

Alcohol and Other Drug Problems and BC Women:

A Report to the Minister of Health
from the Minister's Advisory Council
on Women's Health

November 1997



**BRITISH
COLUMBIA**

Ministry of Health and
Ministry Responsible for Seniors

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The Minister's Advisory Council on Women's Health has a mandate to provide the
Minister of Health with information and advice critical to the promotion of
women's health in British Columbia.

Canadian Cataloguing in Publication Data
British Columbia. Minister's Advisory Council
on Women's Health.
Alcohol and other drug problems and BC women

Includes bibliographical references: p. 24
ISBN 0-7726-3421-1

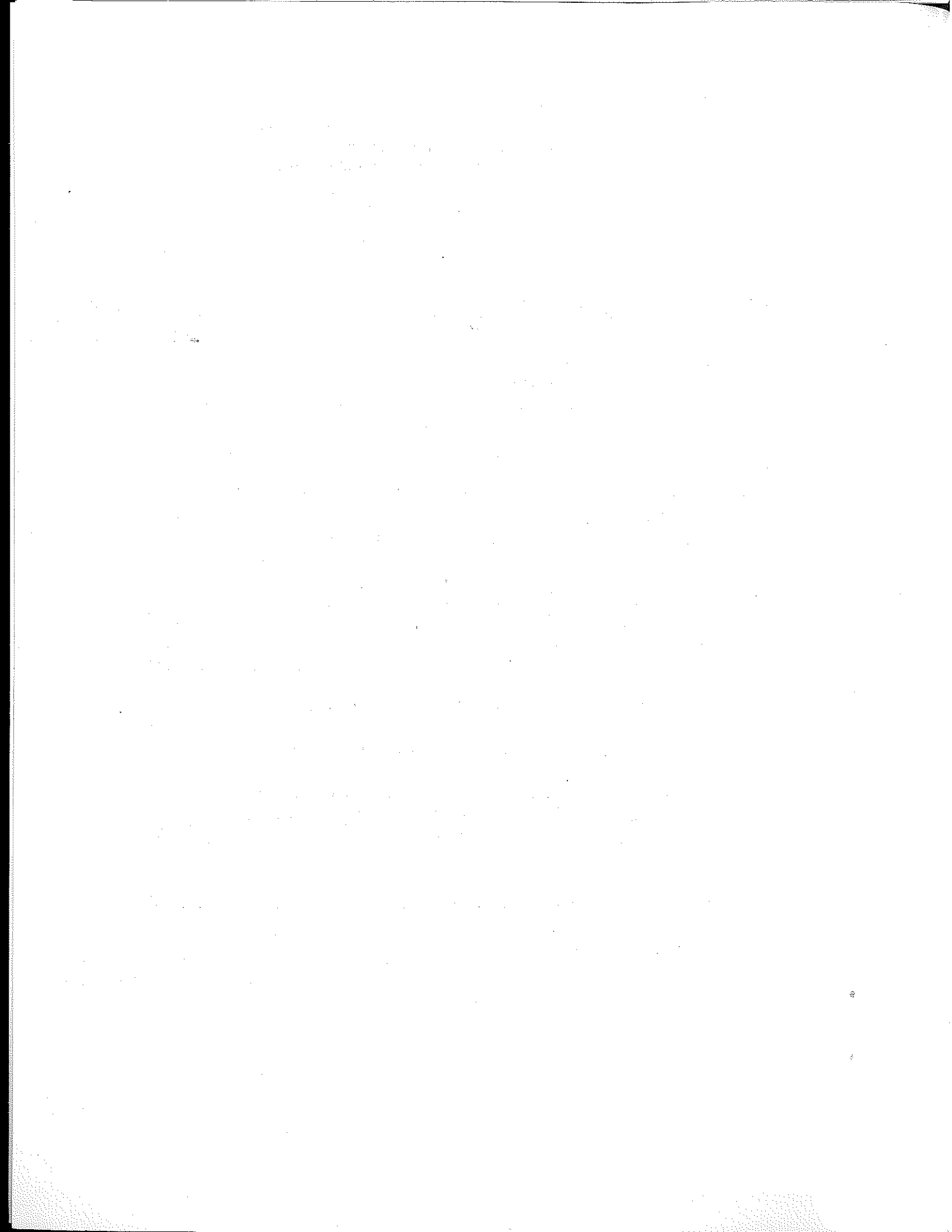
1. Women - Alcohol use - British Columbia -
Prevention. 2. Women - Drug use - British
Columbia - Prevention I. British Columbia.
Ministry of Health and Ministry Responsible for
Seniors. II. Title.

HV5137.B74 1997 362.29'18'082 C97-
960336-6

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SUMMARY OF RECOMMENDATIONS

The Minister of Health appoint an inter-ministerial, inter-sectoral working group, comprised of individuals knowledgeable on alcohol and drug issues:

- from all ministries with a stake in this issue,
- from community-based services involved in the addictions field,
- who have been personally impacted by alcohol and drug misuse, and including
- representatives of the Alcohol and Drug Services Provincial Women's Committee

to work to ensure that:

- progress made to date on prevention and treatment of alcohol and other drug problems in women is not lost through current restructuring of service delivery, and at minimum,
- further steps are taken by the ministries involved towards addressing the following urgent priorities in the areas of prevention, early intervention and treatment.

Prevention priorities:

- substance use by pregnant women
- substance use by teenaged girls
- over-prescription of tranquilizers and other mood altering prescription drugs to women of all ages, especially senior women

Early intervention priorities:

- Identify ways for the health care and human service systems to implement consistent and respectful early intervention efforts with women, towards stopping or slowing the progression of alcohol and other drug problems. Such efforts must take into account the need for service providers to be welcoming, compassionate, and respectful towards women accessing services, and supportive of the empowerment of women as informed participants in their own health care.

Withdrawal management and treatment priorities:

- Identify policies and practices which serve to create barriers to women accessing the treatment services they need to improve their own health and that of their children and work to eliminate these barriers
- Identify ways of ensuring that health/social service Regions have the expertise in place to support and enhance a managed system of care for those with alcohol and other drug problems
- Identify ways to address critical gaps in the treatment system of care for women, such as detoxification and supportive sober housing programs
- Identify ways in which communities and the lay self help movement can be supported in providing pretreatment support, popular education and consciousness raising, community development and aftercare.

A BACKGROUND ON WOMEN'S USE OF ALCOHOL AND OTHER DRUGS

i) Recent initiatives to identify and address the needs of women with substance use problems

Prior to the 1970s there existed virtually no research on women with substance use problems and virtually no gender specific treatment programming. Since the 1970s there has been a steady increase in both the quality and quantity of research on women as well as a growth in specialized women's programming. However women continue to be underserved in both prevention and treatment programs and information remains scarce in many areas.

In BC in the past five years up until spring of 1997, responsibility for programming for alcohol and other drug problems fell under the provincial Ministry of Health. During this period, significant attention was brought to the treatment needs of women and several promising initiatives were put into place. These initiatives were guided by a Provincial Women's Committee, chaired by a Women's Treatment Consultant within the Ministry. Examples of these initiatives are:

- development of specialized day treatment programming for women, which takes a holistic health approach and which addresses barriers to access, such as child minding and transportation costs (Day/Evening/Weekend Programming for Women or DEWW). It was planned that this programming would be offered in most of the 20 health regions, in line with the "closer to home" goal for provision of health services
- development and delivery of workshops for community-based service providers working on violence and abuse issues with women, along with service providers working on substance misuse issues, on the connections between these two fields. (LINK workshops)
- expanded support to the Aurora Centre to become a provincial center of excellence on women and addictions - including 25 residential treatment beds, day treatment programming, support for early intervention with women to prevent Fetal Alcohol Syndrome (FAS) and other alcohol and other drug related developmental disabilities, and support for research to enhance women's treatment program development and outcome evaluation efforts.

At the same time as these positive initiatives were being put into place by government, others were identifying that these changes in no way addressed all the needs of women with substance use problems in the province. Examples of other needs identified in this period include:

- For 1993, data from the Coroner's Office and the Office of the Provincial Medical Officer indicated that the leading cause of death for women between the ages of 30 and 34 years of age was drug overdose. In September 1994, after eight months of consultations, the Chief Coroner, Vince Cain, submitted to the Attorney General, the Report on the Task Force into Illicit Narcotic Overdose Deaths in BC. He made recommendations for expanded support for a continuum of public health and treatment services, and for extensive changes across ministries to address health determinants and support subgroups especially impacted by substance misuse. He considered women and children as one of these subgroups and opened a section on the needs of women and children with the statement that "it is clear that improved treatment options are urgently needed". He went on to make

recommendations for expanded support to specialized women's treatment programming on the levels of harm reduction, detoxification, outreach, residential and non-residential treatment and aftercare housing. He also expressed concern about the barriers to treatment for women such as:

- lack of services, long waiting lists for existing services,
- lack of support for child care while attending treatment,
- coexistence of poverty, experience of violence and abuse, marginalization, and
- fear of losing children if they identify as needing treatment.

To address these barriers he recommended:

- establishment of more treatment centers for women which include support for daycare for children whose mothers attend treatment;
 - provision of daycare, travel and financial support to mothers attending substance abuse treatment programs;
 - increasing the availability of safe, supportive housing for recovering women and their children; and
 - review of governmental policy and practices which remove children from mothers or families suffering from addiction, recognizing the threats to parents seeking treatment and the benefits of early intervention and referrals to treatment.
- In 1995, a coalition of street-involved women and service providers in Vancouver's Downtown Eastside undertook an extensive assessment of needs of women in this area. In the report *The Place to Start – Women's Health Care Priorities in Vancouver's Downtown Eastside*, they highlighted the grim inadequacy of alcohol and drug services addressing the needs for women in this area – on all levels of outreach and harm reduction, detoxification, residential and non-residential treatment and aftercare.
- This was followed in 1996 by a community research project sponsored by the regional Alcohol and Drug Services administration regarding a sobering centre or alcohol and drug crisis centre in the Downtown Eastside. See *Under Siege and Still Looking for Solutions: Results of a Community Design for a New Alcohol and Drug Service for Vancouver's Downtown Eastside*. Other regions of the province have also identified the need for more adequate detoxification services, and more adequate linkages between those providing detoxification and treatment services. A report done in 1994 for the WilpSi'satxw Community Healing Centre in Kitwanga, entitled *Detoxification: Practice and Services in Northwest British Columbia* concluded that there was: "haphazard and limited provision of detoxification services" in the Northwest and "limited and poor referral patterns to other treatment resources from agencies in contact with detoxifying clients".
- Another unmet need was identified by a coalition of hospitals and agencies in Vancouver including BC Women's, St Paul's, Sunny Hill, Sheway and the Vancouver Health Board. They applied for and received *Closer to Home* funds to examine and address the need for a more adequate response to pregnant women accessing hospital perinatal services.

In spite of the validity of the Cain and other recommendations and the support of them by the addictions field, new and consistent funding has not been allocated to implement them. In the face of historical underfunding of alcohol and other drug treatment services and no new funding over

the past 5 years, the field has been crippled in its ability to address gaps in services and emerging needs.

ii) The current context

It is in this context that the Minister's Advisory Council on Women's Health identified the need for advocacy regarding women's treatment needs.

The purpose of this report is to outline concerns and opportunities for maintaining and enhancing a system of care for women with alcohol and other drug problems or at risk of developing such problems and to make recommendations to the Minister on the role of the Ministry in acting on these concerns and opportunities.

As this report was being prepared, significant changes/upheaval to the addictions field in BC began taking place which underlined the need for articulating the need for improved services for women with alcohol and other drug problems in this province. These include:

- *Regionalization of health and social service management* – Prior to 1997, the responsibility for contract management for alcohol and drug services was relegated to 5 Regions with support from a Central Office in Victoria on issues such as ethical standards of workers, accreditation of services, information management, standards of clinical practice and promoting a managed system of care. The further recent regionalization of services and decision-making to 20 regions from 5 presents significant challenges to maintaining/promoting a managed system of care which is responsive to women's needs, much less providing expanded services.
- *Public focus on pregnant and parenting women who use substances* – Several cases involving mothers using alcohol and other drugs have been the focus of public attention. In one of these cases a Winnipeg woman who used solvents during pregnancy was taken to court by the Winnipeg Family Services in an attempt to have her declared incompetent to make decisions, and forced into treatment under their custody. This case has recently been heard by the Supreme Court of Canada. Another of these cases involved a young woman who was accessing some addiction treatment services, but who died from an overdose leaving a child found with her body six days after her death. Many other such cases exist underlining the need for more adequate approaches by social workers to support women in accessing treatment, expanded services, and increased public understanding of and compassion for women with substance use problems.
- *Move of the responsibility for Alcohol and Drug Services to the new Ministry for Children and Families* – In the spring of 1997, the responsibility for funding and management of alcohol and drug services for both adults and youth was moved to the newly created Ministry for Children and Families. While it is still too early to see all the ramifications of this move, several concerns have been identified related to the impact on access to treatment, by women.

A regrettable limitation of this report is the lack of significant attention to issues related to women and tobacco. The smoking prevention and treatment field has historically been segregated from the field dealing with other drug (including alcohol) problems. Consumers and experts agree that a more integrated approach, which builds on the strengths and successes of both fields, would be beneficial. However examination of these worthy issues are beyond the scope of this paper. The

newly funded Centre of Excellence on Women's Health has plans to examine how to support a more integrated approach on these issues to promote women's health. This document will examine issues related to the preservation and enhancement of the system of care responding to the needs of women with alcohol and drug problems other than tobacco.

iii) Levels of substance use by women

It is difficult to get accurate information on levels of use. The following levels were established through national surveys and documented in *Women's Use of Alcohol, Tobacco and other Drugs In Canada* (1996) Addiction Research Foundation of Ontario and *Horizons Two - Canadian Women's Alcohol and other Drug Use: Increasing our Understanding* (1996) Health Canada:

- Approximately 67% of women in Canada drink alcohol, making alcohol the most commonly used drug by women.
- 28% of women in Canada smoke cigarettes
- 14% of Canadian women report use of prescription pain medication.
- 5% of Canadian women report use of sleeping medication and tranquillizers.
- 3% report use of cannabis
- less than 3% report use of illicit drugs.

These surveys indicate overall levels of use which have not substantially changed over the past ten years. Recent American studies however indicate that while overall use has not increased, levels of use amongst specific sub-populations, such as pregnant women have significantly increased. We also see patterns of illicit drugs use changing over different periods of time, with heroin and cocaine 'popular' at this point. While these illicit drugs are not used at the epidemic level predicted by the American press, the individual and collective health problems related to their use are significant.

Certain groups of women have substance use patterns that differ from the general population of women. For example, young women between the ages of 20 and 24 (peak childbearing years) report they are more likely to drink 5 or more drinks on a single occasion. Women who have experienced physical and/or sexual violence are more likely than other women to take medications. Older women are very much more likely to be prescribed tranquillizers and sleeping medications.

It is estimated that approximately 10 to 20% of all those using alcohol and other drugs experience problems with use - ranging from negative consequences of occasional heavy use to dependence arising from regular and heavy use. Of course it is not only the 10% - 20% with the alcohol and other drug problems who are adversely affected by their misuse, but a broad trail of family and community members connected to these people.

While federal statistics provide a broad view of use by the general population, it is compelling to look specifically at statistics on women actually getting treatment for alcohol and other drug problems. Of the women accessing the day and residential treatment programs of the Aurora Centre in Vancouver:

- Alcohol is cited as a drug used in a problematic way by 96% of clients
- Cannabis by 72% of clients
- Nicotine by 61% of clients
- Cocaine by 61% of clients and other stimulants by 30% of clients
- Minor tranquillizers by 47% of clients
- Hallucinogens by 42% of clients,

Opiates (heroin and methadone) by 31% and other narcotics by 43%
Sedative hypnotics by 18% of clients
Inhalants by 12% of clients

iv) **Health and Economic Costs of Substance Use**

The costs of substance use are stunning. The Canadian Centre on Substance Use issued a report in 1992 entitled *The Costs of Substance Use in Canada*.

This report outlines the costs as:

- Health care system costs
- Costs of workplace programs (EAP etc)
- Costs of social welfare and related programs
- Costs of prevention and research
- Law enforcement costs
- Costs of fire and traffic accident damage
- Loss of productivity of those in/not in the workforce

For these costs in 1992 they estimated that substance use cost \$18.45 billion in Canada (\$2.3 billion for BC).

This figure in no way captures the tragic personal and social impacts of substance use to individuals and families. It does however give a sense of the tremendous opportunity to reduce health care costs (such as hospitalizations for traffic and other accidents, liver cirrhosis and withdrawing infants from alcohol and other drugs taken by their mothers during pregnancy, etc) if prevention, early intervention and treatment efforts were to be improved.

v) **Gender specific differences and the need for women-centred care**

Many gender specific factors related to women's use are now documented in the literature. For the purpose of this paper, five of these factors are briefly summarized, given their direct implications for the delivery of prevention and treatment services.

1. **Health factors related to women's use of alcohol and other drugs**

Women develop a wide range of adverse health consequences from the use and misuse of alcohol and other drugs *over shorter periods of time and with lower consumption levels than men* do. Health problems associated with women's use of substances include alcohol-related liver disease and cirrhosis, sexual dysfunction, infertility, menstrual irregularities, alcohol-related cancer, hypertension, obstructive pulmonary disease, severe malnutrition, alcohol-related cognitive deficits, plus HIV and all the other health consequences associated with injection drug use.

2. **Guilt, stigma and shame** – In the forefront of psychosocial influences on women's use and misuse of substances is the stigma arising from societal attitudes towards substance use and women. (Finkelstein et al, 1997) This societal stigma is often internalized, causing women to feel intense guilt and shame as their substance use/misuse continues. Guilt and shame also underlie the often well-founded fear that they will lose their children if their substance use becomes known to those in authority.

3. **Experience of violence and abuse** - Women experience high rates of sexual and physical violence both as a precursor and consequence of alcohol and other drug involvement. Women whose childhood histories include sexual assault are significantly more likely than women without these histories to report substance misuse as well as depression, anxiety and other mental health problems are.
 4. **Co-occurrence with mental health problems** such as depression, post traumatic stress disorder, panic disorders and eating disorders - Research has shown that as many as 2/3 of women with substance misuse problems may have a co-occurring mental health problem. Substance using women are between 3 and 4 times more likely to have an anxiety disorder than women in the general population. As mentioned above, there is a high correlation between trauma, PTSD and substance use and misuse. Substance use is correlated with eating disorders among women, especially bulimia. Approximately 40% of women accessing treatment at the Aurora Centre in Vancouver cite symptoms characteristic of eating disorders. Women with substance misuse problems are at high risk for attempting suicide and for drug overdose.
 5. **Misinformation and denial in the part of those in a position to help** - Women often encounter denial and experience negative and punitive attitudes among helping professionals. Women appearing for routine medical and prenatal care are not often identified as needing treatment. Other health, social and women's service providers are also often reluctant to discuss alcohol and other drug use on the part of women they serve and to identify women in need of treatment. Physicians also contribute to alcohol and other drug problems in women through the over prescribing and inappropriate prescribing of mood altering drugs.
- vi) **A framework for addressing women's substance use - Women-centred care and a continuum of alcohol and drug related services**

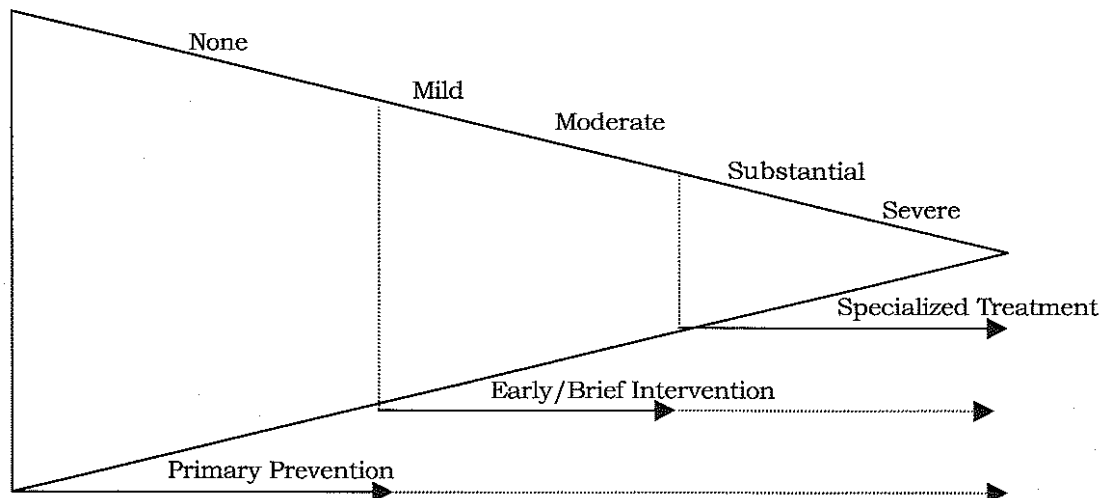
The Council believes that health care services offered to women, whether for substance use or other health problems should be *women-centred*. Women centred care:

- recognizes the importance of, and directly addresses gender differences, as described above and also
- supports the empowerment of women to be informed and active participants in their own health care, with the right to control their own bodies;
- involves women and their health care providers in an interactive process defined by mutual respect and collaboration; and as well supports women learning , and with, each other;
- responds to the diversity of women's health needs over the life cycle, and to the needs of unique populations, such as women with disabilities, lesbians and women from different cultures;
- supports participation by making the environment for delivering services accessible and welcoming (addresses literacy and childcare needs, has flexible hours, a welcoming atmosphere, non-threatening assessments, etc);
- involves holistic and comprehensive approaches, incorporating the knowledge and practices of those working in different disciplines and traditions;
- involves popular education and consciousness raising, community development and organizing to bring about positive change in the health of both men and women

This document attempts to combine these principles of women centred care with principles of care inherent in a biopsychosocial perspective to alcohol and other drug problems. In the past 10 years,

the addictions field has gradually moved from acceptance of the disease model to a biopsychosocial perspective, as its framework for understanding and acting on substance use/misuse. The graphic below provides an overview of some key assumptions of the biopsychosocial model and its implications for prevention and treatment.

Overview of Alcohol/Drug Related Problems and Corresponding Levels of Prevention/Treatment Activity

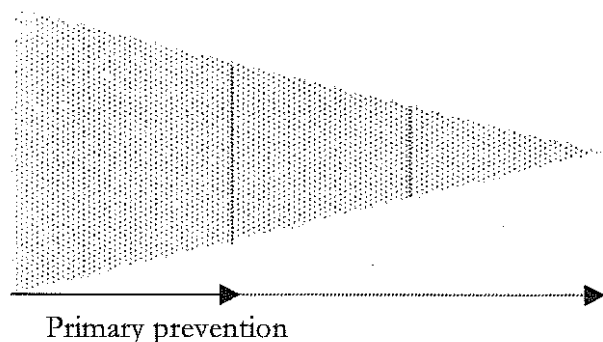


Adapted from Broadening the Base of Alcohol Treatment. (1990) Institute of Medicine, Washington DC

The triangle represents the general population, laid out according to levels of alcohol and drug problems experienced by that population. The dotted lines indicate that problems lie along a flexible continuum and that there are corresponding levels of intervention appropriate to the levels of problems experienced. The graphic is not intended to emphasize the categorization of problems but to give a sense of the scope of the need for these various levels of intervention. To be successful in addressing alcohol and drug problems, all levels of intervention are necessary - primary prevention activities for the largest proportion of the population, early intervention activities for a substantial proportion of the population, and treatment activities for the smallest proportion (estimated at up to 20% of the total) but for those with the most substantial problems.

This paper will examine prevention and treatment needs within this general framework overlaid with the perspective of women-centred care.

B ALCOHOL AND DRUG MISUSE PREVENTION PROGRAMMING DIRECTED TO WOMEN



Primary prevention describes interventions aimed at preventing a health problem from occurring.

Levels of primary prevention approaches:

- a) Individual/interpersonal/immediate environment
- b) Environmental/community-based approaches for reducing use
e.g. multi-component school-linked, community approaches
e.g. counter-advertising and promotion restriction

i) Current programming in BC towards the prevention of alcohol and other drug problems in women

- *General prevention activities undertaken by the addictions field* - To date most of the prevention work on alcohol and drug issues in BC has been done by school-based prevention workers. In addition, counsellors in outpatient clinics were funded to allocate 25% of their time into prevention work, but this did not adequately allow for extensive leadership on comprehensive, community-based prevention strategies. Funding was also provided for specialized prevention projects each year in the five former Alcohol and Drug Services Regions. No leadership on the provincial level on women and prevention has been taken other than on prevention of fetal alcohol syndrome. With the move of the responsibility for alcohol and drug services to the Ministry for Children and Families, the provincial Prevention and Health Promotion Section of the former Alcohol and Drug Services has been dismantled.
- *Prevention of impaired driving* - While impaired driving is not as significant a problem for women as for men, the high profile Counter Attack social marketing program funded through ICBC deserves mention as prevention programming.
- *Prevention directed to school-aged girls* - With the move of Alcohol and Drug Services to the Ministry for Children and Families and with regionalization of health/social services, continued support for school-based addiction prevention specialists is uncertain. Prevention initiatives if taken, may fall to nurses working in schools, who are already challenged to address health needs and who are not specialists in the area of prevention of substance misuse problems. Current prevention specialists see tremendous opportunities for building on, and expanding school-based services by: supporting peer support groups; using smoking prevention as a "way in" to discussing decision-making about other drugs; using teen parent programs to offer information about prevention of fetal alcohol syndrome; using curriculum on career and other decision making, to make links about decision making about drug use, etc. It has long been recognized that acting to support awareness, self-esteem, peer support and decision making among girls and young

women provides a solid foundation for prevention of substance misuse at this age and throughout the lifespan. The "Girl Power" prevention program developed in the US is a promising program directed to this age group and designed to prevention both substance use and victimization.

- *Prevention directed to women attending college* - The trend in universities and colleges is towards taking an active role on health promotion and substance misuse prevention through sponsoring of alcohol free events, peer support initiatives, social action theatre, wellness events, health fairs, etc. The extent of work being done in universities towards preventing alcohol and drug problems in college-aged women is beyond the scope of this paper; however it is hopeful that such programming is available to women of this age group accessing higher education.
- *Prevention (of Fetal Alcohol Syndrome) directed to women of childbearing age* - Provincial and community-based experts on FAS have been successful in advocating for support of FAS prevention initiatives targeted to women at risk. The BC Strategic Plan for Addressing Alcohol and Drug Related Developmental Disabilities is the result of a very successful partnership of governmental and community representatives towards defining and acting on prevention needs in this area. Numerous communities, both aboriginal and non-aboriginal are undertaking some excellent FAS prevention initiatives. The Liquor Distribution Branch, the BC Medical Association, the BC FAS Resource Society, the YWCA Crabtree Corner FAS Prevention Project, government ministries, and others have been/are involved in creating and distributing prevention-related materials on FAS for use by local and regional groups. Provincial coordinators funded by the BC government, and strategically placed outside of government have strongly supported the implementation of the Strategic Plan with BC communities, and provided national and international leadership on this issue. A clear commitment exists for continuing to implement the Plan through community-based prevention strategies supported by provincial coordination. The Ministry for Children and Families has just announced some funding under a *Healthy Beginnings Healthy Lives* strategy. The focus of this strategy is healthy children and it is uncertain if communities will take the approach of expanding prevention, harm reduction, early intervention and treatment of women with substance use problems, as a means to prevention of FAS under this strategy.
- *Prevention directed to senior women* - There exist several interesting short-term projects regarding the prevention of over-prescription and over-use of psychotropic medications by seniors. An example is the Better Sleep project in Victoria.
- *Prevention directed to all women* - The Provincial Women's Committee of the former Alcohol and Drug Services has discussed the need for provincial leadership on prevention of alcohol and drug problems in women, specifically the creation of materials which could be used in local and regional strategies. No action has yet been taken and it is not identified as a priority in the current context of reorganization of services.
- *A provincial prevention strategy in another jurisdiction* - The Ministry for Women's Equality has developed and implemented a very interesting prevention strategy entitled *A Safer Future for BC Women* that supports work towards the prevention of violence by community-based equality seeking organizations. It demonstrates that prevention work can be done on a very complex problem using a woman-centred approach, and one grounded in community development theory. It has four components under which equality-seeking group may seek support for prevention projects which address the root causes of violence:

- i) *Community Action* – Applicants work in partnership with a community partner (organization, institution or business) on a violence-prevention project and MWE matches funding from this partner
- ii) *School Action* - Applicants work in partnership with a school or school group to reach young people towards developing the attitudes and behaviors needed for healthy, equal relationships. MWE provide funding and the school or school group provides in-kind support.
- iii) *Speaking Up and Speaking Out* - Applicants receive funding for projects that help increase women's participation in decisions that will affect their lives.
- iv) *Change Agents* – Similar to the *Community Action* component, applicants are supported in undertaking violence prevention projects without partners when there exists discrimination, when they are working on a controversial topic, or when they are located in a community with few resources

ii) Summary of issues related to delivery of prevention services

The Advisory Council identifies that:

- Girls and women in BC are under-served by scarce alcohol and drug prevention programming.
- When prevention programming is not in place, women end up using much more expensive forms of health care (it costs \$500 to \$1000 per day to treat a woman at BC Women's Perinatal Substance Use Unit)
- Prevention efforts need to start early and continue throughout a woman's life, tied into the specific challenges facing women at each age. There is need to overlay such a life span approach with an approach which also takes into consideration those groups of women which have been traditionally under served in prevention programming – such as aboriginal women, disabled women, lesbian women, women offenders.
- Successful prevention strategies are comprehensive ones, requiring participation, cooperation and collaboration between various sectors, and an understanding of health determinants. Two examples of prevention work in BC which exemplify this approach are the Strategic Plan for Addressing Alcohol and Drug Related Developmental Disabilities and the *Safer Future for BC Women Program*
- Investigation is needed into models for effective substance use prevention programming with women that take into account: issues facing women over their life span; women's relational context and all the other biological, psychological, social and spiritual factors that influence use; and the societal and women's issues impacting on use, such as racism, stigma, sexism, poverty, violence, isolation and unemployment. It is especially important, given what is known about the relationship of guilt and shame to women's use, that models be found which begin from an empowerment, versus a deficit or shaming approach.
- Those doing prevention work on the community level need training in how to do prevention/health promotion work (beyond simply raising awareness of problems), and long term support to realize desired changes. Training is needed on approaches that focus not only on the individual woman, on her structural and relational context. Also needed is training on

how to put into place long term policies and programs that address the determinants of health (nutrition, education, housing, clean water, safe home and work environment, safe and inclusive exercise opportunities).

- Prevention work is part of a continuum of interventions needed to address the needs of those both at risk of developing alcohol and drug problems and those who already have developed these problems. Prevention initiatives must be supported without sacrificing support to treatment initiatives in the process.

"Awareness, education and the need for action must be built on a community-by-community basis. Substance use problems (including smoking) must be seen as a public health problem. Awareness is the first step. Then, individual communities need to find ways to respond and prevent problems by addressing the social factors that precipitate substance use problems, such as family violence, isolation, discrimination and inequity. Women-centred health promotion programs designed to increase empowerment and self esteem amongst rural women would be helpful."

Rural Women and Substance Use: Issues and Implications for Programming

"Substances that put the largest number of Canadians at risk are the legal ones - alcohol, tobacco and psychotherapeutic drugs."

Canada's Health Promotion Survey 1990 Technical Report, p 111

iii) Recommendations regarding prevention of alcohol and drug problems in women

Therefore, the Advisory Council recommends that:

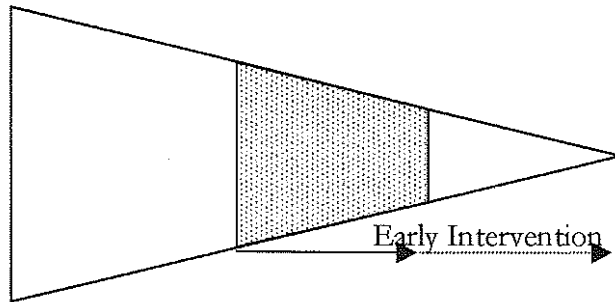
the Minister of Health appoint an inter-ministerial, inter-sectoral working group, composed of women

- knowledgeable on alcohol and drug issues from all ministries with a stake in this issue,
- from community-based services involved in the addictions field, and
- who have been personally impacted by alcohol and drug misuse, and including
- representatives of the Alcohol and Drug Services Provincial Women's Committee

to work to ensure that:

- progress made to date on prevention and treatment of alcohol and other drug problems in women is not lost through current restructuring of service delivery, and at minimum,
- further progress is made towards addressing the urgent prevention priorities:
 - Substance use by pregnant women
 - Substance use by teenaged girls
 - Over-prescription of tranquillizers and other mood altering prescription drugs to women of all ages, especially senior women

C SECONDARY PREVENTION/EARLY INTERVENTION PROGRAMMING DIRECTED TO WOMEN



Secondary prevention refers to efforts to slow or stop the progression of the problems through early detection and early treatment. The setting for early intervention efforts lies not within the specialized addictions treatment sector, but within agencies and institutions that provide health, social and other services to women.

Early intervention efforts by allied professionals/paraprofessionals involves

- identification of women with problems
- brief therapeutic attention (This will be the extent of work for those with mild to moderate problems. Brief intervention can also be useful for those with substantial problems)
- referral of those with substantial problems to treatment services.

Note the existence of specialized treatment services is the foundation of early intervention efforts. If treatment services do not exist, are not accessible, are not known/visible, then those in a position to do early intervention are unlikely to undertake it.

It is the theory of the Institute of Medicine in the USA, that if alcohol problems experienced by a population are to be reduced significantly, it is critical that we focus efforts on the largest population of drinkers, those amenable to early intervention efforts, as well as providing a spectrum of interventions that matches all levels of problems.

Broadening the Base of Treatment for Alcohol Problems, 1990

i) **Current early intervention work with women with substance use problems in BC**

- *Early intervention* is a large gap in the alcohol and drug continuum of services. Partly this is explained by the fact that historically prevention planners/policy makers/providers have seen *prevention* as work done with those without substance use problems and treatment planners/policy makers/providers have seen *treatment* as that done in specialized addiction treatment services with those with substantial problems. Thus *early intervention*, done in a range of community-based settings with those with mild to substantial problems has not been actively supported by either camp.
- While many individuals within health and social services accessed by women have/are advocating doing screening, brief counselling and referral on substance misuse issues, to date only the Pregnancy Outreach Programs have implemented policy and practice on consistent screening.

- As follow-up to his successful Doctor's Stop Smoking project, Dr Fred Bass with support from the BCMA has been investigating a broader alcohol and drug screening, brief intervention and follow-up strategy which family physicians could implement in the course of their work.
- The BC/Yukon Association of Transition Houses has plans to develop a core training module for transition house workers and workers in Children Who Witness programs on working with women with alcohol and drug problems on the part of violence workers in the context of these programs
- The Ministry for Children and Families is currently supporting a position based at the Aurora Centre to provide provincial coordination of early intervention initiatives with women to prevent FAS. The key work goal for this position is "that health professionals and paraprofessionals throughout BC will have increased understanding of maternal substance use associated risks, screening strategies, early intervention approaches and effective treatment programs and resources; and will be integrating this understanding into their ongoing work with women."

ii) Summary of issues related to delivery of early intervention

The Advisory Council identifies that:

- Women are under-served by lack of consistent early intervention efforts towards slowing or stopping the progression of alcohol and drug problems, on the part of a broad range of health service providers and others providing services to women
- Given what is known about the connection of women's substance use with other issues in their lives, early intervention on substance use issues needs to be done by a very wide range of professionals and paraprofessionals including:
 - Family Physicians
 - Physicians working in hospital settings (in emergency settings, perinatal units, on Chemical Dependency Resource Teams, etc)
 - Gynecologists
 - Public Health and other Nurses
 - Social Workers working in the child protection field
 - Those working in mental health clinics (with women with eating disorders and other mental health problems)
 - Those working in domestic violence and sexual assault victim services
 - Those working in HIV & STD services
 - Those working in family planning services
 - Those working in the Justice system
 - Those working with the elderly
 - Those working in community centres, "street" services, and shelter services
 - Those working in pregnancy outreach programs, perinatal clinics and midwifery services
 - Those offering community-based parenting groups
 - Those working in women's centres and in services working with First Nations women, lesbian women, women with disabilities,
 - Those working in debt counselling services

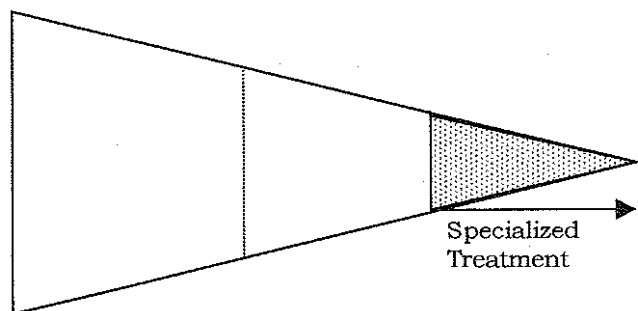
- Those working in community college and university counselling departments and health clinics
- Professionals have not been adequately trained on substance use and its treatment. Alcohol and other drug problems have not been considered legitimate health issues, despite the substantial health, social and economic impact of substance use. Substantial training on early intervention for professionals and paraprofessionals is needed. Such training must address:
 - Overcoming fears/bias and committing to taking a role
 - Building understanding of alcohol and drug use, and the many issues associated with use,
 - Building of skill in identification/screening/asking questions, skill in motivational interviewing and referral skills
- An accessible, organized, visible treatment system needs to be in place to receive those identified through early intervention efforts. Professionals and paraprofessionals will not be motivated to do brief work with women on substance use unless they perceive that an appropriate treatment system is backing them.
- During recent public debate about mandatory treatment for women using substances during pregnancy, health professionals were vocal in their opposition to making the health system a party to coercive action against women who use. A challenge in undertaking early intervention is to offer it in way that ensures that women feel safe, respected and in control of their own health, not shamed, forced into care against their will.

iii) Recommendations regarding early intervention with women

The Council recommends that the working group identified above also:

- Identify ways for the health care and human service systems to implement consistent and respectful early intervention efforts with women, towards stopping or slowing the progression of alcohol and other drug problems.
Such efforts to expand early intervention work with women, must take into account the diverse needs of all women, not only those who are parenting children or at risk of having a child affected by FAS.
Such efforts must take into account the need for service providers to be welcoming, compassionate, and respectful towards women accessing services, and supportive of the empowerment of women as informed participants in their own health care.

D DETOXIFICATION AND TREATMENT PROGRAMS DESIGNED FOR WOMEN



Treatment refers to the broad range of services including identification, brief intervention, assessment, diagnosis, counselling, medical services, psychiatric services, psychological services, social services and follow-up for persons with alcohol (and other drug) related problems. The overall goal of treatment is to reduce or eliminate the use of alcohol (and other drugs) as contributing factors to physical, psychological and social dysfunction and to arrest, retard, or reverse the process of any associated problems. *Adapted from Institute of Medicine definition*

i) Current detoxification and treatment programming in BC

The following table gives an overview of treatment services in BC in existence at the time of the transfer to the Ministry for Children and Families

Type of Service	# of programs funded at the time of transfer to MCF (direct and funded services)	# of women-specific services	Estimated demand for women for this level of care in BC each year (using Rush model)
Detoxification	17	0	4,500 to 9,000
Outpatient assessment	124	0	6,800 to 13,700
Outpatient counselling	"	0 (but many offer women's groups)	2,900 - 5,700
Case management	"	0	8,500 - 17,000
Aftercare	"	0	
Day treatment	29	22	1600 - 3200 (this is likely a low estimate, given the Ontario system did not offer much of this level of care at the time of development of the model by Rush)
Residential treatment	10	3	500 - 1000
Supportive recovery	11	9	700 - 1400 (this is likely underestimated given the different use of supportive recovery beds in BC from the half way house model used in Ontario)

ii) Issues related to providing withdrawal management and treatment services to women

1. Access to treatment services

- Barriers related to visibility of services - Given that guilt, shame, (unconscious) denial, low self esteem and depression are characteristic of women with alcohol and other drug problems, it is amazing that they do seek treatment! In this context, service providers stress the importance of having visible, free-standing services, so that when women with substance use problems are ready to examine their use, they know that services are available, and where services are located. Service providers have found it critical to their success to put significant effort into outreach to ensure that people know of their services, and to ensure that they understand they will be treated with compassion and respect when they come for service. This need for a visible and approachable service identity is in direct contradiction with the policies of MCF with its unitary mandate of child protection, lack of emphasis on parental and adult health, consolidating of services/folding alcohol and drug workers into multi-disciplinary teams, prioritizing of service to those who have child protection issues, etc
- Barriers related to confidentiality of personal information - It is no coincidence that the self help group with the most profound impact in the addictions field has the word 'anonymous' in its title. Women experiencing the guilt and shame about using, and the possible impact of their use on their parenting, need assurance that their confidentiality will be respected when accessing services. This too is compromised in the current MCF context, with the Ministry's very broad information-sharing policy.
- Economic barriers - Women face a range of personal, interpersonal, and structural barriers to recovery. An example of a structural barrier is the cost for women with low incomes for child care, housing and transportation while they attend treatment. Recently the Ministry of Human Resources issued policy that threatened support of transportation costs for women attending treatment and support for housing while attending treatment by women who are not parents.
- Barriers related to fears of child apprehension and coercive treatment - Stigma and public hostility toward pregnant and parenting women with substance use problems create significant barriers to accessing services. The recent public attention on women who were pregnant/parenting and misusing substances, and the current government reorganization have exacerbated these access problems. This has served to make women even more concerned that they will: have their children automatically apprehended if they identify as needing help; be forced into mandatory treatment if they identify as needing help; be unable to get their children back if they place them in temporary care while they seek treatment.

2. Providing different levels of care, matching women to the treatment level needed and ensuring information and people move easily with the levels of care

It is accepted that individuals experience many different kinds of problems around the consumption of alcohol and drugs. Such problems range from the hyperacute to the severely chronic, and from the mild to the extremely severe. It is also accepted that individuals that manifest these problems are themselves diverse, affecting the type of treatment they need. Thus researchers, policy makers and planners have stressed the importance of individualized assessment

of problems and matching of clients to the appropriate treatment level. This presumes an organized system of treatment services.

The multi-leveled system of services in BC has involved:

1. prevention and health promotion services
2. harm reduction programming
3. withdrawal management services and "sobering up" services
4. assessment, pretreatment counselling, matching of client to level of care needed, identification of a case manager
5. counselling and education, on an outpatient basis
6. day treatment programs
7. short term, intensive residential treatment
8. longer term residential support and rehabilitation. This level of care is used to support individuals accessing outpatient/day treatment, awaiting residential treatment and/or needing aftercare following intensive treatments.
9. aftercare and relapse prevention counselling
10. community-based self help or mutual aid groups

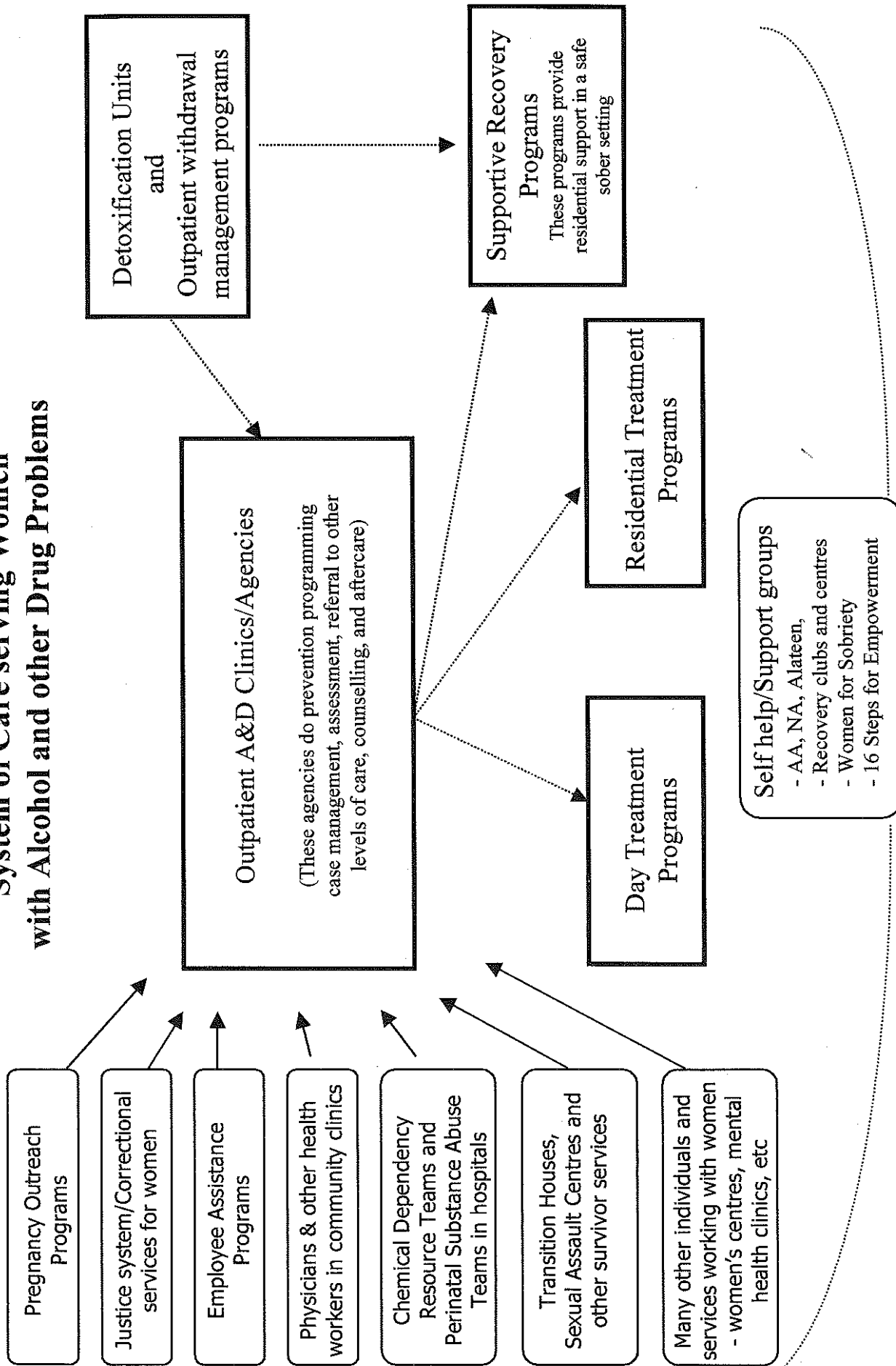
The following diagram (page 19) illustrates the provincial administrative vision for BC's system of care and case management process. This conceptualization continues to be important as a framework and represents the best knowledge of effective practice in the field to date.

However there have been major challenges to the implementation of a comprehensive, integrated in practice in BC, including:

- lack of clear definition of matching criteria to each level of care, and lack of training and direction to utilize the systemic model and matching hypothesis
- lack of certain types of care in BC (e.g. lack of support for withdrawal management services, lack of residential support beds, lack of outpatient counsellors to provide timely assessment services, case management services, and brief treatment services)
- inadequate staffing levels within some components of care such as outpatient services, so that case management and access to assessment and matching services is compromised
- lack of services for those needing immediate residential care such as pregnant women with substance use problems at risk of having a child affected by alcohol and drug related effects. As happened with the woman from Winnipeg involved in the recent Supreme Court case, a woman who is still using, yet in need of immediate supportive prenatal care, withdrawal management and treatment in a supportive setting free from alcohol and other drugs, would likely have to go on a waiting list in BC for the very limited residential care in BC, despite the policy of priority treatment for pregnant women.

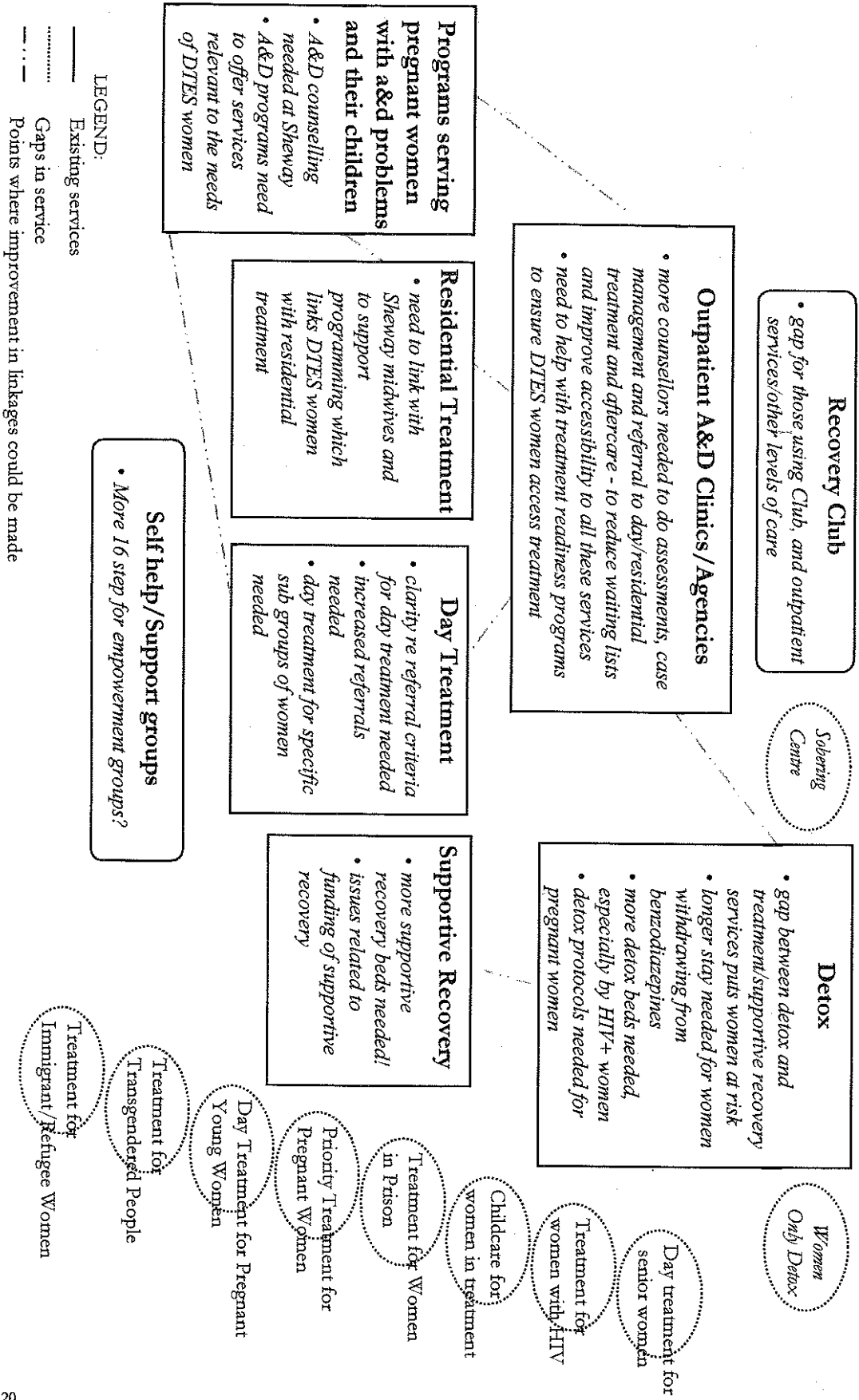
The diagram on page 20 provides an example of how these gaps in the system of care for women, were seen by service providers in Vancouver, at a meeting of the Vancouver and Area Women's Service Providers Network in March of 1996.

System of Care serving Women with Alcohol and other Drug Problems



The professional alcohol and drug field is grounded by the self help movement

Summary of Issues raised at the March 27 1996 meeting on the Continuum of Care of Alcohol and Drug Services serving Women in Vancouver Health Region



Another concern regarding the system of care for people with alcohol and other drug problems is related to recent governmental structural changes. With regionalization and the folding of alcohol and other drug services into the Ministry for Children and Families, there is no longer a management structure with expertise in alcohol and drug problems. This compromises the commitment to provide these basic levels of care, and to knowledgeably pursue improvement in the provision of a managed system of care.

3. Support for treatment providers and the lay self help movement

New information about the physiological impact of alcohol and other drugs, and on efficacy of forms of intervention (such as harm reduction) and treatment become available daily. Just as we have recommended that other professionals and paraprofessionals integrate intervention on substance use/misuse into their practice, so too do alcohol and other drug treatment providers need to integrate intervention on issues such as eating disorders, HIV and violence/abuse into their practice. Providers of prevention and treatment programming need support towards learning and integrating this current information from their own field and other fields into their ongoing practice. In the current context of regionalization and integration into MCF, this is challenging. The following quote from a service provider sums up this concern.

"There is so much to be done! We should be putting our tremendous positive energies towards improving quality of care for women with addictions problems in BC based on new research and understanding of things like harm reduction and women-centred care - not spending diminishing energies on worrying if our existing services are going to survive and how to cut back on funding and services. We (service providers in this province) are very demoralized!"

A service provider

Finally, it must be mentioned that a great strength of the addictions field is the strong self-help movement which underlies it. In our efforts to define and expand the system of care for women with alcohol and other drug problems it is important not to undermine this lay system of care, to support its ongoing development and to respect the knowledge arising from it. "Lay-organized self help approaches are effective in large part because they address the felt needs of both the providers and receivers of care - to provide is to receive, in part" (S. Ruzek and J. Hill). The lay self-help movement plays a large role in building awareness of the nature of alcohol and drug problems, in meeting early recovery needs for intensive support, and in supporting the ongoing healing and self discovery, either following formal treatment or instead of it.

iii) Recommendations regarding treatment and withdrawal management services

The Council recommends that the inter-ministerial working group advocated above:

- Identify policies and practices which create barriers to women accessing the treatment services they need to improve their own health and that of their children, and work to eliminate these barriers

- Identify ways of ensuring that health/social service Regions have the expertise in place to support and enhance a managed system of care for women with alcohol and other drug problems,
- Identify ways to address critical gaps in the treatment system of care for women such as detoxification and supportive sober housing programs.
- Identify ways in which communities and the lay self help movement can be supported in providing pretreatment support, popular education and consciousness raising, community development and aftercare

E EPILOGUE

On October 5, 1997, the Minister's Advisory Council on Women's Health sponsored a discussion session with northern women in Prince Rupert. The session was jointly organized with the First Nations Women's Group of Prince Rupert and also involved representatives from Regional Health Boards and Councils. The concepts and recommendations outlined in this paper were considered by the over 50 women in attendance representing aboriginal and non-aboriginal services working with women in the Northwest.

This group brought the following important additional perspectives to the issues and recommendations made:

On prevention and healing

- The health system needs to be more accountable, by providing health care that supports healing on the levels of body, mind and spirit, and supports preventative care. This means that more resources need to be allocated to prevention activities and alternative healing options. Preventative health care is very important for our planet, families and communities.
- We need to build awareness of health issues and responsibility for our health through an approach that is compassionate, non-judgmental and healing. A healing approach supports the opening of people's hearts, belief in oneself and one's ability to be healthy, and self-responsibility for acting on health issues.

On early intervention

There are many obstacles to care for northern women, which require community responses including:

- on-reserve/off-reserve service delivery issues
- lack of financial support for treatment in court-mandated situations
- individual social workers having the power to decide who is referred to treatment
- lack of services in rural areas, lack of continuity in care, need to leave community for care, resulting in lack of access to children and supports during critical times in treatment
- lack of information on which to base choices regarding care and alternative care

- turnover/burnout in service providers making for lack of consistency in care, from referral to aftercare
- lack of confidentiality in small centers, and likelihood of family members working in the services to be accessed

On treatment, rehabilitation, healing, aftercare and employment training

- Beyond treatment, we need to think into terms of "healing" and "rehabilitation", which involve not only treatment for substance misuse, but also an ongoing process of inner growth, self-discovery, self-transformation and community reconciliation and integration.
- In order for rehabilitation to be achieved, the community needs to respond to women returning to a community after treatment, so that she feels valued, is able to find meaningful work, and make her contribution towards a better, healthier community.
- Community service providers and physicians must have the trust of the community, cultural sensitivity, significant knowledge of how to support those who are detoxing, knowledge of women-centered care. Support workers carry a heavy load and frequently burnout.
- We need examine the challenges inherent in achieving the three goals of protecting children, supporting parents to get appropriate treatment and keeping families together. This is especially problematic when child protection workers are the gatekeepers to the treatment system for women with alcohol and other drug problems.
- First Nations people have unique issues to be addressed when reconciling their past, present and future, unique voices to be claimed in recovery, and need for strong communities to support their recovery.
- Communities, governments, employers and unions in northern communities need to address the need for useful job training, creation of new types of jobs, and an end to discrimination against those recovery from substance misuse.
- New modalities of treating people with alcohol and other drug problems need to be explored, modalities which can be delivered in the community, rather than forcing people to leave their communities for care. "Support centers" are an option to explore, which could provide temporary child care, temporary housing, help with financial needs, self help groups, structured activities, recreation for women and children, drop-in counselling, and referrals to other services when necessary. Such centers could support empowerment and community integration, and address fundamental problems in the context where these problems arise.

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List of People Consulted

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Those contacted regarding early intervention:

Representatives of Pregnancy Outreach Programs at their annual conference in May 1997
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Janet Amos - developer of the LINK educational materials
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Angie Todd-Dennis, Association of First Nations Women
Monika Chappell, DAWN Canada
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Laurie Drabble, consultant with California coalition which developed training for social workers on
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Those contacted regarding treatment and women-centered care:

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Robin Barnett, Health Promotion, BC Women's