirmed that the Drinkers Lounge is one of the only spaces that they are not kicked out of for drinking.

At the Drinkers Lounge, members described a sense of belonging and acceptance, sometimes for the first time in their life. Members were accepted for who they are and where

they are at in their life and given access to support. The members knew that in this space they could make a mistake and would still be accepted and supported, rather than barred or criminalized for their behaviours.

The non-abstinence model is a key part of this accepting space. The members feel that they are not being judged or stigmatized for drinking and are not repeatedly told to quit, as they are in most other spaces. They are instead supported in achieving their goals at their own pace, and understand that drinking, recovery, and healing involves different cycles.

Emotional Support

An important support for the members was structured emotional support programming that is designed to help the community process and heal from the extreme amounts of grief and trauma that they have experienced. Sometimes, this emotional support allowed people to move away from drinking and violence as a coping mechanism for dealing with their trauma and grief. To create a sense of trust, understanding, and healing, it was important that these groups be done in a community-oriented way, facilitated by peers, and where each member was able to offer support to each other.

Community

Increasing evidence shows that people are healthier when they have community connections (Block 2018, 182). Research has shown that MAP programs have the potential to reduce feelings of isolation and disconnection from social networks (Nielsen et al. 2018, 22), and provide people with a sense of home and belonging (Pauly et al. 2016, 10). Many of the

members explicitly described the Drinkers Lounge as a place that felt like home. They felt a sense of family, support, and community that dramatically improved their well-being and quality of life. Some described feeling like an outcast in their family and in society and felt a sense of belonging at the Drinkers Lounge for the first time in their life. The Drinkers Lounge has explicitly centred the community aspect of healing in their model as an important part of improving community health.

The Social Determinants of Health

To recognize the importance of the social supports in mental health care it is necessary to unpack how we understand drinking and addiction. When describing alcohol and drug use in their stories, most of the members confirmed that substance use was s a response and coping strategy to deal with difficult life circumstances, such as trauma, anxiety, stress, and abuse (Brown et al. 2018, 91). Some of the members chose to continue drinking because it was the only way they had to cope with the grief and trauma they were experiencing.

Most of the drinkers have previously engaged in other types of services for drinkers (AA, treatment, detox), often numerous times. However, they often returned to drinking because of the marginalization, isolation, poverty, and lack of resources they returned to after they left these programs. Clinical services for drinkers assume that the cause of the harms drinkers are experiencing is alcohol itself or their inability to reduce their drinking. As a result, they focus on removing alcohol from their lives, rather than improving their socioeconomic opportunities.

Neoliberal ideology, which permeates biomedical understandings of health, creates an individualistic understanding of addiction (Morrow 2013, 327). As the drinkers explained, they were often blamed for their circumstances by doctors, police, the justice system, and the general

public. Some faced more overt discrimination and racism, and their inability to quit drinking is labelled as an innate or moral failing, often connected to their Indigeneity. However, more often, drinking is pathologized, and it is seen as caused by a chemical imbalance or physiological flaw (mental illness) or as a physiological response to an addictive substance. The members confirmed that these understanding of addiction, which do not acknowledge their socioeconomic circumstances, only lead to further discrimination and stigmatization.

The Drinkers Lounge model worked so well for the members because it recognized the importance of biomedical supports, and the physiological effects of long-term alcohol use, but prioritized social supports. Offering social supports rather than focusing on substance use itself recognizes the profound impact social determinants can have on health. The members explained that the social supports they received at the Drinkers Lounge gave them the stability and support they need to begin improving their quality of life in a substantial and long-term way.

Deinstitutionalization and Peer Work

The Drinkers Lounge can be seen in the context of the deinstitutionalization movement as a successful grassroots community alternative for health and mental health care. This model is a successful example of a psycho-social rehabilitation model (Morrow and Jamer 2008) because they provide a wide variety of supports that people need to improve their mental and physical health.

The peer leadership model at the Drinkers Lounge has proved to be extremely successful in increasing the well-being for those involved and those receiving care. This model recognizes the importance of peer leadership in community organizations and renegotiates the meaning of expertise in mental health (Boschma, Davies, and Morrow 2014, 9). This model has succeeded in

engaging an extremely marginalized group of people because it recognizes that the peers are the experts at providing effective services to their community. The drinkers at the Drinkers Lounge readily recognize what types of services are needed in the community and are already offering these supports to each other in their own time. The Drinkers Lounge model follows their lead by offering structure and support for them to continue the work that they are doing.

In addition, this model is more effective than clinical models because receiving services from other members creates a sense of trust and understanding. The peers have a knowledge of the community and each other that allows them to offer appropriate individual supports. In addition, their experiences in the community allow them to respond to the behaviours of other community members in a way that is non-judgmental and does not stigmatize them further. Their experience of street-entrenched life often makes them more emotionally and intellectually able to respond to challenging situations than staff members who have no experience living on the streets.

The staff transitions during my research highlighted the importance of having staff members that embrace the principle that peers are effective leaders with real expertise. The staff that embraced these values actively worked with the peers to take on leadership roles, responsibility, and decision-making power. When new staff members did not embrace this, the peers recognized this immediately and began to feel frustrated, which led to social disintegration in the Drinkers Lounge space.

This research confirms that victim models of care do not empower people or offer solutions (Johnson 2016, 35). The staff and members explained that while it was important to recognize the systemic barriers to their health, it was crucial that the care did not characterize them as passive victims. This model recognizes their abilities and strengths and gives people the support they needed to utilize these and become active accountable members of the community.

As Logie (2019) explains, we need to move beyond a focus on oppression, and focus research on resilience and strength of marginalized groups, and how they survive and support each other, despite the structural barriers they face.

Decolonizing Health Care

Many of the most marginalized drinkers in Vancouver are Indigenous. It is crucial to refute any racist narratives that imply that problematic drinking is something intrinsic to Indigenous people. First of all, it is not factual that Indigenous people drink more than any other group. In fact, 35 percent of Indigenous people in Canada are abstinent, which is twice as many as the rest of Canada (Johnson 2016, 62;128). Instead, the stories the participants shared demonstrates the immense amount of trauma and loss that Indigenous communities face. Much of this is direct or intergenerational trauma that relates directly to the violence that was enacted through genocidal colonial policies in Canada, such as the residential school system (National Inquiry into Missing and Murdered Indigenous Women and Girls 2019). In addition, Indigenous people who experience disproportionate rates of homelessness (Canadian Observatory on Homelessness 2019), poverty, incarceration, discrimination, and violence (Truth and Reconciliation Commission of Canada 2015). This means they are more at risk to the harms associated with drinking and experience them in a more powerful way.

Throughout this research, I found that people outside of harm reduction circles were skeptical of the Drinkers Lounge model. For some, racist ideas of Indigenous people and a denial of the systemic racist genocidal policies in Canada lead them to believe that they are not deserving of additional care. However, what came as a surprise was people who were reluctant to engage with services for Indigenous drinkers because they fear it will propel racist stereotypes

that Indigenous individuals are more likely to be drinkers. Again, these fears are based on individualistic ideas of addiction and mental health, where an individual is to blame for the harms they are experiencing. However, it is the colonial legacy that has increased the harms associated with drinking for Indigenous people. This complicated conversation around Indigenous drinkers makes many people reluctant to engage with this issue and could be why funders are also reluctant to fund these types of services. Avoiding this conversation can only further exclude and marginalize the community.

It is crucial that we also understand the systemic barriers that prevent Indigenous people from accessing services. To address these barriers, it is crucial to develop models of care that serve the specific needs of Indigenous people, and the Drinkers Lounge has taken steps in this direction. While many of the participants recognized the need for more Indigenous staff members and services providers, the Indigenous peers, with the support of the staff, have incorporated Indigenous models of healing within the Drinkers Lounge. By following the lead of and listening to the members, the Drinkers Lounge acknowledges Indigenous healing methods and perceives them to be equally as valid or important as biomedical models of health. While biomedical models of health care tend to minimize or dismiss the benefits of cultural healing methods, the members have explained that they are vital to their well-being and have helped them heal, move forward in their lives, and reduce their substance use.

As Clark et al. (2017, 167) explain, many Indigenous people do not understand mental health as the absence of disease. Instead they see it in a more holistic way that is collective, Indigenous centred, and incorporates the social dimensions of health. The Indigenous centred peer leader model at the Drinkers Lounge resists Eurocentric biomedical and psychiatric paradigms (Ibrahim 2017, 125) and confronts the dominance of the expert model (Block 2018,

183) where a hierarchy of knowledge places medical experts as the only legitimate producers of knowledge.

Neoliberal and Biomedical Ideology

The Drinkers Lounge offers an alternative space and a model of health care that resists individualistic pathologizing narratives of health. Despite the success of this model, it is clear that biomedical and neoliberal models of health still retain their dominance in the Canadian landscape. The Drinkers Lounge has grown exponentially and has engaged hundreds of extremely marginalized people and connected them with health care services and other supports. Yet the Drinkers Lounge has consistently struggled to maintain funding and is still struggling to stay open.

As other scholars have discussed, the transition to deinstitutionalized models of care has not been accompanied by increased funding to alternative community organizations (Morrow and Jamer 2008). The PHS's experience with the closure of DURC and the precarity of the Drinkers Lounge shows that the government continues to prioritize funding for more clinical models of care that treat addiction as a biochemical issue.

The staff also found that funders rely on statistics as a more scientific and thus accurate representation of how well a model is working, rather than the stories and lived experiences that are continually confirming that this is the type of care that marginalized people want and need to improve their health. In this way, biomedical and Eurocentric ideas of knowledge continue to dominate health care and decolonial models of care and methodologies are undermined. To address this, funding and partnerships will need to be extended to grassroots community models of health care.

Planning for Health Equity

The Drinkers Lounge offers a model of health care that can be useful for planning other health care and prevention services across Canada. As Maynard (2019) explains, this is a ground-breaking program with immediate relevance to every city in Canada due to the ubiquitous lack of health services aimed at street entrenched drinkers.

The success of this program lies in its flexibility to adapt to the community and follow their lead. There is no one-size-fits-all way to design health care that meets the needs of various marginalized communities so this flexibility in the design allows them to meet the specific needs of the population. When addressing health inequities, effective health care cannot ask marginalized community members to conform themselves to services. Rather, it needs to make space for them and their needs. Despite our ideas surrounding mental health and addictions, a social justice approach to reducing health inequities means providing every person with access to care despite of where they are in their life. Refusing people access to health care rather than creating a space where they feel welcome will only further marginalize people and increase health inequities.

While this model can be used as a blueprint, the services themselves need to be designed by local communities, as they are the ones who know the best what their needs are and what model of care would best serve them. Often individuals or grassroots groups are already doing this work in the community in small ways and health care planners need only to support this work.

Following the lead of the community members doing this work and supporting the work of grassroots community groups is effective in two ways: First, this model of care is more likely

to meet the needs of marginalized populations, and second, the work itself will serve to empower and heal the community and reduce health inequities. However, for this to work, it is crucial that the model takes seriously the work and expertise of the community and works with them as community partners, planners, and leaders with valuable knowledge and skills.

In addition, while medical supports need to be a part of the support, the model needs to create a continuum of care that addresses the importance of the social determinants of health, such as access to medical housing and other socioeconomic opportunities. This means that rather than focusing on abstinence, care needs to focus on a range of social supports.

Part of allowing these models to succeed will be questioning our hierarchies of knowledge and the dominant narratives surrounding health and mental health. We need to move from biomedical and neoliberal ideologies, and create health care that values community, belonging, Indigenous knowledge, lived experience and expertise, and communal approaches to care and leadership. We need to look to the extreme margins and rather than fault the individuals there, look at how the way we view health care is creating barriers for them to access it.

In conclusion, the best way to build effective health care models is to fund, support, and follow the lead of people already doing this work in the community. The solutions to many of our social inequity problems already exist, but we do not value the expert knowledge of the people who hold the answers. By only valuing top-down models and closing down community-led services that do not follow traditional models of health care will only further marginalize people and have a harmful effect on their health. This will lead to further health care costs and more entrenched inequity. Instead, we ought to support communities like the Drinkers Lounge that are at the forefront of resisting and challenging harmful ideologies and models of health, leading new movements, and developing new structures and ways of organizing (Morrow and Weisser 2012, 39).

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