BC Partners for Mental Health and Addictions Information

Visions

BC's Mental Health and Addictions Journal

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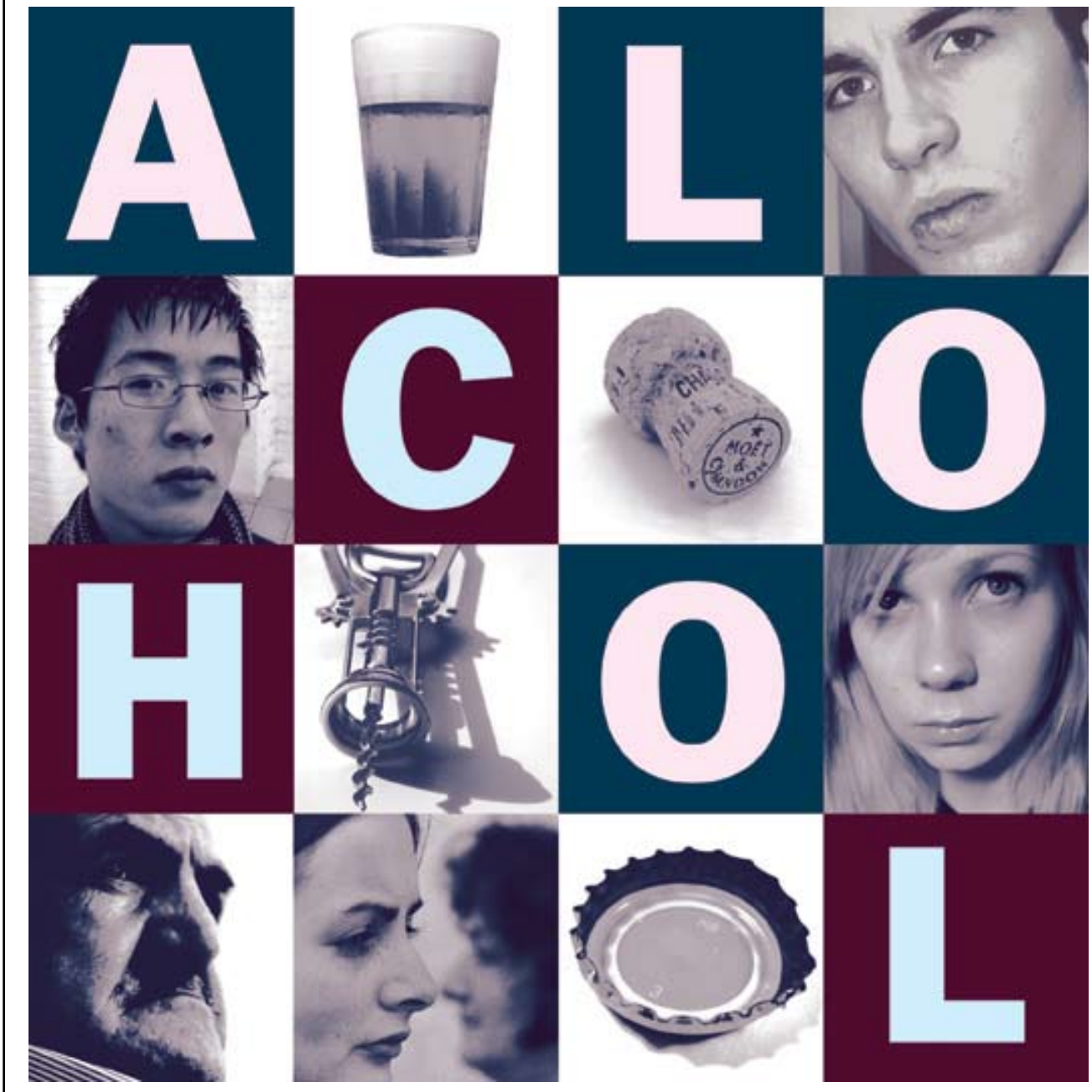

Kim Meier

background

experiences & perspectives

bc partners

Seven provincial mental health and addictions agencies are working together in a collective known as the BC Partners for Mental Health and Addictions Information. We represent the Anxiety Disorders Association of BC, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health Care, Jessie's Hope Society (formerly ANAD) and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

visions

Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. Visions is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.

The BC Partners are grateful to the Provincial Health Services Authority for providing financial support for the production of Visions

alternatives & approaches

regional programs

To use a metaphor often used in addictions, alcohol is the elephant in the room. While crystal meth is the current drug strategy target, alcohol addiction continues to devastate families and communities in numbers far greater than the drug du jour. This is not to say that drugs like crystal meth aren't devastating and kill people, but these drugs are illegal and don't typically have the level of social acceptance that alcohol, readily available and obtained through a reputable dealer, has. Alcohol is usually offered at social gatherings and comes to be synonymous with celebrations. It is what you drink after work with friends, what you have at parties. But its dark side is the impact on generations of families of alcoholics, on deaths due to intoxicated driving and alcohol-induced suicide and violence, and its unquestioned place in our society.

Alcoholism takes many forms. Binge drinking is now a recognized problem on Canadian university and college campuses. The functional alcoholic still exists in many Canadian families and we have all seen the destruction caused by alcoholism with people living on our city and town streets and in aboriginal communities. And yet, resources for treating alcohol addiction remain woefully underfunded. Families still struggle for years trying to get help and many, too many, fall apart because of it. This was my experience and the experience of many who write their stories for this issue of *Visions*.

For many people with mental health issues, alcohol starts off being the way they manage their symptoms. It works well for a time to quiet distressing emotions, fears and anxieties—even eases social interaction. But, as will most drugs, alcohol can quickly turn into the problem and can ultimately mask the presence of other problems. Alcoholism makes the diagnosis, treatment and recovery from mental health issues much more complex. It also layers on another type of stigma: lack of willpower. While we as a society might be more willing (now) to accept a diagnosis of mental illness, the idea of addiction is still rife with moral judgment and condemnation. Really, where does that get us?

Isn't it about time that we generously funded a cross-substance addictions system that has adequate resources, multi-level models of assistance and detox/treatment for those who ask for it, when they ask for it? Aren't our families, our communities and our children worth it?

Christina Martens

Christina is Executive Director of the Canadian Mental Health Association's Mid-Island and Cowichan Valley branches. She has an MEd in Community Rehabilitation and Disability Studies and is working towards her doctorate in Policy and Practice in the Faculty of Human and Social Development at the University of Victoria

subscriptions and advertising

If you have personal experience with mental health or substance use problems as a consumer of services or as a family member, or provide mental health or addictions services in the public or voluntary sector, and you reside in BC, you are entitled to receive *Visions* free of charge (one free copy per agency address). You may also be receiving *Visions* as a member of one of the seven provincial agencies that make up the BC Partners. For all others, subscriptions are $25 (Cdn.) for four issues. Back issues are $7 for hard copies, or are freely available from our website. Contact us to inquire about receiving, writing for, or advertising in the journal. Advertising rates and deadlines are also online. See www.heretohelp.bc.ca/publications/visions.

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The opinions expressed in this journal are those of the writers and do not necessarily reflect the views of the member agencies of the BC Partners for Mental Health and Addictions Information or any of their branch offices.

Alcohol
our Favourite Drug

Tim Stockwell, PhD

Tim is Director of the Centre for Addictions Research of BC (CARBC) at the University of Victoria (UVic), Co-leader of the BC Mental Health and Addictions Research Network and a professor in the psychology department at UVic

I'm delighted to have the opportunity to introduce this special issue of *Visions*.

We are all familiar with alcoholic beverages and most of us enjoy drinking them. Everyone is now familiar with the dangers of drunk driving—even though the problem still plagues us, there has been a huge advance in awareness from a generation ago. Through literature, movies and popular culture in general—and all too often through personal experience—we are also aware that some people develop alcoholism or engage in alcohol abuse. The personal stories in this issue testify to the social and health damage that alcohol-related problems bring.

An array of risky drinking patterns poses different degrees of risk to health and safety, ranging from low to extremely high. The great extent of these patterns demands not only the best possible range of accessible treatment programs, but also an effective regulatory system for what is clearly "no ordinary commodity."[1]

Hazardous drinking patterns

It is useful to distinguish three major kinds of potentially hazardous drinking patterns.[2]

Drinking to intoxication

Even occasional heavy alcohol use can place the drinker at risk of injuries and acute medical conditions, especially in high-risk settings. Two out of every five British Columbians drink at the recognized risk levels of 4+ drinks in one day for women or 5+ for men.[3] One out of every five do so at least once a month.[4] The majority of alcohol-related deaths among Canadians are from these acute effects of alcohol.[5]

Regular use of alcohol above risk levels

Among British Columbians, 5% of women and 9% of men drink above the Centre for Addiction and Mental Health guidelines' upper limits of nine drinks a week for women and 14 for men.[4] This significantly increases the risk of various cancers, strokes, birth defects, liver cirrhosis and other problems. As a group, such high-risk drinkers still contribute less to the overall burden of alcohol-related harm in the community than the more numerous low-risk drinkers as a group—a phenomenon known as the "prevention paradox."[6]

Alcohol dependence

A small proportion of drinkers meet criteria for a diagnosis of alcohol dependence. Alcohol dependence varies in severity and includes elements of both psychological and physical dependence, with impaired ability to control consumption. People suffering from alcohol dependence are most likely to experience acute and chronic harms from their drinking. They are also at most risk of mental health problems; in particular, anxiety states and depression.[7]

The case for economic and regulatory harm reduction strategies

An analysis of the *2004 Canadian Addiction Survey* found that although reported consumption was 30% of what would be expected from known alcohol sales, most drinking reported placed the drinker at risk of acute or chronic harm.[4] Rehm et al estimate that approximately 4,500 Canadians, up to age 70, die each year from alcohol-related causes.[8] The health benefits of low-risk drinking have recently been questioned,[9] but even if the benefits are real, very few people drink in a pattern that would protect against heart disease (less than one drink a day for women and one to two drinks a day for men). These facts make a compelling case for taking the regulation of alcohol's price and availability extremely seriously.

These days, everyone in mental health advocates for an "evidence based" approach to treatment and prevention of problems from substance use. Regarding alcohol, evidence suggests universal strategies that impact all drinkers are needed. The strongest evidence for successfully reducing harm at the population level points at a variety of economic and regulatory strategies: keeping alcohol prices in line with the real cost of living; taxing the alcohol content of drinks rather than taxing the cost of making them; and limiting the trading hours of licensed premises and also limiting the density of late-night liquor outlets in entertainment areas.[2] We also need the best and most accessible treatment services for people with severe alcohol-related problems, and a range of humane harm reduction strategies, including "wet shelters," for people with chronic dependence who are unable to respond to standard treatment programs.

The Centre for Addictions Research of BC recently identified major shortcomings, from a public health perspective, within the alcohol taxation system in Canada. I argue that remedying these shortcomings offers the greatest opportunity to reduce, across the whole community of BC, such problems as alcohol-related road trauma, alcohol-related violence, fetal alcohol syndrome, and liver disease and alcohol dependence. These remedies would at least involve:

- Updating alcohol excise taxes with the cost of inflation (not done since 1991)
- Taxing the alcohol in drinks so that there are price incentives for manufacturers, retailers and consumers to select lower alcohol content beverages
- Ensuring minimum prices are regularly updated and high-strength drinks are banned from the market[10]

An invitation and a challenge

At CARBC we believe it is essential to have accurate data on risky alcohol use and related harms at local, regional and provincial levels. It is also essential that the evidence for "what works" in prevention, treatment and policy be well understood and integrated into local practice. Together, these elements can form a powerful evidence base for improved responses—including making the case for more and better services. Conversely, high-level policy changes, such as alcohol tax reforms, are more likely to occur when they carry the moral authority of support from those engaged in service delivery. I therefore invite you to study the articles and stories in the coming pages, to visit our CARBC websites (www.silink.ca and www.carbc.uvic.ca) and then consider how you might express your support for improved alcohol policies in BC.

footnotes

1. Babor, T., Caetano, R., Edwards, G. et al. (2003). *Alcohol: No ordinary commodity—research and policy.* Oxford, UK: Oxford University Press.

2. Loxley, W., Tounbourou, J., Stockwell, T. et al. (2004). *The prevention of substance use, risk and harm in Australia: A review of the evidence.* Canberra, Australia: Australian Government Department of Health and Ageing.

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7. Rehm, J., Room, R., Monteiro, M. et al. (2004). Alcohol use. In M. Ezzati, A.D. Lopez, A. Rogers et al. (Eds.), *Comparative quantification of health risks. Global and regional burden of disease attributable to selected major risk factors.* (pp. 959-1108). Geneva: World Health Organization.

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10. Stockwell, T., Leng, J. & Sturge, J. (2006). *Alcohol pricing and public health in Canada: Issues and opportunities* (Technical Report). Victoria, BC: University of Victoria, Centre for Addictions Research of BC.

I'm a course writer with the School of Social Work at the University of Victoria and am currently developing a distance education course for the undergraduate program titled Critical Perspectives in Mental Health Practice. In this course, we are planning on including four articles from the Suicide issue of *Visions*, plus an article from the Cross Cultural Mental Health issue. *Visions* is a fabulous resource that provides a wide diversity of information to practitioners, students, and consumers of mental health services. I would recommend that everyone in contact with issues around mental health read this journal regularly. *—Peter Monk, Victoria*

we want your feedback!

If you have a comment about something you've read in Visions *that you'd like to share, please email us at bcpartners@heretohelp.bc.ca with 'Visions Letter' in the subject line. Or fax us at 604-688-3236. Or mail your letter to the address on page 3. Letters should be no longer than 300 words and may be edited for length and/or clarity. Please include your name and city of residence. All letters are read. Your likelihood of being published will depend on the number of submissions we receive.*

notes

Visions Survey

We would like to thank everyone who took a few moments to complete the Visions survey that ran late last year. Congratulations to Joanne from Kitimat for winning the prize draw. Stay tuned for key results from the survey to be published in a subsequent issue.

Criminal Justice Issue

Correction and acknowledgement

Visions would like to apologize for neglecting to acknowledge a reprint note in an article that appeared in the recent Criminal Justice issue. Bill Rankin's article "Treating Offenders with Mental Disorders" (pp. 27-29) originally appeared in the Correctional Service of Canada's corporate magazine *Let's Talk*, Volume 30, No. 2, 2005. The article was reprinted with permission.

Additional resources

Two additional resources to add to the Criminal Justice issue:

- Crime and Punishment is the theme of the Spring 2006 issue of *Cross Currents: The Journal of Addiction and Mental Health*, produced by the Centre for Addiction and Mental Health in Ontario. To receive a copy of Volume 9#3 for $5, contact the editor at hema_zbogar@camh.net or call 416-595-6714.
- For an exploration of ethnocultural minorities and the corrections system, see the articles on ethnicity and culture in *Let's Talk*, Volume 30, No. 2, 2005. Available at the Correctional Service of Canada's Ethnocultural Initiatives page: www.csc-scc.gc.ca/ethnoculture/index_e.shtml

have a story idea? we want to hear from you!

Our next two issues of *Visions* will be looking at treatments for young people (Summer 2006) and 'first responders' (for youth and families) such as police, ERs, family physicians, teachers, school counsellors, or faith communities (Fall 2006).

If you have a story idea, please contact us at bcpartners@heretohelp.bc.ca or call 1-800-661-2121

Alcohol and British Columbians

Sara Perry

Sara is Research Coordinator in the Communication and Resource Unit of the Centre for Addictions Research of BC (CARBC). CARBC is a University of Victoria-based centre dedicated to research and knowledge exchange on substance use, harm reduction and addiction

While methamphetamine and other illicit drugs catch more media attention, alcohol is the drug that should concern British Columbians the most.

According to the results of the *2004 Canadian Addiction Survey*, about 80% of BC residents over the age of 15 drink alcohol.[1] Roughly half of these consumers drink to the point of intoxication at least occasionally, putting themselves and others at risk of falls, accidents and violence.[1] Intoxication refers to drinking five or more alcoholic beverages in one sitting for men, and four or more drinks for women.[2]

Remarkably, few British Columbians question the amount of alcohol they drink or the potential harm they can cause to themselves and others while either slightly intoxicated or heavily inebriated. This is especially true for people who see themselves as harmless drinkers—the type who are responsible consumers most of the time, but drink to excess once in a while. The fact is, however, that it only takes one night of "overdoing it" to make a poor choice that results in the ruining of a relationship or career, or ends in injury or death. Half of all alcohol-related harms are caused by people who normally drink wisely, but just happen to let loose and over-drink on a particular outing or occasion.[3]

Alcohol-related deaths occur more often and in more places than most people realize. Every year in Canada, about 8,100 lives are lost to alcohol, and alcohol costs the nation nearly $14.6 billion in various health, social and economic expenses. In British Columbia alone, the financial burden of alcohol-related harms can be estimated at just over $2.2 billion.[4]

Many alcohol-related harms are the result of drinking to intoxication while in situations where "no alcohol" is the safest option, such as:

- before driving
- before operating heavy equipment or machinery, or in other situations where alertness is required
- when using other depressant substances and medications, such as pain killers, sleeping pills or tranquilizers
- when trying to conceive, when pregnant or while breastfeeding
- when dependent on alcohol, or when a close relative has a problem with alcohol
- when experiencing mental or physical health issues

Age and gender are also factors in a person's drinking patterns and potential for harm. For example, alcohol has a more profound effect on older people, particularly senior citizens. Similarly, alcohol affects women differently than it does men. Women have less water in their systems to dilute alcohol, meaning a woman who drinks the same amount as a man of similar size and weight will feel the effects of alcohol faster and more intensely. And, since women can get pregnant, they have more potential to cause harm to others. Pregnant women who drink can transfer alcohol into their babies' systems, which may in turn affect growth and brain development, or lead to fetal alcohol spectrum disorder (FASD).

While elderly people and women have unique risks when it comes to alcohol consumption, statistics show the most dangerous mix to be young single men and excessive amounts of alcohol. Ninety-five per cent of young males in British Columbia (19 to 24 years old) identify themselves as current drinkers—a number that is slightly higher than the national average of 92%, and nearly 10 points higher than current drinking rates among young BC females (86%).[1]

According to the *Canadian Addiction Survey*, more than 27% of men in British Columbia reported regular drinking patterns that put their health or safety at risk, compared with 14% of women. However, an alarming 39% of residents between 15 and 24 years old reported hazardous drinking patterns. The number jumped to 46% for "males only" in that same age group. Considering these figures, it is no surprise that over 50% of all the alcohol purchased in British Columbia every year is consumed in hazardous ways.[3]

Alcohol dependence is another issue that plagues British Columbians (not to mention people in other parts of Canada). According to the BC Ministry of Health Services, approximately 120,000 people in BC have a high probability of alcohol dependence. Another 224,000 have some indication of alcohol dependence, with 77% to 89% of this group experiencing problems in their life as a direct result of their drinking patterns.[5]

Since alcohol causes more harm than other drugs to British Columbians—with the exception of tobacco—it only makes sense that government bodies and service providers devote their efforts to helping people in the province better understand the facts about low-risk and high-risk alcohol consumption patterns.

For information about BC's Low-Risk Drinking Guidelines, visit Substance Information Link at www.silink.ca.

footnotes

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How much is too much and how often is too often?

Alcohol consumption guidelines

Nicole Pankratz

Nicole is Publications Officer in the Communication and Resource Unit of the Centre for Addictions Research of BC (CARBC). CARBC is a University of Victoria-based centre dedicated to research and knowledge exchange on substance use, harm reduction and addiction

Alcohol plays a role in the way many people deal with dilemmas and celebrate successes. Whether it's drinks with co-workers after a hard week on the job site or a bottle of wine with a spouse to mark a year of marital bliss, alcohol seems to be one of the first things British Columbians cling to when sailing through the sometimes stormy, sometimes serene seas of life.

Most alcohol consumers in BC drink what they believe is a casual or moderate amount of alcohol. They don't classify themselves as alcohol dependent and don't believe they pose any significant health or harm risks to themselves or others.

The fact is, however, that half of all alcohol-related harms in the province are caused by casual or moderate drinkers: the types who go on the occasional bender and end the night in a bloody punch-up, or the kind who have one too many cocktails at a family function and then try driving home. Sometimes casual drinkers let so loose at a party they lose all concept of safe sex. And there are others who drink a moderate amount of alcohol every day, slowly pickling their insides without knowing it.

Figuring out how much is too much, or how often is too often, can be difficult for people who like to drink. But it's worth the effort, especially since some consumers may have a problem with alcohol without knowing it. Similarly, some may know they drink more than they should but don't know how—or how much—to cut down.

Tools are available to help people understand alcohol use patterns, one of them being BC's low-risk drinking guidelines. Developed by the Centre for Addictions Research of BC (CARBC), these guidelines are meant to help alcohol consumers reduce the risk of causing alcohol-related harm to themselves and others.[1]

low-risk drinking guidelines

avoid intoxication

- Limit your evening's alcohol intake. For men, this means drinking no more than four standard drinks, and for women three drinks. Consume less than these amounts if you are lower than average weight, elderly or below the legal drinking age
- Drink slowly. Men of average weight should drink no more than two drinks in the first hour, while women should stick with one. From then on, both men and women should consume only one drink per hour
- Combine alcohol with food and alternate alcohol drinks with non-alcoholic beverages

choose abstinence in situations where "no alcohol" is the most sensible option

- When operating vehicles, such as automobiles, all-terrain vehicles, snowmobiles and bicycles
- When alertness is important, such as while working with machinery or participating in physical activities
- When using other substances, including medications such as sleeping pills or pain killers
- When trying to conceive, pregnant or breastfeeding
- When trying to manage serious alcohol dependence
- When there is a family history of serious drinking problems
- When suffering from mental health problems or other health issues, such as liver disease

put limits on your drinking frequency and amounts

- Limit your weekly intake to 20 drinks or fewer for men, and 10 or fewer for women
- Build non-drinking days into your week, especially if drinking to the maximum daily amount (the more often you drink to the daily maximum, the more alcohol-free days you need to have to avoid going over the weekly maximum)

know the facts about alcohol's contribution to heart health

- Only older individuals—men 40 and over, and women 45 and over—benefit from light drinking. Small increases in the risk of some cancers begin from just one drink a day, meaning the heart benefits of light drinking do not come without a price
- The protective effect of alcohol can be

footnote

1. Centre for Addictions Research of BC. (2006). *Low-risk drinking guidelines.* Retrieved from the CARBC Substance Information Link website at www.silink.ca.

> for more information about the alcohol and drug information and referral service see p. 34

For more on alcohol health myths and facts, see "Alcohol and your health: Less is more when it comes to healthy living" under Substance Use / Addictions on the Canadian Health Network website at canadian-health-network.ca

achieved with as little as one drink every other day, while the maximum heart health benefits can be obtained by drinking two standard drinks a day in the case of men, and one drink a day for women

- Red wine is not the only alcoholic beverage that provides cardiovascular benefits. All alcoholic drinks contain ethanol, the substance responsible for improved cardiovascular health. While having a drink or two has a place in a healthy lifestyle, alcohol use can also lead to death in more than 50 different ways—in the short term and over the long term—and results in over 6,000 premature deaths in Canada each year

If you or someone you know is repeatedly drinking beyond these low-risk guidelines, consider getting help.

Understanding the Link Between Alcohol and Anxiety

Stephenie Gold, MA

Stephenie has a master's degree in counseling psychology. She has worked on several research projects involving evidence-based programs for child and adolescent anxiety, and is currently developing resources for the Anxiety Disorders Association of British Columbia (ADABC)

For more details on treating co-occurring substance misuse and anxiety disorders, see the Lingford-Hughes reference at the end of the article

When you feel shy while at a party full of strangers, do you sometimes reach for a glass of wine or a cold beer to help you 'loosen up'? If so, you are not alone. Many people who are socially anxious use alcohol to decrease their anxiety and to cope better with social situations. While it may be common to occasionally use alcohol for a temporary boost of "liquid courage," research suggests that the link between alcohol and anxiety is not always so straightforward.

A brief look at anxiety

Everyone knows what it is like to feel anxious—butterflies in the stomach, rapid heart rate, dry throat, and racing thoughts. Anxiety is the most common mental health concern, with one in 10 people suffering from levels of anxiety that are problematic and significantly disruptive to their daily lives.[1]

While occasional feelings of anxiety are common, anxiety that is debilitating, intense and long-lasting is characteristic of an anxiety disorder. Some of the more common examples of anxiety disorders are social anxiety disorder; panic disorder (with or without agoraphobia—i.e., the fear of public places and/or of going outside, which often results in the sufferer becoming housebound); generalized anxiety disorder; and specific phobias. Untreated anxiety can lead to continued avoidance of anxiety-provoking situations and missed opportunities, creating a significantly decreased quality of life. Fortunately, with the right kind of professional help, anxiety disorders are treatable for the vast majority of people.

The anxiety–alcohol connection

Researchers have found that the risk for having either an anxiety disorder or alcohol use disorder is about three times greater if the other disorder is present.[2] This is particularly true for people with social anxiety disorder (SAD), with one in five people also meeting the criteria for an alcohol use disorder (i.e., alcohol abuse or dependence).[3]

Socially anxious individuals report finding temporary relief from debilitating shyness and self-consciousness when consuming alcohol, and thus are more likely to use alcohol as an *anxiolytic* (i.e., it reduces feelings of anxiety). In this way, alcohol quickly becomes a means of coping or of self-medicating. Once alcohol has become a primary coping mechanism for people with SAD, alcohol dependency may be close behind. Over time, these socially anxious individuals may require increasingly higher doses of alcohol.

SAD usually begins early in the adolescent years (and therefore precedes alcohol dependency), so clinicians have a valuable window of opportunity to treat SAD before alcohol dependency begins.[3]

A vicious cycle

Although it makes sense that anxiety symptoms can lead to alcohol dependence, in fact, the opposite can be true as well. Both long-term alcohol misuse and alcohol withdrawal can significantly increase anxiety levels. One study of American war veterans in an alcohol treatment program found that 98% reported at least one symptom of anxiety during drinking or withdrawal, with 80% experiencing heart palpitations and/or shortness of breath, and 4% experiencing at least one panic attack.[4]

When feelings of anxiety are a consequence of heavy drinking, alcohol is said to be acting as an *anxiogenic* (i.e., it creates feelings of anxiety). Unfortunately, it is during this uncomfortable time of heightened anxiety that an individual is most tempted to use alcohol to self-medicate. As Matt Kushner, a leading researcher in

The Role of Nutrition

in recovery from alcohol and drug addiction

Sarah Fielden

Sarah is an interdisciplinary PhD student with the Institute of Health Promotion Research at UBC, a member of Vancouver Dietitians in AIDS Care, and a Michael Smith Foundation for Health Research graduate trainee

Alcohol and drug abuse take a major toll on the human body. Recovering from alcohol or drug abuse is a gradual process, and nutrition is one of many issues that require attention. Alcoholism is especially hard to recover from as the detoxification stage is complicated (requiring careful monitoring, medications and support) and alcohol itself is difficult to avoid in the course of everyday socializing. Food is vital in helping the body rebuild itself and maintain health.

When you abuse alcohol and drugs, you:

- Consume less food (except with marijuana use)
- Choose foods that are less nutritious and/or may skip meals
- Increase the speed at which your body uses up energy
- Increase the loss of nutrients through vomiting and diarrhea
- Damage your gut so that it can't absorb the nutrients in food properly

Food influences the way the brain functions. When your body isn't producing enough brain chemicals (neurotransmitters) or the chemicals are out of balance, you can feel irritable and anxious. You can suffer from food cravings, anxiety and an inability to sleep. Resulting stress can also affect memory and/or make people paranoid, tired, dissatisfied or depressed.

What and how to eat during recovery

During recovery, you should eat a diet that will balance the levels of serotonin (a hormone that helps with relaxation) in the brain. This involves eating foods high in carbohydrates, especially the complex carbohydrates found in starchy foods like legumes (e.g., beans, lentils and peas), root vegetables (e.g., potatoes and carrots), pastas and

Alcohol and Anxiety | *continued from previous page*

the area of anxiety and alcohol describes: "[D]rinking leads to greater anxiety, which in turn, leads to more drinking. Once this vicious cycle is firmly in place, which disorder is operating as the cause and which is the effect becomes murky."[6]

Alcoholics may begin to experience panic attacks for the first time when withdrawing from alcohol. Declining blood-alcohol levels cause feelings of having 'shakes and sweats,' which can be very similar to the physiological symptoms of anxiety. During the withdrawal period, anxiety is most likely caused by neurochemical changes as well as environmental/life stressors. Not surprisingly, individuals diagnosed with panic disorder often avoid alcohol because of their extreme sensitivity to changes in their bodily sensations.[5]

To summarize, the relationship between alcohol and anxiety can be described as a *reciprocal causal relationship*, which means that anxiety disorders lead to alcohol dependence, and alcohol dependence lead to anxiety disorders.[7]

Issues in treatment

For individuals suffering from co-occurring alcohol use disorder and anxiety, pharmacological and/or psychological interventions (e.g., cognitive-behavioural therapy, which looks at the role of thinking in how a person feels and behaves) are the two means of treatment. However, what disorder should be treated first is not always immediately clear. Some evidence suggests that the alcohol use disorder should be the first line of treatment, since drinking is often used to avoid feelings of anxiety.[8] When deciding on a treatment plan, it is essential for clinicians to establish whether or not both clinical problems are present and, whenever possible, to ascertain which disorder developed first.[8]

Fortunately, research in this area continues to grow, helping researchers and clinicians better understand the factors that contribute to the development and perpetuation of these frequently co-occurring issues.

footnotes

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3. Book, S.W. & Randall, C.L. (2002). Social anxiety disorders and alcohol use. *Alcohol Research and Health, 26*(2), 130-135.

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breads. Eating these foods in combination with protein in your meals will keep you at your best.

Deficiencies in B-complex vitamins such as thiamine, folate or folic acid, and B^{12} are common with alcoholism, and inadequate stores of other B vitamins and vitamin C frequently occur. Chronic alcohol consumption also increases the loss of minerals like zinc, magnesium and calcium from the body. Iron is an exception to this and is rarely deficient because alcohol damages the stomach lining, thereby increasing iron absorption.

In the first year after you stop using alcohol or drugs, your nutrition needs are higher than normal. You need to make sure you're feeding your body good food on a daily basis. Even if you eat a healthy, varied diet while using drugs and alcohol, fewer nutrients are available to satisfy nutritional needs since a lot of those nutrients are being used to detoxify your body.

For nutrition advice, remember dialadietitian.org or 1-800-667-3438

Malnutrition during alcohol use shows up in several ways. In the short term, you may become very tired and have a weaker immune system—which means that you're more susceptible to infections. Other symptoms include dental problems, digestive problems (e.g., diarrhea, constipation and gas), skin conditions, and changes in the way foods taste. During long-term alcohol use, there are risks for brain damage, nerve damage, liver disease, heart and pancreas problems, and certain types of cancer. These problems need to be identified and treated during the recovery process—ideally by a team of health care professionals.

In the early stages of detoxification and recovery, you need to introduce meals slowly, since your body might not be used to digesting food. It's a good idea to start off with small and frequent meals. Some people may start to gain weight. If you want weight management advice, see a nutritionist. If, however, gaining appropriate amounts of weight bothers you or your eating behaviour seems out of control, you may need professional help for body image and/or disordered eating problems.

Food shouldn't replace drugs as a coping mechanism. Sugar and caffeine are common substitutes used during recovery because they produce highs and lows. These low-nutrient foods can prevent you from consuming enough healthy food and they affect your mood and cravings. However, these foods are preferable to starting alcohol or drug use again.

A diet for recovery should include:

- Complex carbohydrates (50% to 55% of the calories you consume), which means plenty of grains, fruits and vegetables
- Dairy products or other foods rich in calcium (calcium-fortified beverages, tofu, kale), two to three cups per day
- Moderate protein (15% to 20% of calories): two to four ounces twice a day of meat or fish (or another high-protein food such as tofu)
- Fat choices (30% of calories), preferably good oils such as canola, olive, flaxseed and those found in fish

Supportive structures and services must be part of the recovery 'diet'

Behavioural interventions are of limited use without supportive social groups and structures that improve access to safe and nutritional foods, alleviate poverty and treat additional mental health issues. Health care providers and different community-based agencies, including alcohol and drug treatment-specific organizations, have free services in mental health, nutrition and food provision, as well as other social services. These are great tools in the recovery process, and they can provide holistic care and support if you are recovering from addiction.

nutrition tips for recovery ...

- Try **healthy choices** for fast foods (salads, grilled chicken burgers, smoothies) if you don't like to cook
- Eat a **variety of foods** from all the food groups (fruits/vegetables, grains, dairy and meat or alternatives)
- Eat food **high in fibre**, such as bran and oat cereals and muffins, legumes, fruits and vegetables
- Eat **breakfast** and try not to skip other meals
- Slowly **cut back** to drinking less than two cups of caffeinated coffee, tea or pop a day
- **Limit sugar** and sweets
- Drink plenty of **water**
- Take **multivitamins** (talk to your health care provider about the options)
- Enjoy some form of **activity** every day
- Learn **new ways** to deal with stress and anxiety
- Seek **support** (counsellors can help with this)
- Talk to a **dietitian** for advice on nutrients, how to manage symptoms such as constipation and diarrhea, and for low-cost eating tips

... and for life

Drinking More and Enjoying It Less

Girls, Women and Alcohol

Nancy Poole, Amy Salmon and Lorraine Greaves

The authors are researchers at the British Columbia Centre of Excellence for Women's Health

Alcohol touches the lives of many women and girls. Alcohol is the most common substance used by girls and women, and a significant number of girls and women drink at risky levels. However, until recently, little attention has been paid to the impact of alcohol on female health. Recent evidence about patterns and consequences of alcohol use in women and girls sheds some light on how drinking can affect women and on the types of supports that are useful when women have problems with alcohol and other drugs.

How much do women drink in Canada?

A recent Canadian addictions survey found that approximately 77% of Canadian women drink and 14% regularly drink at risk levels for short- and/or long-term harm.[1] While drinking rates for men have historically been higher than women's rates, that may no longer hold true. A recent survey of Canadian university students found that 87.1% of female and 84.0% of male students used alcohol in the past 12 months.[2]

In addition, there are changes in drinking patterns towards more risky types of use among women, which are also of concern. More than a third (34%) of female students in the Canadian university student study reported consuming five or more drinks on a single occasion at least twice during the past month; around 11% reported consuming eight or more drinks.[2] These levels of alcohol use by girls and women are especially troubling, since drinking guidelines for women recommend no more than two drinks per day.[3] In the *Canadian Addiction Survey,* over 85% of the alcohol consumption by women ages 15 to 24 exceeded Canadian guidelines.[1]

What influences this use of alcohol?

Girls and women use alcohol for a wide variety of reasons, including desires to improve mood, increase confidence, reduce tension, lose inhibitions or enhance sex. Alcohol is relentlessly promoted to women through advertising, movies and television shows, which imply that drinking will bring them health, happiness, success, sophistication and freedom. *Spin the Bottle: Sex, Lies and Alcohol*, a video by Jean Kilbourne, uncovers the deception in this advertising and shows how it can influence young women's decision-making about drinking.

Girls and women also use alcohol (as well as a variety of other drugs) to cope with difficult life circumstances or with feelings that are overwhelming. For example, experiences of sexual abuse and physical abuse (which are more common among girls and women than among boys and men) are strongly related to the problem use of alcohol and other drugs. Girls who have been sexually abused are more likely than others to use substances, and to use them earlier, more often and in greater quantities.[4] Drinking to cope with issues like this can be part of a destructive cycle, where answers are sought in substances, rather than through more adaptive supports or making other kinds of changes.

What does alcohol do to girls and women?

There are well-known sex differences in the ability to process alcohol. For example: women's bodies have less water than men's bodies, so alcohol is less diluted in a woman's body.[5] Because women's bodies process alcohol differently than men, women can become intoxicated after drinking half as much as men.[6] Alcohol can diminish motor coordination, judgement, emotional control and reasoning power—increasing risk of accidents, injuries and vulnerability to violence—so women need to be aware of these differences and not try to keep pace with men when they drink.

Heavy alcohol use can have devastating effects on women's health. Women have a higher risk of dying from alcohol-related accidents than do men.[6] Women develop health problems from heavy

drinking, such as liver disease, earlier than men.[5,7] Other alcohol-related health risks that are higher for women include high blood pressure, osteoporosis, breast cancer, gastric ulcers and alcoholic hepatitis.[7,8] Drinking can also increase the risk of mouth and liver cancer, major depression, epilepsy, hemorrhagic stroke and cirrhosis of the liver. These risks can increase when alcohol and other drugs, such as tobacco or medications like benzodiazepines, are used at the same time.

What are the barriers to getting help?

For women who have problems with alcohol, many barriers can get in the way of finding and getting support and treatment. One of the biggest barriers women can face is not having people in their lives who support their desire to get well. Pregnant women or mothers often fear losing custody of infants or children if they seek help. Women with mental health problems, including depression, can also find it hard to access treatment for alcohol and other drug problems. Often women aren't aware of what treatment or other supports are available. However, women can and do overcome these barriers. Supportive relationships with professionals, family and friends are the key to women getting help.[9]

Treatment can take many forms and no single method works for everyone. Programs that provide help with all aspects of women's lives—physical, emotional, spiritual, vocational—and that also support healing from past trauma, can be particularly useful. There is a range of mutual aid groups for women available in British Columbia, including Alcoholics Anonymous and 16 Steps for Discovery and Empowerment. Other self-help groups on related topics, such as self-esteem and recovery from trauma, can also be helpful in combination with these recovery-oriented groups. Withdrawal management, outpatient counselling, day treatment groups, supportive living programs and residential treatment programs are also available across BC to varying degrees.

A key resource for women in BC is the Aurora Centre, a provincial women's treatment centre based at BC Women's Hospital.

related resources

> For **Aurora Centre** see aurora.bcwomens.ca

> For information about the video **Spin the Bottle: Sex, Lies and Alcohol** see www.jeankilbourne.com/video.html

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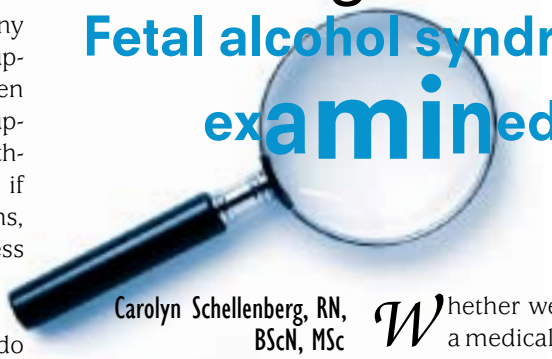
What knowledge and whose knowing counts?

Fetal alcohol syndrome examined



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Whether we live with a medical diagnosis or make use of diagnoses in our work, a diagnosis is a form of knowledge and a way of knowing, which we take for granted. Medical diagnoses belong to a system for classifying diseases,[1] disorders and problems in daily living and for directing attention to causes, modes of treatment and interventions. Diagnostic categories tend to be accepted as authoritative and factual, and, for the most part, they remain unquestioned.

In recent years researchers have been inquiring into the taken-for-granted nature of medical knowledge and the authority granted to the "knowers"—the individuals who produce such knowledge. Anthropologist Bridgette Jordan suggests that: "The power of authoritative knowledge is not that it is correct, but that it counts."[2]

The medical diagnosis of fetal alcohol syndrome is particularly suited to critical inquiry about what knowledge and whose

knowing counts. Fetal alcohol syndrome, commonly called FAS, is a medical diagnosis applied to children who show physical and/or neurodevelopmental characteristics that are associated with—many would say caused by—women drinking alcohol during pregnancy. The FAS diagnosis may also be applied to adults who are believed to have been prenatally exposed to alcohol. However, though applied to the offspring, the diagnosis directly implies that birth mothers are responsible.

In this article, I invite readers to critically question the current view of what causes FAS and how it is that we come to "know" about the birth mothers in this way.

'Knowers' change FAS 'knowledge' over time

Medical knowledge on FAS has developed over time to shape our common understandings of its "cause." Fetal alcohol syndrome appeared in medical literature in 1968, when a French doctor published his studies of children born to mothers described as alcoholics.[3] In 1973 researchers in the United States named the syndrome "fetal alcohol."[4] There were several factors common to all the women in the US research: all were heavy drinkers, poor and recipients of the US welfare system. Moira Plant insists that FAS has only been found in women whose drinking can be classified as heavy or alcoholic.[3] The factors of poverty and of an 'identifiable' or heavy drinking problem, which were found in the original descriptions of FAS, were subsequently ignored.[3] Nevertheless, hundreds of papers have been written in an effort to determine just how much alcohol consumption puts a fetus at risk and to try and determine what those risks are. There is, however, no conclusive evidence in this regard.

The diagnosis of FAS has also undergone changes over time. While more elaborate systems of diagnosis are now used, doctors continue to rely on four main criteria: 1) facial characteristics, e.g., a thin upper lip and flattened ridge between the nose and upper lip; 2) growth deficiencies such as low birth weight; 3) nervous system involvement, including a range of learning difficulties, and cognitive and behavioural problems; and 4) confirmation of maternal alcohol use during pregnancy.[4]

Rethinking 'cause'

The diagnosis assumes there is a direct causal relationship between maternal alcohol consumption and affected babies. Alcohol is a known teratogen, which means it can be harmful to a fetus. Yet, there remain many unanswered questions about the role of alcohol and other factors that may contribute to fetal harm.[5] Even among women who are chronically heavy drinkers, only some women will have an affected child.[4,6] Definitions of heavy drinking vary widely, and the practice of identifying a pregnant woman as a "heavy drinker" may also affect the likelihood that her child is identified as FAS.[7]

There is a growing body of research to suggest that there are other factors such as nutrition, maternal health, paternal alcohol use and genetic susceptibility that may, like alcohol, be associated with FAS.[3,8,9] Research shows that, while certain changes in the fetus are strongly associated with maternal alcohol consumption, poor folate (i.e., a B-complex vitamin) status is also associated with high alcohol consumption, thereby suggesting that the deficiency of nutrients such as folate may be implicated.[10] Birth defects are likely interrelated with multiple components, including nutrients, genes and enzymes.[10] Paternal alcohol consumption may also affect the fetus through a direct effect on the father's sperm or reproductive organs.[11]

There is no single cause of FAS

The single-minded focus on alcohol as the cause of FAS fails to account for other factors that also contribute to neurodevelopmental problems, low birth weight and even FAS-like appearances in children. Standardized psychological tests and facial and growth measurements show variations between cultural groups and create the potential for over- and misdiagnosis.[12,13] It is impossible to prove that the abnormalities of mental deficit, growth delay and maladaptive behaviour in any one child are the result of prenatal alcohol exposure, since these abnormalities are not unique to FAS.[7,12]

Armstrong and Abel argue that, contrary to popular messages that FAS is a threat to all pregnancies, it occurs predominantly among poverty-stricken women. What women in poverty have in common is that they experience or are characterized by factors such as smoking and poor diet.[9] These areas of research are raising important considerations for understanding FAS and they depart from the authorized approach to knowing what "causes" it. Since each of these factors (e.g., smoking and poor diet) are risk factors for poor pregnancy outcome, they must all be considered if we are to attend to women's and children's health.[14]

The medical diagnosis of fetal alcohol syndrome is presented as fact-based, authoritative evidence that provides a

particular way of knowing women and their children. This way of 'knowing,' however, obscures the women's experiences of poverty, violence, abuse and other factors that contribute to poor health and to problem substance use in the first place. It has directed attention to poor and First Nations women and children who are, disproportionately, the subjects of FAS research and the objects of the diagnosis. Focusing attention on a single cause interferes with gaining knowledge that derives from women's lives and women's experiences, when such knowledge has the power to help and heal both women and their children.

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Words, Values and Canadians

Dan Reist

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Considering the complex nature of modern society, it's easy to see why people—including Canadians—seek comfort in things that organize their choices into neat categories. Whether it takes the form of a combo meal, vacation package or cell phone feature bundle, there is a trend toward simplifying daily matters with a number, label or one-size-fits-all service.

It is of little wonder, then, that professionals in the addictions field in Canada have been calling for similar relief in the form of a neatly packaged tome of substance-related terminology. After all, how effective is it if doctors, clinicians and others in the industry use different words to describe the same substance use issue, or use one blanket term to describe a host of substance-related harms? Similarly, how can researchers and front-line workers pass on information to policy makers, the public and users themselves if nobody speaks the same 'language'? Wouldn't it be easier to communicate if everyone were using the same words, and assigning the same meanings to those words?

At a recent symposium on substance-use terminology, addiction industry professionals from across Canada discussed the question of consensus around language use and considered the idea of developing a 'dictionary of substance terminology.'[1] They soon discovered, however, that it was impossible to decide which group of stakeholders had the right to have the 'last word' on substances. Instead, they looked for a

different approach to the language question—and decided a truly Canadian approach was needed.

Borrowing from our nation's bilingual and multicultural roots, the participants agreed that different people express themselves in different ways, and that all people deserve the right to use their own language. The only way around the word problem would be for all stakeholders to 1) develop 'multilingual' skills so everyone involved can both speak freely and understand others around them, and 2) articulate a set of common values in order to bridge the gaps between languages.[2]

The value of words: Bridging our languages about addictions

While a set of common values was not clearly defined at the symposium, some key words and phrases hinted at several fundamental over-arching principles:

People-centred approach

A people-centred approach puts human beings at the forefront of our actions concerning drug issues, but not so far in front that we forget the external circumstances that make substance use possible and potentially harmful.

Multi-dimensional continuum

This principle involves extending our language of harm beyond substances themselves to address larger matters behind substance use, such as housing, literacy and justice.

Locating our ideologies

In identifying and "owning" our individual language positions (e.g., doctors "own" medical terminology), we can share our facts and opinions, and understand the uses and biases of our (and others') discourse.

Full disclosure and open dialogue

Clear information delivered frankly to Canadian citizens can reduce the confusion and hysteria that often envelop conversations about substance use. Successful relationships (e.g., between parents and children) require open dialogue.

Contextualization

This principle aims to acknowledge that human beings, across time and space, have regularly turned to substances for support, release and spiritual connection. Substance use meets certain human needs, so when we respond to harms associated with substance use, we should be ready to give people access to other tools to achieve the same ends.

Human rights and citizenship

Responses to concerns about drug use must be reflective of our rights as citizens to open, healthy and safe environments, and be free of bigotry, sexism, ageism and other 'isms' that infringe upon our rights.

Choosing our words carefully

In addition to basic principles emerging from the symposium dialogue, a few pragmatic recommendations concerning the language used in the National Framework for Action[3] and related documents were made:

Use simple, general language whenever possible

Framework documents should use the broadest possible language (e.g., substance use and harm) to refer to the field of interest, and use narrowing language (e.g., substance use disorders) only when required. Effort should be made to use common language and avoid the creation or use of technical terms owned by particular interest groups.

Include a glossary in any documents intended for broad distribution

While general language should be used whenever possible, glossaries of terms should be added to documents to ensure clarity around specific or technical terminology. Inevitably, terms that have multiple meanings, or that might be esoteric or specialized, will need to be used. Inclusion of a glossary will encourage authors to be explicit about their language.

Articulate the cost-benefit nature of both substance use and our language choices

By expressing awareness of how our discourse on substance use is connected to our beliefs and decisions about benefits or harms, framework documents could set the stage for meaningful dialogue. Attention could be placed on the larger issue of language, rather than on the individual words. And effort could be made toward avoiding the negative slant that pervades so many substance-related issues.

Use language that is consistent with shared values

Greater emphasis needs to be placed on articulating shared values and linking them to substance use concerns. By framing the issues broadly, artificial distinctions can be replaced by more inclusive constructs. In keeping with the Canadian appreciation for diversity and multiculturalism, our focus should be on drawing out, rather than papering over, the distinct perspectives that co-exist in our current systems.

There is still much work to do in creating a framework that meets the needs of our nation, but all Canadians will benefit from using language that encourages dialogue and respects diversity, while at the same time creating a sense of shared experience.

footnotes

1. The National Symposium on Language was held on January 31, 2006, at the Morris J. Wosk Centre for Dialogue at Simon Fraser University. The symposium was funded and hosted by the Centre for Addictions Research of BC, Provincial Health Services Authority, BC Ministry of Health, and Health Canada.

2. For a more detailed summary of the symposium outcomes, search for *Words, values, and Canadians: A report on the dialogue at the National Symposium on Language* on the Centre for Addictions Research of BC's Substance Information Link website at www.silink.ca.

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Pregnant Women and Alcohol

We need to move from stigma to support

Nancy Poole and Cristine Urquhart

Nancy and Cristine work with BC Women's Hospital, the British Columbia Centre of Excellence for Women's Health and the British Columbia Reproductive Care Program, supporting the implementation of the ActNow Healthy Choices in Pregnancy initiative

Women who use substances during pregnancy have been subjected to much negative social and legal attention over the years.[1] From a health perspective, however, increased evidence about the effects of drinking alcohol during pregnancy has increasingly focused attention—through the lens of risk for fetal alcohol spectrum disorder (FASD)—on women who drink while pregnant.[2] National, provincial and regional frameworks related to prevention of FASD have been developed.[3,4] A FASD policy partnership and research network has been developed, inclusive of the four western provinces and three territories. The BC government is currently promoting action by service providers who serve pregnant women through its ActNow Healthy Choices in Pregnancy initiative, and FASD prevention plans are being developed by each health authority in the province.

Stigma creates barriers

The issue of alcohol use during pregnancy has shifted from a topic of marginal interest, to a more mainstream children's and women's health issue.[5] There is, however, an ongoing struggle to balance a heightened interest from professionals and policy makers with efforts to reduce the social and legal stigma applied to pregnant women who drink. Stigmatization is unjust. It also creates barriers for women who might seek treatment. These barriers contribute to poorer health for both women and their infants.

Understanding alcohol use during pregnancy

Estimates of women's drinking during pregnancy vary. In the 2001 Canadian Community Health Survey, 15.9% of pregnant women in BC indicated alcohol use in the past week.[6] Also in this survey, 12.4% of BC mothers reported alcohol use during their last pregnancy.

Most women are able to reduce or stop their use of alcohol during pregnancy. But for some women this is difficult. Women whose alcohol use has progressed to dependency, and those facing other stressors and health problems such as intimate partner violence, inadequate housing or nutrition, mental health problems, lack of support from partners and families, and problem use of other substances may be unable to stop on their own, even if they want to.

Prevention messages have tended to oversimplify this reality, contributing to the stigma and perception that women who drink while pregnant are evil or bad, and are deliberately harming their fetuses. Prevention messages often focus only on the alcohol use and imply that it is a simple matter for all women to "just say no" to alcohol during pregnancy. These messages ignore the dynamics of addiction and the burden of other health and social problems that many women face.

Prevention—a three-level strategy

Level 1 Building public awareness and community action is central. The aim is to shift attitudes from negative to compassionate toward women who have substance use problems, promote understanding of determinants of health, reduce systemic barriers to care, and bring people together to work on community-level solutions. This level forms the groundwork for the other levels of prevention.

In developing effective public awareness campaigns about alcohol use during pregnancy, it is a challenge to create awareness of the risks using messages that are not overly threatening, that speak to women in diverse circumstances, and that promote positive, informed action by women, their partners and their communities.

fetal alcohol spectrum disorder

Fetal alcohol spectrum disorder (FASD) refers to a range of birth defects and developmental disabilities associated with prenatal alcohol exposure, including facial abnormalities, growth deficiencies and central nervous system impairment (such as impaired motor skills, visual problems, learning difficulties, poor impulse control, and problems in memory, reasoning and judgement).

Level 2 There needs to be open and nonjudgmental discussion of alcohol use with all women of childbearing years, including pregnant women. These women need to be informed about the risks of substance use during pregnancy and about help that is available to assist them in reducing or stopping their alcohol use. Physicians have long been recognized as important providers of this information, yet many other service providers who come into contact with women are also in a position to provide this information and support.

When this level of prevention is in place, all women will be informed of the risks of drinking in pregnancy, women who are using alcohol in risky ways will be helped to reduce or stop their alcohol use during pregnancy, and women with substantial alcohol and other health problems will be linked to comprehensive care.

Level 3 There need to be comprehensive services designed for women at the highest level of risk—that is, pregnant women and mothers who have serious substance use problems and other health and social problems. Fundamental to this work is a holistic, nonjudgmental, harm reduction service orientation. Services that operate from this perspective support improvement in women's health by providing choice about the health support women receive, by recognizing and accepting the pace of change women are able to make, and by meeting women "where they are at."

Pregnancy Outreach Programs have been a cornerstone of support for pregnant women in rural and urban communities throughout British Columbia. The multi-faceted Sheway program in Vancouver and the Maxxine Wright Place Project in Surrey are examples of how perinatal services can work with other community services to solve problems of access to care and to support women's health by providing services "wrapped around" women and their babies. These programs work in partnership with innovative providers of withdrawal management services such as those at BC Women's Hospital, as well as with child welfare services and many other community-based providers of housing, children's, Aboriginal, violence, nursing and other services.

Many smaller communities are creating smaller scale perinatal support networks that are based on a compassionate and comprehensive service orientation.

Each of these levels of prevention is important in itself, and optimally, they reinforce each other. As each level of prevention builds, the stigma associated with substance use in pregnancy is reduced and we move forward with effective support of women's health that truly makes prevention of FASD possible.

related resources

> **Pregnancy Outreach Programs**
To locate a Pregnancy Outreach Program in your community go to www.bcapop.ca

> **Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women**
13729 92nd Avenue, Surrey, BC V3V 1H9
Phone: 604-587-3835; Fax: 604-581-3908
E-mail: Denise.Penaloza@fraserhealth.ca

www.atira.bc.ca/maxxine.html

> **Vancouver Native Health Society - Sheway**
533 East Hastings Street, Vancouver, BC V6A 1P9
Phone: 604-216-1699; Fax: 604-216-1698
E-mail: sheway.sheway@vch.ca

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Drowning Pool

An editor's journey with alcoholism

Paul Sullivan

Paul has worked in media for more than two decades. He was former Western Editor for the Globe and Mail, Managing Editor of the Vancouver Sun, Host of the Early Edition on CBC Radio Vancouver, and has been an editor, editorial vice president, producer or columnist for West Magazine, The Journal (CBC TV), Telemedia Inc., The Winnipeg Sun, the Winnipeg Free Press, and Globe Investor Gold. He is currently President and Chief Strategist of Sullivan Media

I think I realized I was an alcoholic as I was trying to convince myself I wasn't one.

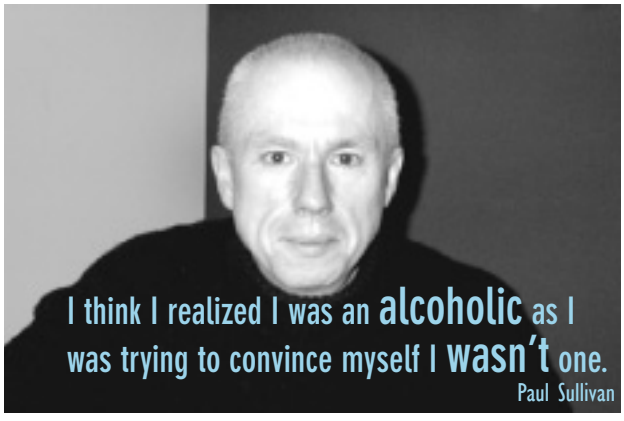
I was a young man and quite fancied myself as a smart man. I had showed some promise through school, a promise never quite realized, but it was enough to convince me of my own genius.

Beneath the thin ice of my self-confidence, there was a deep, dark pool of frigid water, a drowning pool of fear, self-loathing and insecurity, and like all plumbing problems, the longer I ignored it, the more flooded my basement became.

So I did everything I could to avoid the truth. I didn't "drink"; I was a "party animal." I drank like the young Hemingway: romantic, resolute, and, if doomed, it was an attractive, deferred kind of doom.

But who was I kidding? I was drunk before I got to the party, and by the end of the party, a babbling, drooling lunatic. The next morning was a frenzy of forensic archeology, piecing together the shards of a blackout, a broken mind, frantically hoping I didn't really say that or do that or act like that.

My life revolved around drinking. I would line up the weekend based on drinking events: Friday night: go out for dinner, get bombed; Saturday: pub crawl, get bombed; Sunday: start with brunch, get bombed. And that was just the weekend. I could easily consume a bottle of wine at lunch, sometimes two, if I was feeling expansive. Every meal required alcohol—food was optional.



Yet, those were the 70s and wretched excess was cool. So I told myself. It was no more cool than it is today, but I could drink like a rock star even if I couldn't sing or play the guitar. Thirty years later, I break out in a cold sweat just thinking about the way I was.

One day, I remember, the illusory music died. I was reading *Time* magazine, which I disdained because it wasn't *Rolling Stone,* didn't speak with the voice of a generation, and if it did, that generation wore plaid. The article in question was about alcoholism, which didn't apply to me, and the article featured a sidebar quiz: Are You an Alcoholic? No, I snorted, and filled in the quiz. As it turned out, I was right. Of the 36 signs of alcoholism, I only exhibited 34 of them. See, I told you, I said to the long-suffering woman who eventually became my wife (and who continues to be my wife today, thank the Lord), I'm no alcoholic.

At the time, I literally could not drink coffee in public. I was unable to raise the cup to my mouth without shaking so violently, I would spill the scalding coffee all over the table and myself. On those rare nights I was sober, I would lie in bed afraid to close my eyes in case I died. I would often drive home from the pub after consuming 24 glasses of draft beer. But I was not an alcoholic.

These days, I believe the only test you need is that you want to keep drinking. Back then, I was elaborately parsing and spinning every manifestation of my addiction to alcohol. But that test stayed with me, and like the writing on the wall, it refused to go away. I found myself referring to it almost daily, as I continued to knock them back, arguing and muttering to myself. I would weave my way to the men's room, banging against walls, staggering over the urinal, reassuring myself that I wasn't an alcoholic because I failed to qualify on two out of 36 points: I didn't drink alone and drinking did not affect my work. It got to the point where even those self-justifications were out of date, but no matter—when I took the test, that was the case, and the test became my rock, my reference.

How could I be so stupid and blind? Well, it was pretty easy. I was a slave to alcohol and alcohol was

calling the shots. It was a very near thing. Finally, I think, a tiny shred of that IQ I worshipped so vainly saved my life. My intellectual pride forced me to read the writing on the wall, and the message could not have been more plain: "You may have dodged two of the 36 signs," it said, "but, you idiot, you've admitted to 34! You're at least 90 per cent an alcoholic! What's more important," the writing on the wall continued in a more compassionate vein: "you're suffering so much…why do you want to suffer so much?"

It was not an epiphany. I was not suffused in white light. In fact, I was more than a little bit in love with my own suffering. Finally, however, the prospect of further humiliation won the day. I didn't want to stop, or the alcohol that I craved didn't want me to stop, but I had become fat and uncomfortable and a distinctly old 27. My hair had gone grey at the temples. I was becoming a social pariah. Even then, I quit three times (to lose weight, I told myself) before I took my last drink: New Year's Eve, 1982. I was 32 years old. I was lucky to see my 30th birthday.

I'm a big one for ceremony. I actually quit for real one morning during the previous November, after downing more than a dozen jumbo martinis with a "friend," being rolled by a cab driver, left drooling in the snow, and crawling home. But I allowed myself one more night on the town, then said goodbye to alcohol. At that point, I finally knew that drinking was going to kill me, and all things considered, I was more afraid of dying than not drinking.

I've been sober ever since. Like the rest of my fellow non-drinking alcoholics, I take it one day at a time. I realize that every person's addiction is woven into a unique tapestry of genetics, environment and upbringing. No two snowflakes are alike. It has become a lifelong quest to read the tapestry, to pore over it like a medieval manuscript, looking for illumination: Why me? Therapists and I have sifted through the clues, and slowly, self-knowledge is accumulating. But self-knowledge is not a cure. It helps, but the pool is still dark and deep. And if I don't watch myself, I know I'll drink it dry. i

Me and Detox

On beating my demons

Patrick Schnerch

Patrick resides in Victoria, BC, and lives with a dual diagnosis of bipolar disorder and alcoholism

Prologue

On a Friday night in November 2004, I was so drunk leaving the bar that I didn't know how to get home. I staggered the streets for hours and eventually laid down beside the road and passed out.

The police picked me up and took me home. My wife was deeply hurt, and I was ashamed and belittled by the experience. Soon after I found out that my long-term alcohol use was causing my liver to harden around the outer edges. Alcoholism. I made my mind up to fight back.

Detox 'Diary'

Day 1

My last drink was at 8:00 pm last night. I arrived today at 9:00 am, a little frightened of what I had gotten myself into. My bags were inspected: I wasn't allowed to have a cell phone or alcohol-tainted products such as aftershave lotion or mouthwash. By the time I settled in I would normally have been on my third or fourth beer. Then, I'm at the bar for opening time and am kicked out by 9:00 pm, having downed about 14 or 15 beers altogether.

The staff is very pleasant. I have a private room with a lamp and desk. There are two kitchens, a TV room, a public phone and a smoking area in the courtyard. The courtyard has locked doors, so people in detox can't just leave. You can mingle with other patients or pick a corner and 'veg out.' I needed to gather my thoughts on how this all happened to me, so I found myself a little corner and that is where I sat. I made myself a pot of coffee (decaf—regular is very harsh on the body). I was ready to start my detox.

I began to write in my journal. I became depressed and remorseful, reflecting on what I must have put my family through, especially my wife. I am saddened that my behaviour has been so selfish—that *my* feelings were all that mattered. When I'm sober, I'm a kind and loving soul who worships the ground my wife walks on. And I've failed her parents by not being a productive and loving husband to their daughter. But when I drink, I only consider my own pleasures. I turned all this hurt inward and cried, realizing for the first time what I have done to others. This is very painful.

The medical staff tested my vital signs several times today to determine the levels of alcohol in my system. They check your blood pressure, pulse, temperature, check for shakes and listen to your heart to determine a score; if your score is 10 or higher, they administer Valium to calm down the withdrawals and prevent a seizure. My levels were a little high, but I didn't need drugs to calm me down.

I had no appetite and didn't eat all day. This is very common. When I'm drinking, food is of no importance.

I phoned my wife after she came home from work. She is my lifeline while I'm in here. We're only allowed 10-minute phone calls. I told her this is a first-class facility, equipped and staffed with everything you could need and that visiting hours were twice a week at 7:00 pm for one hour. My wife said she was very pleased we had made this decision together to seek help. I agreed, and we said our good-byes.

I remained isolated from the other residents. I tried to make peace with myself and God, but couldn't stop beating myself up. I wanted to die.

Day 2

After a restless night, I woke at 2:00 am, highly agitated. The only time I ever have a good sleep is after a very heavy drink; otherwise, I am up at all odd hours during the night. I had several cigarettes in hopes they'd calm me down. The on-duty nurse checked my vital signs. They were still up, but didn't need intervention.

Detox was the shock to the system I needed. Away from everyone—and, especially, away from the bottle—I had to face my failures head on. I wrote in my journal for several hours. I hated myself for becoming an alcoholic. I realized my life had no value while I was drinking. I was a lonely 'drunk' sitting at the kitchen table drinking decaffeinated coffee and thinking of all the years I had wasted, rotting at the bottom of a whiskey bottle. How could I ever know my full potential if I was always under the influence? And my relationship with my wife has suffered. I want my wife to be happy again. I want to be the man she married

At two days without a drink, I didn't physically feel too bad and didn't have any urges to drink. I had anxiety and slight tremors, but this was relatively mild, which amazed me. With the amount of alcohol I had put in my body on a daily basis, I should have been spinning like a top.

It seems that my addiction is more psychological than physical. I've noticed a pattern of becoming highly agitated and unable to cope with stress. Since my prescribed medication doesn't calm me down, I drink for relief. I don't feel better; it just numbs the pain for a while. Feel-

ing nothing is better than hurting. I get that when I drink. Nothing else works. Here at the detox centre, there is no stress to test my will. However, I don't trust myself on the outside.

I had already had four pots of coffee by the time the others got up. I took my medication and again phoned my wife before she went to work. Just hearing her voice gave me strength. Her support is very necessary to me. Without her, I would have been on the streets or dead already.

After the phone call, I went to the courtyard for a cigarette. I finally grew the courage to join the others. Most were on the stabilization program, which runs for 28 days. Many encouraged me to take the program after I complete my detox. It includes mandatory sessions on how to beat your addiction. It also guarantees another 28 days of no access to your favourite drug.

I still wasn't hungry; coffee and booze have been my staple fare for a long time. I had basically been awake a whole day already and was tired, so went back to bed, skipping lunch and dinner.

My wife came to see me in the evening. It made me think of what life must be like in prison. It was difficult for me to convey to her what was happening. We did a little tour of the facility, then sat in the kitchen and held hands. I told her about the rehabilitation program. She wanted to see how I was after detox.

After my wife left, I went back to my room to write in my journal. This solitude and absence of alcohol made me think much more clearly and already I felt better. I was surprised that the physical withdrawal was quite easy for me. This gave me added confidence, which I need. My depression was lifting and I no longer doubted that, with a little common sense and determination, I could beat this thing. I took my evening medication and went to sleep.

Day 3

Again, I woke at 2:00 am. The sedative effects of my medication had worn off, so I went to the courtyard for a few cigarettes. I felt very hyper and full of uncontrolled energy. Usually, I'd grab a drink and a cigarette when I felt this way. At least I was in a safe place, where my energy wouldn't get out of control.

If I lose control I can injure myself—or others. When manic, I am also usually psychotic with hyper sexual tendencies that can get a person into a lot of trouble. Sometimes, I cut myself to ground with reality. Being drunk and disorderly is actually a blessing in disguise. When I get ill, I become a danger to the public and my family; when I am drunk the danger no longer exists. Which route would you take? I don't want to hurt anyone. I am dealing with human lives; drinking myself to death is much more humane.

After my grueling night of questions, I was quite distraught. My thoughts ate at me like maggots on a corpse. Saddened and belittled, I sat with my coffee. At best, I was suicidal; if I had a gun, the choice would be easy and instant. Fortunately, the resources weren't available. But the problem is still there smoldering . . .

After a few cigarettes and a couple of coffees, I went to bed for the day, again skipping lunch and dinner. Not even God would look down upon me. I was alone and hurting. My soul died and, crying, I fell asleep.

Several hours later I awoke and phoned my wife. After that I had a sandwich and a glass of juice—the first thing I had eaten in over three days.

During the day I was wakened for an evaluation by the resident doctor, who was concerned about my sleeping habits. After reviewing my medication, she noted that my antidepressant, which I take at night, is notorious for insomnia. She changed the timing so I would take my antidepressant in the morning, which should

> "When I'm **sober**, I'm a kind and loving **soul** who worships the ground my wife **walks** on...
>
> But when I **drink**, I only consider my **own** pleasures."

give me more energy during the day.

After examining my chart the doctor questioned my need for detox. My vitals were low and physically I was not showing any signs of dependency. Even though I drink 14 beers a day, this didn't register on their testing. It puzzled her that I was physically and mentally more capable in life compared to other patients.

Today, two gentlemen from the drug rehab support group Narcotics Anonymous came to tell us how they beat their demons. My feelings came alive when they told their stories. Their lives were empty; now they help others deal with addictions. I plan to attend the men's support group. After, I took my medication and went to bed.

Day 4

I woke up at 1:30 am today. The nurses barely ever test my vital signs now, since my levels are near normal. It takes three to four days for alcohol to leave your system and my body has already flushed most of the poison out. I may be discharged tomorrow.

Physically, this has been a piece of cake. I still have problems with my sleep and eating habits, and I still get agitated and nervous, which is a trigger for me to drink. I hope I can find another method of arresting my agitation. The detox has kept me away from alcohol until I could dry out. I feel very content. What an amazing difference a few days can make.

I phoned my wife, then went out for a cigarette. The other residents were awake by this time. They are good people who have had their fair share of tragedy.

The big question is: can I survive the stresses beyond these walls? I know how ferocious my illness can be and when push comes to shove, I really don't know what I will do. It is so comfortable in here, but I can't stay forever. I am apprehensive, as well as happy, about leaving tomorrow.

I missed lunch and dinner, but later had a sandwich and a juice from the refrigerator. I phoned my wife and told her I was coming home. She can't wait to see me tomorrow, and I am anxious to see her. She is proud of me for doing this. It shows her I still care. Our marriage is very important to me, and I don't know what I'd do without her.

It was a quiet evening. I had a few cigarettes and mingled with the other residents and that's about it. I'll take my medication and go to bed. Tomorrow is my big day.

Day 5

At 2:00 am I was up having my coffee. My vitals were tested one last time and the alcohol has cleared my system. I had a couple of cigarettes and feel a little less agitated. I have more energy and am alert. I haven't felt this way for decades.

The hard part is yet to come. The detox program scared me straight, but I still have a few demons to vanquish. Life is full of challenges and I am willing to take them on. But I am also worried that I may fail. This scares me.

Everyone is awake now and I have phoned my wife. I am just waiting for my release into the 'wild.'

Later on day 5

At 10:30 am I was free to go. There were no bells or whistles, just a few hugs and healthy handshakes. I got into a cab and came home. Upon arriving, I noticed there was no alcohol in the house. I don't remember the last time that was the case.

The energy and renewal I feel is extraordinary. After a few hours, I made pork chops and salad for dinner and waited for my wife to come home. We ate and cuddled on the couch. A new man, I was very happy to be home.

Epilogue

My sobriety barely lasted eight months.

Most of my drinking is a self-medication measure: I've used booze to suppress my pain during depression, calm myself down during mania, and put myself to sleep. I can also induce a dissociative state by drinking.

At 12 I was diagnosed with manic depression/schizophrenia. After a traumatic move from my loving aunt and uncle's place to go live with my dad, I became severely depressed and entered a world of darkness, where my father and stepmother couldn't reach me. My mind would shut off and I'd enter my dark sanctuary. I grew accustomed to shutting out the world.

I don't need protection anymore, but I still yearn for it. I still remain in a dissociative state for several hours every day, and alcohol helps me get there at will. It's not the alcohol I miss, it's the tranquility. It's hard to let go of my security blanket.

In June 2005 I was stricken with another serious depression. I sought medical help, but was sent out to the dogs after a five-minute appointment. Desperate, I once again turned to alcohol. I took the bus to the nearest pub, got plastered and once again was brought home by the police because I had passed out on the roadside.

I'm having great difficulty calming the beast. But I am working with my addictions councillor and plan to go through detox *and* the 28-day residential rehabilitation program.

Patrick Schnerch went through **Victoria Detox**, one component of the continuum of addiction services provided by Vancouver Island Health Authority's **Withdrawal Management Services**. Clients may stay up to seven days for detox. Says Patrick, "The staff was fantastic—very professional, caring and compassionate. It is free of charge and even the poorest person is welcome." The detox centre can be reached at **250-213-4444**.

For detox centres in your community, call the BC Alcohol and Drug Referral Line at **604-660-9382** or **1-800-663-1441** (outside the Lower Mainland). Or, visit the online directory at **www.kaiserfoundation.ca**

A Daughter's Story

I was 13 years old when I realized that alcohol had taken over my dad's life.

One day, when I was 10, I walked home from my grandma's house to find our front-door window smashed in. I panicked and ran back to my grandma's—luckily she lived just a block away—to tell her what I had found. My grandma and I ran back to my house, and found a trail of blood leading from the front door all the way to the kitchen, where the phone was off the hook and papers were scattered everywhere.

I ran to my parents' bedroom, where I found my dad lying with his feet hanging over the edge of the bed. He was bleeding—and my dog was barking; she knew something was wrong. My dad had been so drunk that he couldn't open the door with his key, so had punched through the window.

Several years after the window-breaking mishap (and others), we moved to a new home in a bigger town now far away, so that my brother and I could be closer to school. I was 14; my brother is two years younger. School was good, but family issues kept arising, causing family feuds. Our family was getting ripped apart. Things kept getting worse, my relationship with my dad grew thin, and I couldn't handle listening to my parents fight night after night. And my brother would yell and scream and cry when the fighting got to a certain point. After a year or so of this I would threaten to move out unless things either got fixed or my dad moved out, but my mom always convinced me to stay. Finally, my dad did move out when I was 16, and things improved at home.

My dad is pretty good between getting his disability cheques. Once he gets money, though, he starts phoning and phoning, and he's usually drunk. The conversations my brother and I have with our dad have no meaning. Every five minutes he forgets about what he has just told us, so he repeats himself. It is hard to hang up on my dad, but I have to sleep sometime—I spend about 25 hours a month on the phone with him. His behaviour lasts about five days and then he'll be so broke that he can't go anywhere. He tries to borrow money from me, my brother or, sometimes, my mom, and sometimes we give in to him.

He thinks we have a good relationship now that he has moved out, but to me, it's nothing—we don't have a relationship. I feel sorry for him, because he's a lonely drunk. I've tried to help my dad by finding the AA groups and by talking to counsellors to help me communicate and deal with him better. But no matter how I try to help him, he denies that he is an alcoholic.

I didn't understand how alcoholism could ruin a family until that day when I found my dad sprawled on the bed, bleeding. That image has stayed with me ever since. I will never forget the memories he left me with after his alcoholism destroyed our home.

Donna*

Donna is 17 years old and is in grade 12

** pseudonym*

For a wife and mother's perspective, see page 31

He thinks we have a **good** relationship now that he has moved out,
but to me, it's **nothing**—we don't **have** a relationship.
I feel **sorry** for him, because he's a lonely **drunk**.

The Destructive Path of Alcohol and Mental Illness

A.M.R.

A.M.R. is a 48-year-old woman who has worked in various levels of government service for many years and is a mental health consumer recovering from alcohol addiction. She enjoys reading and writing

The eldest of four girls, I was born in Montreal into a black, evangelical church-going family of Caribbean ancestry. Starting in my teens, I sensed I had problems: I suffered from "bad nerves" and suicidal tendencies, for which my GP prescribed medication. In 1975, when I was 18, my parents moved us to the west coast. My problems, but not my prescription, followed me out to Vancouver.

Life overwhelmed me and led to bouts of severe depression and despair. I was fortunate to acquire well-paying jobs, but used to always encounter interpersonal problems in the workplace. I wasn't a drinker—I came from a family that never drank, and belonged to a church that didn't tolerate drinking—but about twice a year, during my first 10 years in Vancouver, I'd mix any pharmaceutical drugs I had on hand with alcohol to create a 'cocktail,' with the intent to kill myself. Inevitably, in my alcoholic, drug-induced state, I'd call someone for help and then a clergyman would show up at the door, and, though how it would happen is hazy, I usually ended up on the phone with my GP.

It wasn't until my 30s that I began to drink socially, on special occasions. It was a way to fit in. Back then, alcohol did not control my moods except when I deliberately overdosed. My suicidal behaviour eventually became more critical. I'd call out for help to anyone who might hear me, and soon the police or ambulance would appear. I'd be taken to an emergency room, where my stomach was flushed of the drugs and alcohol mixture. Then I'd be discharged, with minimal community support. This self-harming behaviour was the 'norm' for years.

On the job front, in 1988, I began working in a government position that had high-stress demands. The seemingly inevitable personality conflicts with co-workers and management—I've always had trouble dealing with anyone perceived as in authority—led me to use alcohol to take the "edge off" the work day. Working in this department was so hard on me that I ended up on stress leave—and seeing a psychiatrist, who later diagnosed me as having borderline personality disorder (BPD).

When I returned to work, I was transferred to a different area of government service. This department had a notorious reputation for being the most difficult area to work in. Because of my inability to cope in a tense environment, I began to have one or two drinks in the evening, alone in the privacy of my home. That amount increased over a period of years. I stayed in this position for 15 years and had the opportunity to attend product launches, educational workshops and social functions where I could drink whatever alcohol I chose. By the time I was 40 (in the mid '90s), my then boyfriend and I would drink one or two bottles of wine every evening.

I had been on a rocky road of inconsistent psychiatric care since that BPD diagnosis, so generally had various kinds of prescription drugs on hand. As I moved into my 40s, I engaged in a nightly ritual of drinking alcohol mixed with my psychiatric medications—and I had progressed from using cider to hard liquor.

I was not aware of my changing moods, but others noticed the change in my personality. My fluctuating moods became evident to my co-workers, and my family grew concerned about me drinking while taking psychiatric meds. I didn't seek help because I didn't believe I had a substance use problem.

When an EAP counsellor I saw about work stress suggested I seek help from an addictions counsellor, I half-heartedly secured a counsellor through Vancouver Coastal Health's Raven Song Community Health Centre. I still did not believe I had an alcohol issue. The counsellor was empathetic and didn't initially pressure me to quit alcohol. Instead, she

focused on reducing my intake because it was affecting my mental and physical health. One day, however, she decided to directly address the fact that I had reached the threshold of what was now a substance abuse issue combined with mental illness.

I was still employed, but I began to experience more mental health issues—lots of self-harming behaviour such as cutting and pulling out body hair. And my drinking now obviously affected my job performance: I was hung over and enduring side effects such as unusual sleeping patterns, irritability and depression, and my concentration was poor. One day I broke down on the job in front of some staff members, screaming and crying that I couldn't take it any more. My supervisor, who knew I had mental health issues, rushed me to the hospital.

During my absence from work, my employer was informed that I had an alcohol addiction in addition to my mental illness. To receive sick benefits, I was required to enrol in a 12-step program and to seek help for my mental health problems. I got my doctor to refer me to Vancouver Community Mental Health's Dual Diagnosis Program. I also arranged to attend the Avalon Women's Centre 12-step program, recommended by my alcohol counsellor.

At first, I attended the 12-step program reluctantly. But, by keeping my various counselling appointments, as well as seeing a single psychiatrist on a regular basis for the first time, I moved toward a plan of recovery.

With time and intensive counselling from these agencies, my alcohol addiction was differentiated from my mental health issues and I was able to deal with the problems individually. Once I had gained some mental stability, I was able to attend the Aurora Centre's outpatient addiction treatment program for women. I came to a point where I asked my psychiatrist to prescribe the drug Antabuse,[1] to deter me from drinking. I was well aware that I did not have the willpower to stop drinking on my own, but taking Antabuse was enough to stop me in my tracks.

Because of my inability to
cope in a tense environment,
I began to have one or two drinks in the evening,
alone in the privacy of my home.
That amount increased over a period of years.

I am still in treatment for my concurrent disorders, and I continue to receive support from my addictions counsellor. I have not consumed alcohol since November of 2004, two months after my breakdown at work. I can now see how alcohol complicated my mental illness and how it affected every aspect of my life.

The misery I endured while I was mentally ill and abusing alcohol took a toll on my family and friends, spanning a period of roughly 25 years. But sobriety has lifted the mental fog, and I feel that I'm starting my life over.

footnote

1. Antabuse (disulfiram) is a prescription drug that causes adverse effects, such as nausea, if one consumes alcohol while taking it.

related resources

> **Aurora Centre**
BC Women's Hospital and Health Centre
4500 Oak Street, Vancouver, BC V6H 3N1
Phone: 604-875-2032
E-mail: aurora@cw.bc.ca

www.bcwomens.ca/Services/HealthServices/AuroraCentre

> **Dual Diagnosis Program**
Vancouver Coastal Health
255 East 12th Avenue, Vancouver, BC V5T 2H1
Phone: 604-255-9843
E-mail: BCAMH@vch.ca

www.vch.ca/community/ddp_index.htm

> **Avalon Women's Centres**
Avalon Recovery Society
Kitsilano:
5957 West Boulevard Ave, Vancouver, BC V6M 3X1
Phone: 604-263-7177 E-mail: avalon2@telus.net
North Shore:
203-657 Marine Drive, West Vancouver, BC V7T 1A4
Phone: 604-913-0477 E-mail: avalon-ns@telus.net

www.avaloncentres.org

> **Raven Song Community Health Centre**
Vancouver Coastal Health
2450 Ontario Street, Vancouver, BC V5T 4T7
Phone: 604-709-6400

www.vch.ca/community/Docs/Community_Health_Raven_Song_Brochure.pdf

Self-Medicating with Alcohol?

Hey! I was just trying to survive...

Murphy Kennedy

Murphy is Executive Director of the Canadian Mental Health Association's Kamloops Branch

It doesn't seem like it has been over 15 years since I had my last drink. The memories, good and bad, of my alcohol-saturated life are still vivid, and I can still recount with a relatively high level of accuracy the grief I brought to those close to me. But I had no idea that I was, to use psychiatrically correct terminology, *self-medicating* with alcohol to treat an anxiety disorder and major depression.

Most recovering alcoholics respond to questions about why they drank with claims that they just wanted to "unwind" or "take the edge off." Not exactly hard science; nonetheless, these statements indicate a desire to improve one's mood—and drinking is one way to do that. This makes perfect sense to me. Alcohol was my tool for survival. And, just like I did, many alcoholics unwittingly use alcohol to escape anxiety and/or depression. There is one unfortunate reason for this: it works.

I clearly remember having my first full bottle of beer at the age of six. My parents had taken me along to a dinner party with friends of the family. As usual, I was intensely anxious—I was terrified of this kind of social event. Not long after arriving, I noticed that someone had opened a brew in the kitchen and had forgotten about it. During the next half hour, I spent most of my time in the kitchen. I had discovered my miracle drug: alcohol took away my shyness, paranoia, depression and anxiety, and I never forgot that feeling of freedom.

The average social drinker curtails their alcohol consumption after only a few drinks, possibly experiencing a feeling of loss of control. The alcoholic has a few drinks, and feels *in* control. It is a false sense of control, however, for the phenomenon of craving takes over and the spell is cast. What happens next is usually anyone's guess. Alcoholics have little control over how a drinking binge will turn out. Incarceration, hospitalization, killing themselves or others—all are possible outcomes. This is the reality of alcoholism.

Alcohol worked for me until it didn't work. I then had a serious dilemma: like others who reach their so-called bottom, I faced a situation where the fear of drinking equaled the fear of not drinking. I simply could not see any other way of coping with life except to continue using alcohol, yet I knew that carrying on would kill me. I was 26 years old and suffering extreme physical and mental torture. It was a regular occurrence for me to have severe dehydration, bloody stools and vomit, *delirium tremens*[1] from withdrawal, anxiety and paranoia—all due to my addiction to a drug I had previously believed was my cure-all.

Leading up to June 1990, my drinking had progressed to a state where I could not remember a day in which I had not consumed alcohol during the past year. That's because there wasn't one. I had graduated to a chronic stage in my alcoholism, and if it weren't for an unexpected intervention-of-sorts at work, I don't think I would have lived much longer.

I was a supervisor at the time, and the shop mechanic and I had had a very frustrating day on the job. I invited him out for a drink after work, and he looked at me and said, "I don't drink, and I'm coming up on 20 years of sobriety!" It was hard to imagine a fellow Irishman who hadn't had a drink for 20 years. This baffled me. Over the next few days, I started asking him questions about what he did to stay sober, and he told me he attended meetings of a 12-step recovery program. After a few more weeks of failed attempts at staying sober on my own, I asked him if he would take me to "one of those meetings" he went to. He did. From that day on I've not found it necessary to take a drink.

It is said that 12-step recovery programs aren't for those who need it, but for those who want it. There is a big difference. During my time in recovery, I have seen many alcoholics struggle to stay sober—it's not easy at first. But there seems to be a common denominator for those who are successful: desperation. It seems that no amount of willpower, or of pleading and begging by family members and friends, or of therapeutic treatment ▶

footnote

1. *Delerium tremens* can accompany withdrawal from alcohol, benzodiazepines and barbituates. It features severe tremours and hallucinations.

related resource

> See our article on **self-medicating** in the Men's issue of *Visions*, Spring 2005, at www.heretohelp.bc.ca/publications/visions

"The average social drinker curtails their alcohol consumption after only a few drinks, possibly experiencing a feeling of loss of control. The alcoholic has a few drinks, and feels in control."

My Life with FASD

My name is Francis Perry. I am a thirty-two year old Mi'kmaq First Nations man living with Fetal Alcohol Spectrum Disorder (FASD). I was diagnosed with Fetal Alcohol Syndrome at the age of nineteen. In 1975 when I was adopted at the age of three FASD was just a label, and no one understood this invisible disability. FASD is caused by prenatal exposure to alcohol. My mother drank when she was pregnant.

Francis Perry ▲

Francis is a guest speaker for the Mi'kmaq First Nation Healing Society, sharing his knowledge for the programs Empowering Our Communities on FAS/FAE. These programs provide education, training, healing and support to Aboriginal Communities. Francis' life story has been highlighted as one of the featured articles produced by the Ontario Federation of Indian Friendship Centres. Francis was also featured in a documentary entitled "Reality of a Dream" aired on Aboriginal Peoples Television Network

Early years

Part of the disability was that I was so hyperactive my parents could not believe it, and wondered how to turn me off. I was so hyper my Aunt had to take me to the beach to run off extra energy so my mom could get some rest.

School came and was a complete nightmare for my teachers and myself. Because I was so hyper I was a distraction for the class, not realizing that they were just as a big distraction for me. I was punished and soon they built a three-sided box to help me be less of a distraction to the class. But what ended happening was that I could not interact with my classmates. How do you think I interacted outside of the class? I was tormented, spit on, humiliated and teased. I never understood how or why I was the one that ended up getting blamed for starting it and getting into trouble.

Private school

My parents were told about a private school that specialized in learning disabilities. They thought that private school would be a good place for me. At that time I had been put on Ritalin, a drug for my hyperactivity. The school told my parents that no children at the school were on any medication. Within a week they were calling my parents begging for the Ritalin. After another week they called my parents back and asked them to, "Come and get your kid."

High school

I had moved on to high school, which I was not ready for. In high school we had to change classes for every subject, going to our lockers, grabbing books and finding the right class room was hard. Trying to figure out where to go, the constant movement and the noise of the hall really threw me off. This was overwhelming for me, for I couldn't think. I was often in trouble with teachers. High school turned into community college with a grade six education and turned out to be as frustrating as high school.

Trouble with the law

Things at home were pretty intense, so my parents took a vacation to Prince Edward Island, leaving me home alone. One night my friends and I broke into a

Self-Medicating | *continued*

is enough to convince an alcoholic to admit defeat. Only the sense of utter desperation brought on by continued consumption of alcohol, and the physical, emotional and spiritual bankruptcy that results, is successful in sobering up an alcoholic. It *is* as simple as that. When it hurts bad enough, we quit, and not a second before.

It wasn't until three years into the process of recovery from alcoholism that a friend recognized that I might have untreated mental health problems. A counsellor told me that after the first year of abstinence, emotions and moods settle down considerably, and fears begin to dissipate, and if they don't, some type of psychological or psychiatric treatment is likely necessary. In my case, both types of treatment played a significant role in full recovery.

Hard-liners in the addictions recovery and treatment community preach that any form of medication that corrects one's mood means the person is not "truly" clean and sober. They believe that when symptoms of depression and/or anxiety persist, it is a sign of spiritual immaturity or not enough prayer or positive thinking.

But I thank God for the sensible people put in my path in early recovery. They explained that correction of a mental illness by means of medication is as acceptable as correction of, say, diabetes or any other illness in need of a chemical response. It does not negate real sobriety. This is an important and life-saving piece of information that needs to be shared.

The rooms of recovery are filled with the same level of ignorance and stigma toward the topic of mental illness that exists in our culture. This ignorance and stigma has the potential to destroy a successful chance at recovery—a chance that, sadly, doesn't come twice to every alcoholic. i

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Harm Reduction, Alcohol and Homelessness

Ottawa's Managed Alcohol Project

Kim Meier

Kim is an undergraduate student in cognitive science at Simon Fraser University, currently on a co-op term at Canadian Mental Health Association, BC Division

Reaching out to a homeless population affected by alcoholism is no easy task. This is a high-risk group of individuals more prone to chronic illness and mortality than the general population. They also have more frequent, more expensive and longer visits to hospitals. With mental illness, lack of social support, no home address and lengthy addiction histories, treating homeless individuals with alcohol use problems can prove to be a difficult undertaking.[1]

A team of researchers, headed by Dr. Tiina Podymow, investigated the success rates of a shelter-based managed alcohol program in reducing the harms associated with being homeless and having long-term alcohol addiction. The Managed Alcohol Project (MAP) "wet shelter" study took place in Ottawa. Results were published in the *Canadian Medical Association Journal* earlier this year.

MAP participants were mostly older males with an average of 35 years of alcohol use history and consumed an average of 46 drinks a day. Most had been homeless for more than two years before entering MAP, and all had failed or refused treatment in abstinence programs. The group averaged 13.5 visits to health emergency departments and 18.1 police reports per month.

Participants in the study lived for an average ▶

My Life with FASD | *continued from previous page*

canteen and stole pop, chips, bars and cigarettes. Well I am not the brightest criminal; I left a trail of candy bar wrappers all the way to my door from the canteen, which the police followed. By the time I was a teenager I managed to set a fire, get into trouble with the law, and found myself in jail feeling like a failure. Everything that I did I failed at and became very depressed. By this time in my life I managed to get kicked out of five schools, private school and Teen Challenge (which was for troubled teens). At this time I was thinking about suicide.

Community

When I got out of jail, I was introduced to a religious commune, and it was here that I found hope because they really cared about me. I spent four years with them, learning many things. They taught me how to meditate, which taught me patience. They moved away and I decided to look for my biological family. I ended up in Halifax, Nova Scotia living on the street for about a year and a half.

One day I went to the Friendship Centre in Halifax where I was introduced to Della Maguire and that lead me to getting diagnosed with FASD. With the help of Della the diagnosis would explain why I do some of the things I do, why I find some things just too hard to figure out and why I felt like a failure.

For more information on getting help with FASD in British Columbia, please visit the FAS/E Support Network of BC at www.fetalalcohol.com

Diagnosed

Getting diagnosed was like a weight lifted off my shoulders. Now I know I have a problem and that I am not the problem. Before I was diagnosed I had nothing to work with I didn't know how to express what I was feeling or how I even felt. I was quick to react to a problem before I thought things out. I had no ability to comprehend the consequences of my actions. All I had were feelings of hatred, anger, bitterness, resentment and fear. And my thoughts I feared most, constantly questioning my existence and swamped with thoughts of suicide. I now have something to work with, I know what my limitations are. My life has been a journey.

On my own

Currently I am living on my own in Truro, Nova Scotia. Although most of the time my struggles cannot be seen they are still there. Telling time, counting money, math, grocery shopping, cooking and laundry are a few of the areas that I have trouble with. I have a poor memory and can't remember phone numbers or names, so I have a watch that has a date book, an alarm and a calculator to use when I go shopping for groceries. I go shopping late at night because less people are at the store and I can think clearer. With my calculator I know how much my groceries will cost before I get up to the checkout.

I now work for Mi'kmaq First Nation Healing Society as a guest speaker. I share my story to help others know that there is hope and there are people out there to give you support. Della has been my support for the past 11 years. She is a national presenter on Fetal Alcohol Spectrum Disorder and each time that Della speaks I learn a little bit more about myself and it explains why I found things so difficult throughout my life time.

A Strengths-Based Look

How alcohol use is being addressed at post-secondary institutions in BC

> The BC Partners for Mental Health and Addictions Information Campus Project, funded by the Provincial Health Services Authority, supports communication within and between post-secondary institutions in BC. The Campus Project is currently working with Douglas College, University of Northern British Columbia, University of Victoria and Thompson Rivers University—chosen for regional representation—to improve mental health and decrease substance use problems.

This article focuses on some of the good things happening at post-secondary institutions to support healthier relationships with alcohol use.

Jeff Thompson

Jeff is the Campus Project Coordinator for the BC Partners for Mental Health and Addictions Information. He also provides clinical supervision to a number of agencies in Vancouver's Downtown Eastside and is a certified psychodramatist in private practice

Recognizing problems and opportunities

A recent Canadian Campus Survey (2004) found that 32% of undergraduate students drink at hazardous levels. The misuse of substances is estimated to cost the Canadian health care system four billion dollars each year.[1] There are more than 600,000 undergraduate students in Canada and 24% of Canadians have attended university. Improving health in relation to students' ▶

Harm Reduction, Alcohol and Homelessness | *continued from previous page*

of 16 months in a 15-bed wet shelter, with meals provided. Assisted by a client-care worker, they were administered up to 140 ml of wine or 90 ml of sherry, by request. A 24-hour on-call nurse was available to the shelter, and participants underwent weekly trips to the doctor. Investigators monitored alcohol intake, police reports, hospital visits, hygiene, sleeping patterns, eating habits, and medicine compliance.

Subjects were monitored for up to two years following participation in the wet shelter program. Dr. Podymow and her associates found that emergency visits to the hospital had been reduced by more than a third, with a group average of 8.1 per month. The number of police reports per month for the group also halved, with an average of 8.8. Alcohol intake drastically decreased to eight drinks daily. Participants had improved hygiene and nutrition, were able to regularly attend medical appointments, and all but two consistently took their prescription medication.

Investigators found that while the MAP cost approximately $771 per participant per month while staying in the shelter, an estimated $447 was saved monthly in emergency department services, hospital care, and police services after release from the program.

Researchers note that members of the MAP wet shelter received more supportive care than found in a typical homeless shelter. Although Dr. Podymow concedes the investigation was done with no abstinence comparison group, the harm reduction approach of wet shelters has shown to be successful. In fact, a few participants were able to continue with treatment and quit using alcohol completely. "If it wasn't for the program," one of the program's two female participants tells CBC News, "I seriously say I would've been dead by now."[2]

what is harm reduction?

Harm reduction is a public health philosophy that acknowledges the reality of certain behaviours in society. An alternative to abstinence, the harm reduction approach to addictions treatment seeks to minimize the negative effects of alcohol abuse by empowering the user to control his or her intake to a manageable level. The goal of harm reduction is to promote health and safety and reduce risk to users who are unable to quit.

related resources

> Carrigg, D. (2006, March 21). Winos may get free wine: Homeless alcoholics 'stabilized.' The Province, p. A7.
City of Vancouver drug policy coordinator Donald MacPherson has proposed an alcohol maintenance program for homeless hard-core alcoholics.

> **Drug and Alcohol Findings:** for information on wet day centres in Britain, see the website at www.drugandalcoholfindings.org.uk

> Hwang, S.W. (2006). Homelessness and harm reduction. *Canadian Medical Association Journal, 174*(1), 50-51.

footnotes

1. Podymow, T., Turnbull, J., Coyle, D. et al. (2006). Shelter-based managed alcohol administration to chronically homeless people addicted to alcohol. *Canadian Medical Association Journal, 174*(1), 45-49.

2. Ottawa program offers drinks to homeless alcoholics. (2006, January 3). *CBC News*. Retrieved from www.cbc.ca/ottawa/story/ot-shelters20060103.html

drinking habits could have considerable national impact.

Education institutions are realizing that academic performance, the individual health of students, and the health of the community are all impacted by drinking behaviour. During the year of the survey, 7% of students reported they drove a car after drinking too much. Many institutions recognize things need to improve, and they are choosing to address the problem, refuting any suggestion that excessive drinking is part of the university experience.

Supporting connection

Research by Elissa Weitzman of Harvard University found significantly fewer substance use problems where people had a sense of responsibility and connection to each other (as indicated by levels of volunteerism).[2] Volunteerism appeared to have a protective effect related to substance use problems. Promoting volunteerism and other alcohol-free social connection opportunities may help students develop support networks and strategies to deal with stress.

The Canadian Campus Survey also found fewer substance use problems with students who were living with their families.

Decreasing stress

The Canadian Campus Survey reported 29% of students had elevated levels of psychological distress—twice as high as a non-student population. Student stressors may include adapting to academic, financial, social, and environmental changes. One out of 10 students reported elevated levels of psychological distress along with hazardous levels of drinking.

Universities are attempting to decrease student stress by offering a range of services, from courses in stress management, to free yoga classes.

Promoting non-alcoholic options for socializing

So called "happy-hours" and low-priced promotions are associated with hazardous drinking practices. Many institutions prohibit advertising of low-price promotions on campus. Institutions are generally conscious about not endorsing events that support excessive drinking. A number of student residences (4%) prohibit alcohol use, while 15% of students indicated they would prefer to live in an alcohol-free residence.

Supporting the power of community and policy

Institutions are recognizing that collaboration with local communities is necessary to effectively address substance use problems, since most drinking by students occurs off-campus. Policies that prohibit low-priced alcohol sales or promotional events appear useful in decreasing substance use problems.

There is growing recognition that healthy communities contribute to individual health and vice versa. Some institutions emphasize the need for a caring on-campus community by developing policies and programs that support staff and faculty health—and by accepting a level of responsibility and developing the ability to care for students.

Listening to students

Through the Campus Project, students are being asked to join working groups to explore what can be useful in decreasing substance use problems on campus. Drawing on the expertise, creativity, insight and energy of students has been recognized as a necessary part of addressing substance use problems at post-secondary institutions. Students are in the best position to suggest what initiatives can be most effective.

In summary

By recognizing strengths presently being exercised in dealing with alcohol use problems, we are in a good position to build on them. For example, if we take the strengths of community involvement and listening to students, we could build on them by encouraging the creation of a contest, supported by the community, to solicit solutions from students toward decreasing substance use problems at post-secondary institutions.

related resources

> Kadison, R. & DiGeronimo, T.F. (2004). What are colleges doing about the crisis? And what more should be done? In *College of the overwhelmed:The campus mental health crisis and what to do about it (chapter 5).* San Francisco: Jossey-Bass.

> Potier, B. (2004). Recommendations from the Student Mental Health Task Force. *Harvard University Gazette, 6*(17), 10-12.

footnotes

1. Adlaf, E.M., Demers, A. & Gliksman, L. (Eds.) (2005). *Canadian Campus Survey 2004.* Toronto: Centre for Addiction and Mental Health.

2. Weitzman, E.R. & Kawachi, I. (2000). Giving means receiving: The protective effect of social capital on binge drinking on college campuses. *American Journal of Public Health, 90,* 1936-1939.

Al-Anon and Alateen
Support for the Supporters

Rose J.

Rose is Public Outreach Coordinator for the BC/Yukon Area Al-Anon Assembly

Have you ever tried to stop a loved one from the compulsive, self-destructive drinking of alcohol? Do you feel that you are the only one in the world with this problem? Are you angry when promises to stop drinking are broken? Do you feel that you are responsible for the drinker's behaviour?

Let me assure you that you are not alone. Feeling responsible for an alcoholic's behaviour is common in relationship dynamics with a person who has the disease of alcoholism—a disease that can be arrested, but not cured.

Like many others, I felt that everything I did and everything I did not do set my partner off on a drinking spree, and I didn't know what to do, what to say or how to react. That lasted until I attended my first Al-Anon meeting, where there were other people with whom I could identify. I was told that I do not cause my partner's drinking, and that I can neither control it, nor cure it. What a relief it was to learn that!

Caring about someone who drinks alcoholically and who becomes physically or verbally abusive can turn love into hate and make you try even harder to stop the cycle. Even when an alcoholic no longer drinks, your fear that they will start drinking again causes intense stress and worry.

Al-Anon is a worldwide organization that offers a program of recovery for the families and friends of alcoholics, whether or not the alcoholic seeks help or even recognizes the existence of a drinking problem. Al-Anon Family Groups include Alateen for teenaged members. Membership is voluntary and there is no fee for participation. The only requirement is that one's own life has been deeply affected by someone else's drinking problem.

Al-Anon teaches that alcoholism is a family illness and that changed attitudes can aid recovery. Al-Anon has one purpose: to help the families of alcoholics. This is done by welcoming and giving comfort to families of problem drinkers and those who live or have lived with an alcoholic. Members give and receive comfort and understanding to each other through the mutual exchange of experience, strength and hope. Al-Anon members also offer understanding and encouragement to the alcoholic.

At Al-Anon we learn to accept alcoholism as a threefold disease—physical, mental and spiritual. Those who live with alcoholics generally neglect their own well-being, so Al-Anon addresses members' health needs on these three levels.

Let me step back a bit. At 20, I married a man who was sometimes charming, but was very physically violent when he drank alcohol. Because of the violence, I divorced

do you need al-anon or alateen?

The following questions are designed to help you decide.[1] If you answer *yes* to three or more of these questions, Al-Anon or Alateen may help.

- Do you worry about how much someone else drinks?
- Do you have money problems because of someone else's drinking?
- Do you tell lies to cover up for someone else's drinking?
- Do you feel that if the drinker cared about you, he or she would stop drinking to please you?
- Do you blame the drinker's behaviour on his or her companions?
- Are plans frequently upset or cancelled or meals delayed because of the drinker?
- Do you make threats such as, "If you don't stop drinking, I'll leave you"?
- Do you secretly try to smell the drinker's breath?
- Are you afraid to upset someone for fear it will set off a drinking bout?
- Have you been hurt or embarrassed by a drinker's behaviour?
- Are holidays and gatherings spoiled because of drinking?
- Have you considered calling the police for help in fear of abuse?
- Do you search for hidden alcohol?
- Do you often ride in a car with someone who has been drinking?
- Have you refused social invitations out of fear or anxiety?
- Do you sometimes feel like a failure because you can't control the drinking?
- Do you think that if the drinker stopped drinking, your other problems would be solved?
- Do you ever threaten to hurt yourself to scare the drinker?
- Do you feel angry, confused or depressed most of the time?
- Do you feel there is no one who understands your problem?

footnote

1. Al-Anon Family Groups Headquarters, Inc. (2003). *Are you troubled by someone's drinking? Al-Anon is for you!* Retrieved from www.al-anon.alateen.org/pdf/S17.pdf.

Treatment
What is it? Where do I get it?

Dan Reist

Dan is Director of the Communication and Resource Unit at the Centre for Addictions Research of BC (CARBC). CARBC is a University of Victoria-based centre dedicated to research and knowledge exchange on substance use, harm reduction and addiction

You have finally admitted your drinking (or drug use) is out of control. Now what? People often talk about "treatment." But what is it? Some medication? Some procedure to fix the problem? You go to your doctor who tells you to attend Alcoholics Anonymous. Or, you talk to your priest who suggests some weekly classes at church. But you want "treatment," so someone suggests a local clinic. There you meet with a counsellor who at least starts to do an assessment. Someone is going to find out how sick you are and get you the "treatment" you need.

After several meetings with the counsellor you still haven't been given any "treatment" or sent to any hospital where they can sort out your problems. Instead, you are being asked to explore your beliefs, your feelings and your actions. When are they going to offer "treatment"? You begin to wonder if "treatment" even exists.

According to a Ministry of Health document called *Every Door Is the Right Door*,[1] you have been in treatment all along. Intervention or treatment for substance use problems should happen at several levels and along a continuum of services.

Fundamental to any effective treatment system are the social supports for individuals provided within the community. These social supports include any initiatives that influence the determinants of health for the local population, such as recreational services, faith communities, shelters, immigration services, continuing education, employment services, community centres and other social service programs. In fact, most people who recover from substance use problems never access any other formal services—that is, they do not access specialized addictions programs or see specially trained professionals.

Effective treatment involves a wide range of first responders, from school professionals to police officers, from family physicians to social workers. With proper training, these individuals can offer brief interventions, or provide referrals to other services. These first responders are also important in providing ▶

footnote

1. BC Ministry of Health Services. (2004). *Every door is the right door.* Victoria: Province of British Columbia.

Al-Anon and Alateen | *continued from previous page*

him. Like many other women, I promptly set out to find another man. And I did: a fun-loving fellow I met in the Royal Canadian Legion. He told me the night we met that he was an alcoholic and had previously been a member of AA. He was intoxicated when he told me this. After a short courtship, we married.

I tried all kinds of things in an effort to make my second husband stop drinking. I poured out his liquor, cried, threatened, and on three occasions hospitalized him when I became the violent one. I neglected my own physical health, became a raging crazy lady, and stopped seeking spiritual help. For years I complained to doctors about my husband, never attending to myself.

Eventually my husband went back to Alcoholics Anonymous. Life was better, but not without a new set of problems: I was overly watchful and untrusting of him, fearing his relapse. He had been sober for six months before I was introduced to the Al-Anon 12-step program.

We had to work hard to make our marriage work and learn how to communicate truthfully. These tasks were easier to do with the help of the AA and Al-Anon programs. The many new friends we found through these programs have helped us through the rough spots. The Al-Anon program also helped me to look after myself.

I persuaded my daughter to attend Alateen and follow the program for herself. Alateen is for children who live or have lived with a parent, sibling or grandparent who is a problem drinker. Our family became healthier in every sense, because each of us had a program to follow and to share with each other.

I encourage anyone who lives or has lived with an alcoholic to attend Al-Anon, and to send younger family members to Alateen. The problem drinker does not have to be in a recovery program for family members to attend Al-Anon or Alateen. ▮

Al-Anon can be reached at ***604-688-1716*** *(Vancouver) or through our headquarters at* ***1-888-425-2666.*** *Much of our literature is available at public libraries. See also* ***www.al-anon.alateen.org***

essential supports to people in long-term rehabilitation or community reintegration who have become disconnected from their communities. These services are vital components of treatment.

Specialized addictions services are also important, though they are only part of the treatment continuum. These specialized services include several different elements delivered in different settings. Most individuals will need only one or two components, and one setting is not necessarily better than another. Treatment might involve withdrawal management, designed to help you safely stop using alcohol or other drugs, and delivered in a hospital-like context, in a clinic, or in your home. Sometimes you will be prescribed medications to deal with short-term adjustments or to address another health condition that has been masked by your substance use. Or your doctor may suggest a maintenance dose of a safer drug than the one you have become dependent on. You may benefit from various forms of counselling or group therapy.

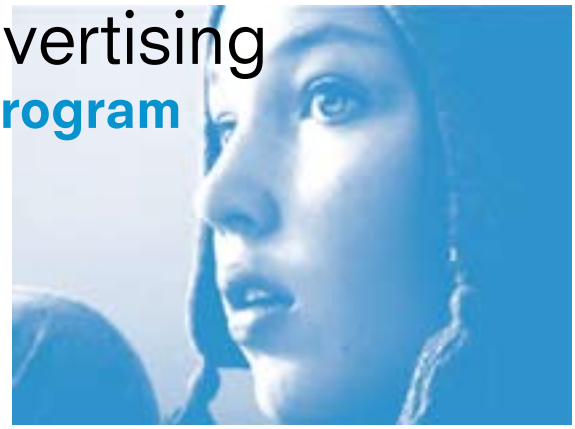
In order to address the issues that contribute to substance use problems, people need a stable residential environment. They may need to get away from their home environment for a short time. In these cases, a variety of permanent or short-term housing options are needed in addition to the more clinical components of treatment.

"Treatment" is about putting your life together in a way that makes sense and contributes to your health and the well-being of the people around you. You are wise to reach out to people who can help you sort out options for addressing your substance use and the harms it is causing.

To contact a substance use professional in your community, call the Alcohol and Drug Information and Referral Service at ***604-660-9392*** *in the Greater Vancouver area, or at* ***1-800-663-1441*** *for the rest of BC.*

Kids Deconstruct Alcohol Advertising

Through New Media Education Program



Ottawa, September 26, 2005—Media Awareness Network (MNet) today launched *The Target Is You!*—a new national education program for youth on alcohol advertising. This series of 10 lessons is designed to help young people understand the significant social and psychological effects of messages in alcohol advertising in influencing their attitudes about drinking.

"*The Target Is You!* will be a great addition to MNet's overall media education resources on a variety of marketing and advertising awareness issues," said Michelle Scarborough, MNet's Executive Director. "With over 300 lesson plans online already, MNet is bolstering its commitment to providing the widest possible array of practical tools for teachers and parents to help kids understand media."

The Target Is You!, which includes 10 lesson plans, backgrounders, overheads and student handouts and activities, was made possible by funding or support from Mothers Against Drunk Driving (MADD Canada), the Canadian Teacher's Federation (CTF) and Health Canada's Drug Strategy Community Initiatives Fund.

"MADD Canada is proud to partner with Media Awareness Network to make *The Target Is You!* a reality," said Andrew Murie, MADD Canada's Chief Executive Officer. "Young people are being overwhelmed with messages on alcohol products but receive very little information on the risks associated with alcohol. This national program gives young people the information they need to make smart choices about alcohol."

The lesson plans, available free of charge on MNet's web site, are designed for students in Grades 4 to 11 and cover a range of alcohol advertising issues including the understanding of brands, alcohol ads and sports as well as messages about gender in alcohol ads.

"This program is extremely timely and relevant for today's teachers," said Winston Carter, president of the Canadian Teachers' Federation. "Canadian teachers have often called for classroom resources in order to instill in their students critical thinking skills to help them navigate our media rich environment. Kudos—once again—to MNet for providing teachers with the tools they need to tackle, in a proactive and effective manner, the issue of alcohol advertising."

Through this new program's media education approach to alcohol-related issues, teachers are presented with a powerful and engaging new tool to reach young people. As students deconstruct and think critically about messaging in alcohol ads and compare these messages to the real consequences of drinking, educators are provided with opportunities to help them better understand and contextualize all the factors that contribute to underage drinking habits.

The Target Is You! is available on MNet's Lesson Library at www.media-awareness.ca/english/teachers

MNet is a non-profit Canadian organization whose mission is to support and encourage media and Internet education, and its widest possible integration into Canadian schools, homes and communities

related resource

Centre on Alcohol Marketing and Youth. (2004). *Clicking with Kids: Alcohol Marketing and Youth on the Internet.* Washington, DC: CAMY. See camy.org/research/internet0304/report-high.pdf

Calling the Alcohol and Drug Helpline Can Provide Impetus for Change

Hazel Smith

Hazel is Coordinator of Communications and Marketing at Information Services Vancouver

The telephone at BC's Alcohol and Drug Information and Referral Service rings often. More than 90 people each day call the 24-hour helpline looking for assistance.

The toll-free service is funded by the Ministry of Health and operated by Information Services Vancouver (ISV), a non-profit agency based in Vancouver.

ISV is an accredited provider of information and referral services, with certified staff who provide confidential assistance in the form of emotional support, practical information and referrals to a wide variety of resources. Service is available in 130 different languages, including 17 Aboriginal languages, courtesy of the multicultural staff and a professional interpretation service. Last year, enquiries exceeded 30,000.

But what many callers appreciate most about the service is that they can remain anonymous.

"People with an addiction often feel a lot of shame," explains an ISV staffer, who is also a registered clinical counsellor. "They are really scared to talk to anyone so when they've finally plucked up the courage to call and we ask them what city they're calling from, they're delighted because they realize we don't have call display, and immediately relax."

The 'relaxation' part of the helping equation is important. Once a person understands that they can't be identified—something that is especially important to people living in small communities—they are much more inclined to talk openly. This, in turn, helps propel them on to the next stage—that of getting help.

"It's only by being open with us that we can provide them with the most appropriate help," the staffer adds.

For alcoholics, the shame can be particularly acute, she says, because alcohol is a legal substance and an integral part of our culture. "People feel they should be able to handle a drink with dinner or a drink with friends after work."

ISV established the province-wide Alcohol and Drug Information and Referral Service in 1989 at the request of the provincial government. It is one of two addiction-based services operated by the agency, and one of four specialized helplines provided by ISV. The other services, which also offer 24-hour assistance and are government funded, are the Problem Gambling Help Line, VictimLINK (for victims of family and sexual violence and all other crimes) and the Youth Against Violence Line.

Alcohol has been the drug of choice for many callers over the years and is still the substance most often cited as causing problems. Approximately one third of calls involve the use or overuse of alcohol. Other substances mentioned by callers include cocaine, heroin, amphetamines, ecstasy, cannabis, LSD, prescription drugs and tobacco.

In the past, people often reached middle age before years of alcohol abuse caught up with them, but that pattern is changing. The growing popularity of multi-drug use among young people has meant that people are experiencing severe problems with addiction at a much younger age.

"We are getting more and more calls from young people concerning their multi-drug use. They're combining alcohol with cocaine—one's an 'upper,' the other a 'downer'—or alcohol with amphetamines, which is a popular choice among young women because amphetamines suppress the appetite."

Calls are often complex, with people describing scenarios involving one or more 'cross-over' issues. So a young man with an addiction to alcohol might also be using cocaine and also be facing criminal charges. Or an elderly woman may be drinking excessive amounts of alcohol to ease the emotional pain of abuse.

Because ISV's staff is trained in all aspects of addiction, as well as issues related to the agency's other specialized services, they are well equipped to respond to callers with multiple problems. ▶

> **Alcohol and Drug Information and Referral Service**
> 604-660-9382 or
> 1-800-663-1441 (outside the Lower Mainland)
>
> **Problem Gambling Help Line**
> 1-888-795-6111
>
> **VictimLINK**
> 1-800-563-0808
>
> **Youth Against Violence Line**
> 1-800-680-4264
>
> **For all services:**
> TTY (collect calls accepted) 604-875-0885
> Fax: 604-660-9415
> inform@communityinfo.bc.ca
> www.communityinfo.bc.ca
>
> ISV also publishes ***The Red Book: Directory of Services for the Lower Mainland***

‘Namgis Treatment Centre

A front-line addictions worker calls for more transition services ▶

> We lose too many people—young people in particular—to the perils of addiction because they have to wait to get into treatment, or because they have no supportive place to go to after treatment.

Alcohol and Drug Line | *continued*

Listening carefully to what a caller is saying—and what they’re not saying—and knowing the right questions to ask enables a staff person to assess the caller’s situation before exploring options with them—talking about the advantages, or otherwise, of choosing one option over another. It’s a process that helps the caller focus on his or her priorities and determine a course of action.

And with access to ISV’s large and comprehensive database of community organizations, government agencies and social services available around the province, staff can refer the person to those resources best able to meet a caller’s particular needs.

Referrals are many and varied, and often more than one is given. Referrals include (but are not limited to) residential or non-residential detoxification services, outpatient services, residential treatment facilities, support groups, counselling and education and prevention resources.

The majority of people who contact the Alcohol and Drug Information and Referral Service are looking for help for themselves. About one quarter of enquires come from people wanting to help someone else (callers may be parents, friends or colleagues), and a small number come from staff at other agencies seeking assistance for clients.

“Whoever calls us, we’re here to help,” the ISV staffer adds. “People are relieved to finally talk to someone and find that there is hope for change. It helps provide the impetus for them to take the necessary steps to get their lives back on track.” ℹ

I appreciate this opportunity to talk about the ‘Namgis Treatment Centre (NTC). I am not speaking for, or on behalf of, the ‘Namgis First Nation, but with an addictions worker’s voice from the front lines. No matter how addiction and recovery may be understood, I believe that the key to recovering from addiction is an inner decision by the individual to confront his or her problem.

It is encouraging that other health and social service professionals are becoming more informed about the nature of addiction, and about the amazing work individuals do while participating in a treatment program. People seeking help need support, not obstacles. It is a courageous step to leave home and family, often travelling many miles to be in a circle of strangers for six weeks and share your life story.

The word treatment can be broken into two meaningful words: treat and me. And the basic message spoken by those who come into treatment is: “I want to find myself and have a better life.” As a First Nation treatment centre, we apply teachings of the Medicine Wheel, which represents the cycle of life and its interconnections. We seek a balance between understanding and action in the spiritual, emotional, mental and physical aspects of our lives in order to achieve personal well-being.

The ‘Namgis Alcohol and Drug Program provides residential treatment and also serves the community with outpatient counselling, assessment and referral, and community workshops. The ‘Namgis Treatment Centre offers a six-week, co-ed residential program that has a full slate of sessions to help individuals open doors of awareness We present topics on addiction and recovery, the medical and physiological aspects of alcohol and other drug use, and relapse prevention. We hold group discussions on suicide, abuse, grief and loss, trauma and family dynamics, and include components of art therapy, yoga and relaxation breathing, recreational bowling and basketball, and arts and crafts. Participants can also choose to take part in community cultural events such as potlatch.

As an addictions worker, it is amazing and humbling to witness the changes people go through—from uncertain fear during the first week of treatment, to a dangerous hope as they celebrate completion of a program. I say dangerous hope because, even though we stress that substance use is a choice, people often return to the same social environment they came from. It can be difficult for an individual to realize that he or she is the only one who has changed. One of the greatest difficulties for those returning home from treatment is connecting with a healthy

Pat Davis

Pat is Program Manager at the ‘Namgis Treatment Centre in Alert Bay, BC

SWAP Introduces Art Therapy and LGTB-Focused Counselling

to Seniors Facing Depression

Jane Thomas

Jane is a communications consultant working with Vancouver Coastal Health

Addressing the unique needs of LGTB seniors

When Richard Matthews became clinical director of the Seniors Well Aware Program (SWAP) in October 2005, he saw a need for expanded services for lesbian, gay, transgender and bisexual (LGTB) seniors living in Vancouver's West End. He wanted to better address depression and the particular issues of shame, stigmatization, trauma and abuse that have led some seniors to use alcohol or drugs to cope.

Mr. Matthews is no stranger to addiction. He overcame his own addictions almost 25 years ago and was a SWAP counsellor in the Downtown Eastside for 10 years before taking on his current role.

"What's unique about LGTB seniors is that many have an added element of shame, because when they were younger, their sexuality wasn't as accepted in society as it is today," says Matthews.

Funded by Vancouver Coastal Health and Fraser Health authorities, SWAP is a non-profit society that has served adults 55 and older for 25 years. SWAP staff includes nurses, social workers, psychologists, addiction counsellors, art therapists and gerontologists.

The society works with about 200 clients each year across Vancouver. Its mission is to promote the physical, mental, social, environmental, sexual and spiritual well-being of seniors facing unique challenges, including social isolation, substance misuse and abuse, and elder abuse. These challenges are addressed through outreach, withdrawal management (where appropriate), and individual and group counselling, advocacy and community development.

In November 2005, SWAP hired a counsellor who specializes in LGTB issues to focus on the West End. Each of the organization's outreach counsellors sees about 20 clients on a weekly basis throughout the year.

"It's not a quick fix," says Matthews. "I believe we're dealing with many individuals whose depression—or perhaps more accurately, despondency—isn't routed in a chemical imbalance, but rather in the social conditions they've had to face. It takes time to look at their life history and put things in context." ▶

'namgis treatment centre

This residential treatment centre is located in **Alert Bay**, British Columbia, on **Cormorant Island**—a short ferry ride from Port McNeill on the northeast coast of Vancouver Island. NTC is funded by **First Nation and Inuit Health** (FNIHB) through the **National Native Alcohol and Drug Program** (NNADAP).

The NTC treatment program is primarily open to status First Nation people; however, non-status people are welcome to apply, with the condition that there is a bed available and funding has been arranged. The NTC serves those 19 years and older, who have applied through an assessment referral process.

For more information, contact the **'Namgis Treatment Centre** at 250-974-5522; e-mail PatD@namgis.bc.ca; or visit www.namgis.org.

'Namgis Treatment Centre | *continued from previous page*

and positive social network. Recovery demands patience and humility, and can get very lonely when the friends you have are not on the same path.

A treatment program for addiction is a short-term solution to what can be a deadly lifelong illness. It is said there is no cure for alcoholism and addiction: that only by "the grace of God" can one recover; that recovery is a "daily reprieve."[1]

The core message I want to express is the desperate and dire need to find facilities and develop sound pre- and post-treatment programs. We lose too many people—young people in particular—to the perils of addiction because they have to wait to get into treatment, or because they have no supportive place to go to after treatment. We need to help people get strong in early recovery. This would be a costly investment, but has the potential of immeasurable benefit. Addiction is not going away. It is destroying our youth and thus jeopardizing the future of us all. ▮

footnote

1. Alcoholics Anonymous World Services. (2001). *The Big Book.* New York: Author.

Providing a creative outlet for seniors

Counselling can be a very effective solution when facing depression. However, not everyone is comfortable talking about his or her mental health, so when Mr. Matthews learned how art was helping sex trade workers in the Downtown Eastside express themselves, he was inspired to find out more, with SWAP clients in mind.

After researching art therapy for seniors and learning there is evidence some seniors prefer, and make progress through, creative and non-verbal expression, SWAP hired two registered art therapists to carry out pilot programs.

Art therapist Debora Broadhurst has led one group, which meets for two hours each week. Participants are existing SWAP clients. They have the choice of creating with pastels, markers, collage, paints and more. Each week a new focus within the overall theme of health and wellness is introduced.

Already there have been a few breakthroughs. Within the first five weeks, participants:

- Overcame anxiety about trying this new way of expressing themselves or about experimenting with new materials
- Expressed goals and interests they wish to include in their lives again
- Expressed special memories and enjoyable activities in their lives
- Identified sensory experiences that helped them move beyond depression when they surfaced

"Putting goals down on paper helps make them more concrete," says Broadhurst. "The artwork is creative and uses imagination, which is a big change from the regular routine many people get caught up in. It's an invigorating and rewarding process."

With signs of success in Vancouver, SWAP's art therapy services have already expanded to Burnaby.

"We're encouraged that this is a useful way to help seniors in general to deal with their thoughts about mental health," says Matthews.

The Seniors Well Aware Program's mandate is to develop and deliver specialized services to clients over the age of 55 who may be experiencing problems due to misuse/abuse of alcohol, prescriptions and/or over the counter medications. For more information on SWAP in Vancouver phone 604-633-4230, in Burnaby call 604-524-8994, or for all locations e-mail swap@vrhb.bc.ca or visit www.vch.ca/swap.

A Safe Place for Women in 12-step Recovery Programs

Avalon Recovery Society

Michelle MacQuarrie

Michelle has been Coordinator at Avalon Recovery Society for the past seven years. She is 18 years in recovery for alcohol addiction

Avalon Recovery Society, established in Vancouver in 1989, is a non-profit organization dedicated to helping women in recovery from addiction. The founders, Helen Burnham and Virginia Giles, recognized a need for a place where women could get away from their drinking or drug using environments, provide support for each other and gather resources. In 1997 Avalon opened a second centre on the North Shore and the two centres now host over 100 12-step meetings each month. We provide facilities for Alcoholics Anonymous 12-step meetings, as well as other 12-step programs.

In the last few years there has been much publicity about the addiction problems in Vancouver's Downtown Eastside. While it's true that the problems are severe and the poverty level is appalling, it's also true that a very small percentage of active addicts

seniors and alcohol did you know...

- Alcohol is the drug most commonly used by older adults
- 58% of women and 73% of men over the age of 65 consume alcohol
- Alcohol use does not cause difficulties in the lives of most older adults, but:
- *6-10% of older adults experience alcohol problems*
- *the rates of problems are much higher (18-33%) among older people with mental health problems, those coming to emergency departments, and those in geriatric units*
- *only a small percentage of older adults with alcohol problems receive help*
- An alcohol problem for an older adult can be a long-standing situation, or one that developed recently. For some people, drinking has been their way of responding to crises throughout their lives
- As people age, their bodies metabolize alcohol more slowly
- Alcohol adversely interacts with over 150 medications commonly prescribed to older adults
- As with younger persons, alcohol misuse among older adults may lead to deterioration in the person's health, family and social stability, and the person's ability to cope with daily life. Alcohol problems often overlap with physical and mental health, housing, and financial difficulties

For more on understanding alcohol problems in later life as a community issue, and how to help older adults, see the Best Practice Information Sheets series (2004) at www.agingincanada.ca

Source: adapted from the Best Practice Introduction information sheet

at Avalon she found other women who had been through similar situations. she was no longer

alone

living in the Lower Mainland live in the Downtown Eastside. Addiction is an equal opportunity disease. Women suffering from the disease are daughters, mothers, wives, sisters, grandmothers, doctors, lawyers, teachers, employees and employers—of every race, every religion and all ages. The women who attend Avalon represent a true cross-section of our society and come to us from throughout the Lower Mainland of BC.

When Sandra (not her real name) first came to Avalon, her life was in complete turmoil. Her alcoholism had negatively affected all areas of her life. Her marriage was on the rocks, parenting was overwhelming, her friends and family were avoiding her, and she was in financial trouble. She was referred to Avalon by her employer after being reported as "under the influence" at work. She was drinking to deal with stress. She was sick, scared, full of guilt and shame, and had extremely low self-esteem and very little hope for the future. At Avalon she found other women who had been through similar situations. She was no longer alone. There was no pressure, no forms to fill out, no questions to answer, no fees to pay—she could just be.

Sandra wanted a different life, but wasn't sure where to begin. We encouraged her to call Vancouver Detox and put her name on the wait-list for a bed. She then called her employer and was granted a stress leave. With those two phone calls, the dam broke. Sandra couldn't stop crying, yet said she felt like the weight of the world had been lifted from her and she felt hope for the first time in years. She had been hanging on for dear life to the things that were killing her.

Sandra came to Avalon every day while waiting for a bed at Vancouver Detox, availing herself of the free childminding service during our noon-hour 12-step meeting. Then, after going through detox, she went on to an outpatient addiction treatment program, and attended meetings at Avalon on weekends.

When it was time to go back to work, Sandra had begun to make some very necessary changes in her life. She is active in a 12-step recovery program, attending drug and alcohol counselling, and working on repairing her marriage and relationships with family and friends. She participates in our professionally facilitated workshops, reads voraciously from our lending library of books dealing with addiction and recovery, and volunteers at Avalon, organizing our clothing exchange closet. Sandra is just one of the many miracles we see. Women, who thought life was hopeless, learn to respect and care for themselves, regain the trust of their families and friends, and become a part of their communities.

Recovery is an ongoing, slow process that requires time and patience. People in recovery would benefit from additional and timely resources within the community. There are waiting lists for most of the community addiction services available. The immediate availability of a detox bed, with medical support, can frequently mean the difference between recovery and ongoing addiction. While Avalon does not provide professional counselling, peer support and 12-step meetings are available immediately and on a daily basis. This can often provide the support needed during the difficult and fragile days of recovery.

Avalon liaises with community health agencies, physicians and others within the professional community on an ongoing basis. Each month Avalon attracts more women through word of mouth and referrals from doctors, counsellors, psychologists, hospitals and our own outreach efforts in the community. Last year we had over 16,000 visits from women seeking to reclaim their lives from the devastation of addiction.

After 16 years, Avalon continues to be a grassroots organization. Our ability to maintain the quality and consistency of services is a constant challenge, but worth every effort. Funding is raised through private donations from individuals, corporations, foundations and the women who visit Avalon. We do not receive government funding; the experience of others has taught us that government funding can lead to cutbacks and closures. Avalon Recovery Society's unique, warm and safe environments continue to make a difference in the lives of women in recovery and in the lives of their families.

Sobering and Assessment Centre

VIHA's Response for Victoria's At-Risk Population

George Lowery

George is Acting Coordinator of the Victoria Withdrawal Management Services, which encompasses Victoria Detox and the Sobering and Assessment Centre

Frederick has lost his wallet again. He knows that he had it with him when he left this morning, but somebody must have stolen it from him today. His dad had made him that wallet, and he sure was sad about losing it.

Frederick told staff at the Sobering and Assessment Centre (SAC) this story when he checked in for the night. He was drunk, but that is the expectation of anyone coming to SAC's door for a bed. Frederick also had some fresh cuts on his face and there was a new bruise on his forehead. SAC staff empathized with Frederick about the loss of his wallet, while the nurse tended to his fresh wounds and assessed him for further injuries. Frederick couldn't remember how he got hurt, but thought he might have fallen.

Frederick is well known to Sobering and Assessment Centre staff. He is 52 years old. He has been a regular client for some time. For as long as he has been a SAC client, Frederick has never had a wallet like the one he describes on this night. It has only been in recent weeks that he has started talking about his missing wallet; how he always has it in the morning, but loses it during his day's adventures. He isn't always sure of the time, or date, or which city he is in. He has also been falling a lot more than he used to.

SAC staff suggest that it is time for Frederick to consider detoxification. Frederick agrees, and when he wakes the next morning, he is transferred to the detox unit down the hall.

Frederick is eventually diagnosed with Korsakoff's disorder—a mental illness involving severe confusion and memory impairment, which is associated with long-term use of alcohol. He will be transferred to a supported living unit, where he will finally be off the streets.

Frederick is not a typical client at the Sobering and Assessment Centre, but he is also far from a rarity. Frederick is merely one of the many addicted individuals who access the centre for a safe, dry and warm sleep, and for a chance to clean up and be checked medically. SAC clients know that they won't be judged and will be welcomed in whatever condition they are in. They will have a chance to do their laundry, have a shower and maybe even talk about what they can do to get counselling or detox services.

The Sobering and Assessment Centre is an important part of the continuum of care for clients dealing with addictions within the Vancouver Island Health Authority (VIHA).[1] It is one of the entry points for these clients into the system if they choose to exercise that option.

In Victoria, SAC is the only community resource that provides shelter for clients who are under the influence of drugs or alcohol. Because of this, the centre has the opportunity few other points of entry have—to make changes in clients' perceptions of their habits. SAC staff see their clientele over a length of time and build relationships with them. Clients are assessed during this time, and are monitored for changes in their physical, mental and emotional health. SAC staff then work with individuals to help them make appropriate choices—something staff are able to do because of the trusting relationship that has been built with clients.

SAC staff are trained to educate clients about community resources that are available, but to do so only at a client's request. The staff know that it is a client's choice to enter recovery; when clients are ready, staff are prepared to assist them with information and guidance.

In Victoria, SAC is the only community resource that provides shelter for clients who are under the influence of drugs or alcohol. Because of this, the centre has the opportunity few other points of entry have—to make changes in clients' perceptions of their habits.

VIHA's Sobering and Assessment Centre in Victoria is unique because of its ability to act quickly once a client has made the decision to enter recovery. The Victoria Detox is physically attached to the SAC facility. Also located in the building is Pembroke Place, a longer-stay stabilization unit. Alcohol and Drug Services, which offers outpatient counselling and group work for recovery, is within a 10-minute walk away. This concentration of resources has proven to be invaluable for helping clients move through the stages of recovery when they are ready. If clients choose to continue their current lifestyle, they can do so, knowing they will receive non-judgemental care at SAC.

Frederick's story is an excellent example of the help the Sobering and Assessment Centre can provide. The sense of safety and dignity that SAC staff provides for clients is very important. The ultimate goal is that, through their interactions with clients, SAC staff empower these clients to make their own choices.

VIHA's Sobering and Assessment Centre (SAC) is located at 1125 Pembroke Street in Victoria and can be contacted by phone at 250-213-4444.

footnote

1. Vancouver Island Health Authority. (2004, February 24). *VIHA opens new Withdrawal Management Services* (news release). Retrieved from www.viha.ca/volunteer_resources/news/soberingcentre.htm.

Basic Information

- Centre for Addictions Research of BC's (CARBC) Substance Information Link: www.silink.ca. Click on 'alcohol' for the Alcohol Resource Centre.
- Prevention Source BC: www.preventionsource.org
- Alberta Alcohol and Drug Abuse Commission (AADAC), basic fact sheets on alcohol: corp.aadac.com/alcohol
- Centre for Addiction and Mental Health (CAMH), Ontario. Order alcohol publications for the public and for professionals from www.camh.net/Publications.

Organizations

this list is not comprehensive and does not imply endorsement of resources

- Centre for Addictions Research of BC: carbc.uvic.ca
- Canadian Centre for Substance Abuse: www.ccsa.ca
- AA BC/Yukon: bcyukonaa.org
- Alanon & Alateen BC/Yukon: bcyukon-al-anon.org

For community organizations, contact the BC Alcohol/Drug Referral Line at 604 660-9382 or 1-800-663-1441

Specific Populations

don't forget all the resources listed at the end of Visions articles as well

Kids and Youth

- CAMH. (2005). When a parent drinks too much alcohol... What kids want to know. www.camh.net
- CAMH. (2005). Wishes and worries: A story to help children understand a parent who drinks too much alcohol.
- LCBO and MADD (2005). Talk to your kids about alcohol. www.talktokidsaboutalcohol.ca
- CARBC. (2006). Hosting a teen party: How to deal with the alcohol question. www.silink.ca
- Alcohol Concern: www.downyourdrink.org.uk
- Adlaf, E.M., Demers, A. & Gliksman, L. (Eds.). (2005). Canadian campus survey 2004. Toronto, ON: CAMH. Type 'campus survey' into the search box at camh.net.

Women

- Brady, T.M. & Ashley, O.S. (2005). Women in substance abuse treatment: Results from the Alcohol and Drug Services Study (ADSS). Rockville, MD: SAMSHA. oas.samhsa.gov/womenTX/womenTX.pdf
- AADAC. What a Woman Should Know: Alcohol and Other Drugs and related materials: corp.aadac.com/for_women/the_basics_about_women
- Minister's Advisory Council on Women's Health. (1997). Alcohol and Other Drug Problems and BC Women. www.hlth.gov.bc.ca/whb/publications/alcohol.html

Aboriginal people

- Korhonen, M. (2004). Alcohol problems and approaches: Theories, evidence, and northern practice. Ottawa, ON: National Aboriginal Health Organization. naho.ca/english/pdf/alcohol_problems_approaches.pdf

Seniors

- AADAC. Alcohol and Seniors: corp.aadac.com/alcohol/the_basics_about_alcohol/alcohol_seniors.asp
- Training for those who care for older adults around alcohol and medication issues. CAMH. Choosing to change: A client-centred approach to alcohol and medication use by older adults; Substance Abuse Administration. Alcohol, Medication and Older Adults [online course]: pathwayscourses.samhsa.gov/aaac/aaac_toc.htm
- Alcohol and Seniors: www.agingincanada.ca. Great links provided by Charmaine Spencer, Gerontology Research Centre, Simon Fraser University.

Fetal Alcohol Spectrum Disorder

- BC Ministry of Children and Family Development. (2003). Fetal alcohol spectrum disorder: A strategic plan for British Columbia. Vancouver, BC: MCFD. www.mcf.gov.bc.ca/fasd
- Chudley, A.E., Conry, J., Cook, J.L. et al. (2005). Fetal alcohol spectrum disorder: Canadian guidelines for diagnosis. *Canadian Medical Association Journal, 172*(5), S1-S21. cmaj.ca/cgi/reprint/172/5_suppl/S1.pdf
- Public Health Agency of Canada. (2005). Fetal alcohol spectrum disorder: A framework for action. www.phac-aspc.gc.ca/publicat/fasd-fw-etcaf-ca/
- BC Reproductive Care Program. (2005). Guidelines for alcohol use in the perinatal period and fetal alcohol spectrum disorder. www.rcp.gov.bc.ca/guidelines.htm
- Canadian Centre on Substance Abuse. (2004). FAS tool kit. www.ccsa.ca/toolkit

Guidelines and Reports

- Canadian Centre on Substance Abuse. (2005). Answering the call: National framework for action to reduce the harms associated with alcohol and other drugs and substances in Canada. Ottawa, ON: Health Canada.
- Stockwell, T., Sturge, J. & Macdonald, S. (2005). Patterns of risky alcohol use in British Columbia: Results of the 2004 Canadian addictions survey. Victoria, BC: CARBC. www.carbc.uvic.ca/alcoholbulletin2005.pdf

Curious to see if your alcohol use is risky? Take the Alcohol Check Up, a short self-test at BC's addictions resource centre: www.silink.ca

BC Partners for Mental Health and Addictions Information
c/o 1200-1111 Melville St.,
Vancouver, BC Canada V6E 3V6