



Alcohol Problems and Approaches: Theories, Evidence and Northern Practice

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NOTE

The information offered in this paper is intended for educational and informational purposes only. NAHO does not offer medical or treatment advice. Any treatment information provided in this paper is not a substitute for a professional medical opinion. The views expressed in this paper do not necessarily reflect those of all Inuit or Inuit organizations.

EXECUTIVE SUMMARY

Inuit communities and regional governments/organizations have identified alcohol abuse as a priority problem. Binge drinking, the predominant pattern in Inuit areas, is a major factor in violence, accidents and injury, employment and family problems, unwanted sexual contacts, etc. However, communities have also indicated they have little alcohol-related information. Inuit Tapiriit Kanatami has said it has no comprehensive information about alcohol issues and treatment.

The purpose of this paper is to provide essential information about alcohol problems, theories about causes and evidence-based best practices in alcohol problem treatment and prevention. Treatment practice in Inuit communities is also examined so gaps in service can be identified. The paper is also intended to be of some practical use by providing basic information about the process and content of effective alcohol services. A glossary of relevant terms is included.

The nature of alcohol problems is explained. The evidence emphasizes that there are a wide variety of problems ranging from mild to severe. (For this reason, the terms “alcohol problems,” “alcohol misuse,” and “harmful drinking” are now preferred among experts and service providers. The terms “alcoholism” and “addiction” imply there is only one kind of alcohol problem, and that all alcohol problems are addiction. The medical terms are “alcohol abuse” and “alcohol dependence.”) Alcohol problems are not always progressive. Most problem drinkers are not physically addicted. Differences between dependence and abuse are described.

The primary theories of cause are summarized:

- disease theory says alcohol problems result in people who have an innate disease that gets worse, which makes it impossible for them to control their alcohol use;
- biological theory says there are genetic and chemical factors in at least some alcohol problems, although details are not yet understood;
- psychosocial theory says learning, social, and environmental conditions and personal psychological factors lead people to alcohol abuse.

Evidence now shows that a complex combination of biological, psychological, and social factors underlies drinking problems.

People also want different kinds of changes: some need abstinence and others just want or need to control their drinking. Many people change their problem drinking without help, but many people need guidance. No one method works for everybody. The main strategies for helping people change their drinking are described.

National and international best practices for treatment and prevention are outlined. The overall recommendation in all best practice reports is that a flexible program of harm reduction strategies (including both moderation and abstinence) and safe-drinking education is necessary.

Finally, information has been gathered about treatment and prevention services in Inuit regions. Conclusions indicate there are serious inadequacies in knowledge, services, and counsellor skills. However, there is also an understanding of the need for change, and efforts are being undertaken to improve service.

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INTRODUCTION

Despite alcohol-control measures such as restricted and dry communities, counselling services, Alcoholics Anonymous self-help groups, and referrals to residential treatment programs, alcohol misuse and alcohol-fuelled problems continue to plague Inuit communities.

Peter Bjerregard and T. Kue Young (1998, p. 158) state:

Misuse of alcohol has many effects on health but in Inuit the most important are accidents and violence resulting in cuts, bruises, fractures, head injuries, etc. Drownings, falls, frostbite, burns and pneumonia are other results of intoxication and there is a direct association between alcohol misuse and suicides. In a longer perspective, drinking also leads to social problems in the home such as spouse and child abuse or family breakup, and to economic problems and loss of jobs due to instability at work. Finally, fetal alcohol syndrome is a serious condition of infants whose mothers have consumed large amounts of alcohol during pregnancy.

They indicate most problems in Inuit communities result from a drinking spree/binge pattern rather than from the effects of sustained excessive consumption over years (that is, what is generally described as alcoholism). Although some research shows more Inuit are abstinent and those who drink do so less often than non-Inuit (Government of Northwest Territories, 1996), it is the quantity in binge drinking that results in problems.

Alcohol misuse and dependence are separate issues, but “even mild to moderate [alcohol] problems can cause substantial damage to individuals, their families and the community” (American Psychological Association, 2001, p. 1). The major role of alcohol in a wide variety of personal, family, and social problems is known and acknowledged by Inuit communities, governments, and agencies.

The issues of alcohol misuse, dependence, control, and treatment have produced emotionally charged debate and controversy because there are different beliefs about why alcohol problems happen. Different beliefs about causes lead to different beliefs about how to treat alcohol misuse. Whatever beliefs are accepted as true by community members, leaders and decision-makers will influence what kind of help is and is not made available. People also do not necessarily know the full range of helpful programs.

Inuit Tapiriit Kanatami (ITK) states there is no comprehensive and central base of information for Inuit about alcohol generally and alcohol programs and initiatives in Inuit regions, although alcohol is recognized as a major problem in their reports.

Pauktuutit Inuit Women’s Association (2001) published a report for Health Canada on alcohol and drug abuse programs in the North. The study surveyed community alcohol/drug helpers about available resources, support and training, as well as their needs. The majority indicated a need for more information and resources for themselves and their clients. The National Native Alcohol and Drug Abuse Program (NNADAP) (1998) review stated that problem drinking was rated as the most serious concern in communities. In the regional workshops conducted by the National Aboriginal Health Organization’s Inuit (now Ajunnginiq) Centre in 2002, Inuit communities across Canada identified alcohol problems as a major concern in personal, family, and community health. They also stressed a great need for information and education about alcohol’s effects and helpful counselling for alcohol problems.

This paper has been prepared as a first step towards filling those information gaps. Its purpose is to provide information about what is known about alcohol problems and what is happening in Inuit areas. The intended usefulness is fourfold:

- to provide evidence-based information about alcohol, alcohol problems and treatment approaches;
- to provide general information about current alcohol services and future initiatives in all Inuit regions;
- to identify positive initiatives; and
- to identify areas of concern and gaps.

From such knowledge, individuals and communities may be able to develop effective and appropriate ways to control the devastating effects of alcohol problems.

Because alcohol is a primary factor in such a large variety of problem behaviours and consequences, the focus is on alcohol specifically rather than on related issues such as fetal alcohol disorders or other abused substances. A comprehensive survey of alcohol approaches and best/better practices may provide new viewpoints and directions for such related issues. The relationship between mental illness and alcohol problems in some people is also acknowledged, but those issues of concurrent problems require greater discussion than is possible in this report.

A bibliography of sources consulted and cited is included. Tear-out appendices include useful web links and basic alcohol information.

Methodology

A literature review was conducted of web-based and published materials concerning alcohol abuse/dependence theories, research and evaluation studies, and current best practices and recommendations. Information gathered included research-based books and articles, historical documents, government reports and publications, and information/discussion papers by relevant agencies and associations. The literature review included North American, circumpolar and international documents including information from Greenland where the population is primarily Inuit and from New Zealand and Australia, which have Aboriginal populations with related issues.

The literature review was supplemented by information and discussions presented at the 46th Conference of the International Council on Alcohol and Addictions (Toronto, October 2003) regarding current alcohol/drug research, policy, prevention and intervention; and at the Canada Northwest Fetal Alcohol Spectrum Disorder conference in Winnipeg, Nov. 19 to 21, 2003.

Reports of territorial/provincial governments in areas with Inuit populations and of the National Native Alcohol and Drug Abuse Program were also examined.

Newspaper articles (*Nunatsiaq News*, *News North*, *Inuvik Drum*, *The Labradorian*, etc.) provided a general picture of community and individual perceptions of needs and knowledge regarding alcohol problems and treatment.

Further information was collected in face-to-face, telephone and/or e-mail contacts with:

- treatment centres in Ottawa and Nunavik;
- community programs in Nunavik and Nunavut;
- Pauktuutit;
- Labrador Inuit Health Commission;
- Inuvialuit Regional Corporation;

- government health and social services departments from Northwest Territories, Nunavik, Nunavut and Greenland;
- training and certification institutions.

Information and examples of materials for community alcohol education were also gathered from national and international web sources, the national Centre for Addiction and Mental Health, and at conferences.

ALCOHOL USE AND PROBLEMS: KNOWLEDGE AND THEORIES

In the past, ideas about alcohol problems and their treatment were mainly based on theories¹ and personal experiences. There was not much research about what was actually happening in many people's lives. Many of our beliefs and treatment programs have been based on those theories and personal experiences. For example, many people and some theories tend to think there is only one kind of alcohol problem, which they generally call alcoholism or addiction. However, in the last 20 years there has been much research and new knowledge. For example, there is a wide variety of problem drinking causes, behaviours, patterns, and methods of change. However, the spread of new knowledge takes time. To give effective help, counsellors need to update their knowledge as new research becomes available. H.E. Doweiko (1996, p. 10) points out there is confusion even among health care and mental health professionals. "Unfortunately, even today there are those who continue to confuse the abuse of a chemical with the more serious problem of addiction."

A Brief History of Alcohol Use

*"Alcohol came [to Inuit] in a brown paper bag with no instructions."
Leah Inutiq (personal communication)*

The world discovered alcohol many thousands of years ago through its natural occurrence in decaying fruit or fermenting bowls of grain in which air-borne yeasts and natural sugars combined. Though the discovery of alcoholic drinks may have been accidental, humans soon learned how to deliberately produce it. Alcoholic beverages became common in virtually all cultures. (The earliest recipe ever found, from more than 5,000 years ago in the region that is modern Iraq, was not for food but for beer). Alcoholic drinks were universally used as an everyday drink, as medicine, as part of social celebrations and feasts, as a means of conflict resolution, and for spiritual purposes. Heavy drinking and even intoxication were not necessarily seen as problems as long as drinkers behaved in whatever way had been set up as acceptable.

Although it is often said Aboriginal Peoples in North America did not know alcohol before the arrival of the Europeans (Smart and Ogbourne, 1986), alcoholic drinks had in fact been produced by at least some tribes from South America to the Plains. Such groups used alcohol primarily in rituals and ceremonies. As was the case with other psychoactive drugs, use was strictly regulated.

All humans seem to have a need for occasional altered consciousness, in social gatherings or for spiritual purposes. Alcohol has been the most common means for achieving that end. But the negative effects were also known. For that reason, all cultures developed rules about appropriate

¹ A theory is an idea or explanation that seems to make sense based on certain observations, but that has not been proven to be true.

use including rules about acceptable and unacceptable intoxication (French, 2000; Heath, 1995; Social Issues Research Centre [SIRC], 1998; and others).

However, Inuit were one culture that had no exposure to alcohol until Europeans arrived. This is probably because their physical environment did not provide the essential ingredients and conditions necessary for alcohol production. (Non-alcoholic fermentation in meat (such as walrus) is produced by a different process, by enzymes in the meat itself.) Thus, they had no physical experience of the effects and no guidelines about how to drink and how not to drink. Cultures that are comfortable with alcohol and have included its regular use in healthy ways have the lowest incidence of alcohol problems (southern Europe and Jews, for example). However, the main role models for Inuit were traders and whalers primarily from Northern Europe, which had historically developed a binge model of drinking (Engs, 1995; Vallee, 1998; Heath, 1995).

Alcohol Problems

Most Canadians drink alcohol at least sometimes. Most people who drink, drink moderately without physical, personal or social problems. Canadian surveys (Statistics Canada, 1999; Single et al, 1994) show that about 2.5 per cent of Canadians drink at levels that indicate dependence and about nine per cent say they have alcohol problems. Overall, about 24 per cent drink more than is recommended as low-risk drinking. Low-risk drinking means drinking at a level that is unlikely to produce any physical, personal, or social problems. (Guidelines for low-risk drinking, as suggested by the Centre for Addiction and Mental Health, are listed in Appendix 1.)

Most people probably do not know that problem drinking and addiction are not the same. People who abuse alcohol are not necessarily addicted. Researchers and experts now emphasize that alcohol problems range along a continuum from mild to severe. An example of a mild alcohol problem might be habitual Friday-after-work drinking that results in regular Saturday-morning hangovers. The most severe problems are physical dependence and life-threatening physical consequences of heavy drinking such as liver disease.

The term alcoholic is increasingly seen as an unhelpful label because it is often thought of as a negative judgment. Being labelled as an alcoholic may therefore discourage people from seeking help even when they know they have a problem. The terms that are used formally by the medical profession, researchers and experts are alcohol dependence for those who are physically addicted and alcohol abuse or harmful drinking for people who are not physically addicted, but whose drinking causes varying degrees of personal, family, economic, and social problems in their lives. Most people who have alcohol problems are not dependent. Not even all of those who have serious problems because of their drinking are dependent. Estimates are that there are about four times as many problem drinkers as there are addicts.

There is no clear definition of addiction. However, both in North America and internationally (e.g., the World Health Organization), the medical profession and researchers have developed specific criteria used in diagnosing both alcohol dependence and abuse/harmful use. These criteria have changed over the years. Experts say more research is needed to develop more accurate concepts. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (1994) and the World Health Organization's International Classification of Mental and Behavioural Disorders (1992) describe the criteria that are used right now:

- Abuse/Harmful Drinking: One or more of these symptoms/behaviours must have been present for at least one year:

- not following through on obligations and responsibilities (e.g., repeated absences from work or school, neglecting home and children);
- legal problems (e.g., being arrested for public drunkenness, assaults while drunk);
- dangerous behaviour while drunk (e.g., driving)
- social or interpersonal problems that involve drinking (e.g., violence, arguments with spouse about drinking); and
- high daily consumption, binge drinking, frequent heavy drinking.
- Dependence: Any or all of the above behaviours, but also three or more of the following characteristics:
 - tolerance (drinking more and more before the effects show);
 - two or more withdrawal symptoms if drinking is suddenly stopped (heavy sweating, hand tremors, nausea and vomiting, hallucinations, agitation, anxiety, and seizures);
 - regularly drinking more or longer than intended;
 - frequent desire to cut down and/or unsuccessful efforts to cut down;
 - spending a lot of time thinking about, getting, drinking, or recovering from alcohol;
 - giving up other previously important activities in order to drink; and
 - continuing to drink even though s/he already has a physical or psychological problem caused by alcohol.

Tolerance (the need to drink more to achieve the same high) and withdrawal symptoms if drinking is suddenly stopped are especially characteristic of dependence (American Psychological Association, 2001). Addiction, then, is uncontrollable, compulsive alcohol craving, seeking, and use even when the person is experiencing negative health and social consequences. A person only becomes dependent if s/he drinks heavily² and regularly.

M. Schuckit et al. (2001) describe three studies that had follow-ups ranging up to five years. Only a small percentage of people who had been diagnosed with alcohol abuse had moved on to become dependent on alcohol even though they continued to drink. Half to a third were still drinking in harmful ways. In other words, these studies and others indicate that alcohol abuse does not usually progress to alcohol dependence.

Habituation

People who drink can become habituated to the use of alcohol under certain circumstances. For example, they may develop the habit of drinking to relieve stress or drinking heavily when out with certain friends. Habituation is a kind of psychological dependence, but it is not the same as physical dependence. Psychological dependence is learned and does not fit with the medical criteria of dependence (Doweiko, 1996; Ogilvie, 2001). A person who feels the need to have one drink every day after work to unwind is psychologically habituated or dependent on that drink. Being psychologically dependent on one drink is not a problem. But the person who is habituated to getting drunk whenever they feel stressed has a problem.

² Heavy drinking is not easily defined because the effects of alcohol depend on a variety of factors: gender, weight, etc. Generally, however, Canadian low-risk guidelines say men should not drink more than 14 drinks a week, women no more than nine, spread out during the week (Centre for Addiction and Mental Health, 2000b). No one should ever drink to the point of drunkenness. The more often a person drinks more than the guidelines, or the more often a person drinks to the point of drunkenness, the greater the risk.

People who are physically dependent lose the physical need for alcohol after only a few days of withdrawal. However, they may resume problem drinking because of habituation that is triggered by certain cues. Cues are psychological or environmental events the person has learned to use as reasons for drinking. Cues can be anything: seeing a certain friend, arguing with the spouse, feeling anxious, thinking about past abuse, etc.

The term addiction is therefore often applied to describe this psychological habituation. H. Ogilvie (2001, p. 77) quotes S. Peele and A. Brodsky's definition of addiction as:

. . . a habitual response and a source of gratification or security. It is a way of coping with internal feelings and external pressures . . . A person is vulnerable to addiction when that person feels a lack of satisfaction in life, an absence of intimacy or strong connections to other people, a lack of self-confidence or compelling interests, or a loss of hope.

Binge Drinking

For the North, it is important to understand the destructive pattern called binge drinking, which is the most common form of alcohol abuse in the North (Bjerregaard and Kue, 1998; Hodgins, 1997; Government of the Northwest Territories, 1996; National Native Addictions Partnership, 2000). There is disagreement about the definition of binge drinking, but the Centre for Addiction and Mental Health (2002b) and most other North American organizations define it as five or more drinks on any one drinking occasion. In practical terms, it refers to a specific episode of heavy drinking leading to intoxication. Between binges, the person drinks at low levels or does not drink at all. This is a typical pattern in the North. For example, a person does not drink at all in a restricted or dry home community, but when s/he visits a community where there is a bar, s/he drinks to intoxication. Or a person does not drink during the week, but socializes on weekends by getting drunk.

Binge drinking is not a sign of physical dependence and does not usually lead to dependence. However, it has the most serious social and behavioural effects. It is a habit that many people have learned and may find difficult to change. Studies around the world show that fights and violence, suicide, family and employment problems, accidents and injuries, property damage, problems with police, etc. are usually the result of binge drinking. Binge drinking by a pregnant woman is also the most dangerous for the developing fetus. Many countries are therefore focusing their efforts on preventing this pattern of heavy drinking to intoxication (World Health Organization, 1999).

Causes: Theories and Debates

There are different ideas and sometimes strong disagreement about what causes alcohol problems. The biggest and most emotional controversy is between those who say the cause is an incurable, progressive, primary disease and those who say it is not a disease, but a behaviour disorder that includes different kinds of problems.

A number of theories have been suggested over the years. Each one seems to make sense in some ways. However, each theory has also been shown to be inadequate in explaining all situations. E.J. Khantzian (2001, p. 1) points out that even the process and duration of addiction/dependence are not clear:

For some, addictive illness takes an unrelenting devastating course with all the characteristics of a malignant disease; for others dependency on substances seems to be symptomatically related to a stressful or distressful phase of a person's life and the reliance on drugs or alcohol is transitory and a temporary aberration; and yet for others they simply chose to stop for reasons that are not always clear.

Researchers simply do not know exactly why some people develop alcohol abuse and dependence and others do not, even under similar circumstances.

Human behaviour and the reasons for behaviour are complicated. Today, researchers and experts agree that, whether or not a disease is involved, alcohol abuse and dependency are based on biopsychosocial determinants—problems resulting from a complex interaction of an individual's biological, psychological, cognitive (beliefs, thoughts, learning), and environmental (social, cultural, economic etc.) factors.

Biological Theories

There is more and more research indicating that genetic and other biological factors are involved in the development of dependence. The World Health Organization (2004) has recently published a thorough summary of the latest research about the brain's role in such addiction.

There is evidence that some people, especially males who have dependent family members, may have some kind of genetic predisposition to developing problems. This does not mean the person will definitely become addicted. In fact, most people from families with alcohol problems or dependence do not develop problems. However, s/he may have inherited certain genetic characteristics that put him/her at higher risk of developing alcohol dependency if s/he drinks heavily. Scientists do not yet understand how or why this possible genetic factor affects some individuals. (Studies of identical twins from such families show that even if one twin has alcohol problems, in half the cases, the other does not. Why does one twin develop a problem and the other does not even though their genetic inheritance is the same?)

There is evidence that certain kinds of brain chemistry are involved in addictions and other compulsive behaviours in some people (World Health Organization, 2004). For example, brain chemicals such as dopamine and serotonin seem to be especially implicated in a variety of ways. Lower levels of dopamine are related with stress. Higher levels are involved in feelings of pleasure. Alcohol can temporarily increase dopamine, making a person feel good. S/he may then use alcohol again to get that same feeling. Frequent heavy drinking seems to interfere in normal brain function and brain chemistry.

Heavy alcohol consumption, especially when combined with poor nutrition, also leads to abnormalities in the liver and pancreas, which are essential in processing vitamins, proteins and other nutrients (National Library of Medicine and National Institutes of Health, 2004b). Nutritional deficiencies lead to physical problems and can cause depression and anxiety because of chemical imbalances. These may then lead to further drinking as a way of self-medicating.

There is also evidence that shows differences in the way people's bodies process alcohol (Rotgers, Kern, and Hoeltzel, 2002). For example, it is known that women are more likely to develop serious physical problems (liver, etc.) than men and sooner. Some women seem to be deficient in a certain enzyme that is involved in metabolizing alcohol. Some studies show that certain people who eventually develop dependence are more able to handle alcohol right from

the beginning. They can drink much more than other people before they show signs of drunkenness. Perhaps because they can drink more before feeling the effects, they in fact do drink more.

Researchers do not fully understand what kind of genetic and biological differences are involved, how the differences lead to an increased risk of alcohol dependence, or even if they definitely do lead to dependence. It is not just simply that there is a gene that causes alcoholism or that alcohol problems are inherited. Rather, it is likely that there may be a variety of genes, biological characteristics, and complex indirect interactions that, in combination with other circumstances, may lead to alcohol dependence in a specific individual. All researchers emphasize that biological factors alone do not fully explain addiction. Biology always combines with social, environmental, and individual psychological factors to produce behaviour. Not everyone with certain genetic or chemical characteristics develops dependence, even when personal and environmental factors are similar to the addict's.

Saying there are some biological factors underlying addiction is not the same as saying addiction is a disease.

Disease Theory

For more than 40 years, one of the strongest beliefs among medical professionals and in alcohol treatment in North America has been the idea that addiction is a primary (caused by an inborn physical abnormality, not by some other physical or psychological problem), chronic (ongoing, always present), progressive (gets worse), incurable, physical disease that can be fatal. The theory says those who have this innate disease cannot control their use of alcohol. When they first drink, the underlying disease is activated. The disease then leads them to drink more and more until it destroys them physically, emotionally, and spiritually. There is no cure, it is said, but the effects of the disease can be stopped if the person stops drinking. This is the view accepted by a large number of doctors in the United States and to a lesser extent in Canada, most American and many Canadian alcohol institutions and organizations, the modern Alcoholics Anonymous and related groups, and many treatment centres.

The concept of addiction as a primary disease developed mainly as a reaction to the belief that people who were frequently and troublesomely drunk were simply bad people. Drunkenness had generally been looked at as a moral problem, sin, vice, or personal failure. By the mid 1800s, another view was developing. It saw alcohol as a highly dangerous substance, chronically drunken people as victims unable to control their drinking and abstinence as the only answer. Out of this 1800s viewpoint grew the first self-help groups including the foundation of the later Alcoholics Anonymous (AA).

AA originally never dealt with the cause of serious drinking problems. AA founder Bill Wilson saw it as a primarily spiritual illness that may have had some unknown physical foundations. (Allergy was one suggested explanation at the time.) Wilson explained that although alcoholism was not technically a disease, he needed to use the term “disease–sick–as the only way to get across the hopelessness” (Wilson, quoted in Kurtz, 2002, p. 7).

The modern disease concept developed in the 1940s to 1960s. The description of the progressive disease of “alcoholism” that is most frequently used is the chart of stages and behaviours (Delaware Technical College, 2004) that was developed by Dr. E.M. Jellinek in 1952. Jellinek himself said his disease concept was an unproven theory based on limited information, should be used carefully, and dealt with only a narrow aspect of alcohol problems.

He soon enlarged his views and identified five different kinds of problem drinkers, of which only two fit into his disease model. Yet the description of those two types came to be seen as factual for all those with alcohol problems. Despite the serious flaws in the theory and its development, this quickly became the view that was accepted and presented as fact by doctors, educators, treatment programs, and courts (White, 2000; Doweiko 1996; Miller and Willoughby, 1997; Ogilvie, 2001). Variations of the Jellinek chart continue to be frequently presented as the factual, definitive picture of alcohol problems.

There are many who disagree with the disease model and many who say it has been damaging (See White, Kurtz and Acker, 2001; and Doweiko 1996, for an extensive review of the controversy). Some of the main criticisms are:

- there is no scientific evidence of a primary disease, but there is evidence that people have a variety of problems with a variety of causes;
- many problem and dependent drinkers stop or control their drinking on their own, which indicates the problem is not an innate, uncontrollable, progressive disease;
- the disease model encourages a belief in a lack of control and beliefs influence a person's behaviour;
- it is especially damaging to groups like Aboriginal people who already feel like powerless victims;
- drinking is a behaviour with problems developing only when the person frequently overdoes that behaviour;
- genetic evidence does not show a direct and inevitable link to addiction;
- the disease model does not deal with variations in drinking behaviour;
- there is no definite model of the disease, but a variety of different, sometimes conflicting, views (e.g., primary disease vs. mental disorder).

M.B. Sobell and L.C. Sobell (1993) describe the results of many well-structured studies that track people over time. The evidence shows that a minority of people (25 to 30 per cent) experience progressively worse symptoms if they continue to drink. However, most people move in and out of alcohol problems with various levels of seriousness and problem-drinking episodes are separated by periods of abstinence or non-problem drinking. In most cases, it is not possible to say definitely that a person who had an alcohol disorder in the past will continue to have problems in the future. Although alcohol dependence seems to have biological elements in some people, the evidence is clear that it is not one kind of disease and that alcohol problems do not necessarily get worse or move along to dependence.

Some experts, educators, and treatment providers now take the view that even though alcohol addiction and abuse may not truly be a disease, the idea that it can be like a disease is helpful. This viewpoint was first used in making society understand that people with alcohol problems should be able to get help. Today, some helpers explain that this belief makes it easier for some people to make sense of their behaviour and work towards change.

Psychosocial Theories

All experts, including those who believe in the disease model, agree psychological, social and environmental events are important elements in the development of problem drinking patterns.

Research shows that learning has a great effect on the development of harmful drinking behaviour. People learn how to drink, what to expect from drinking and to use drinking for

certain purposes. People who have experienced rules about appropriate drinking learn those rules and rituals (although they may not always use what they have learned). Those who see mostly uncontrolled drinking with the intention of intoxication learn to drink that way.

People are also shaped by the consequences of drinking. Human beings continue to behave in certain ways if they get positive consequences for the behaviour. If a person's social group drinks heavily and s/he gets positive feedback from friends for drinking the same way, s/he will be more likely to continue the pattern. If a person gets other rewards from drinking—for example, s/he is more social or less anxious—s/he may also learn to use alcohol as a way of getting that reward and as a way of coping with uncomfortable and painful feelings. These positive consequences may be more emotionally powerful than negative ones like hangovers or family problems.

As was discussed earlier, habit is a learned element of drinking. People learn to use alcohol in certain situations including developing the habit of drinking heavily. In the North, for example, people may get into the habit of drinking heavily each time they go to the bar, whereas they might not drink at all otherwise. Habit can be hard to change because it is a routine that people have developed without really thinking about it—a way of behaving that has become an automatic reaction.

There is much research that shows if a person expects to be affected by alcohol a certain way, s/he will in fact experience that effect. There have been experiments showing that people can become high (that is, they act high and believe they are high) even though they drink only non-alcoholic drinks, if they believe they were drinking alcohol. The Social Issues Research Centre (1998, p.6), describing the evidence, says:

There is overwhelming historical and cross-cultural evidence that people learn not only how to drink but how to be affected by drink through a process of socialization . . .

That is, whatever behaviour people expect alcohol to produce, that is how they will behave, although it is unlikely that most of us consciously realize that our beliefs are a factor in our behaviour. Also, if people believe and expect that intoxication is a normal part of drinking, they may well drink to intoxication. If they believe they have no control over alcohol once they have a drink, they may well drink in an uncontrolled way. If people expect that alcohol leads to aggression, they may well act aggressively. (Many studies show that alcohol-related violence is a learned behaviour, not a universal and automatic result of heavy drinking. See Heath, 1995 for a review of such studies. Alcohol may, however, make people less able to control anger and aggression.)

As was discussed earlier, cultures/societies develop attitudes, beliefs, expectations of effects and standards about alcohol use as well as ways of discouraging unacceptable use. Penalties can be legal ones such as making drunk driving a criminal offence. They can also be less structured, but highly effective negative consequences like social shunning and gossip. The greatest problems seem to arise when a society tolerates heavy drinking and drunkenness rather than having strong clear rules about acceptable and unacceptable drinking behaviour and meaningful punishments.

Subcultures are smaller groups within the main society—teenagers, friendship groups, or church members, for example. Subcultures can also develop their own attitudes, rules, and expectations about drinking. For example, heavy binge drinking is often seen as normal and

acceptable by college students. However, people who belong to religious groups that have strict rules against alcohol do not accept drinking at all.

Some people with certain personality characteristics and in certain environmental circumstances may be at greater risk of developing alcohol problems. Examples are:

- certain mental disorders (e.g., anxiety, depression) may be more likely to lead to harmful alcohol use;
- people who have antisocial personalities (that is, they are aggressive, do not follow the rules of society, do not take responsibility for what they do, do not relate well to other people, etc.) are more likely to abuse alcohol;
- people whose social group drinks heavily may develop problems themselves;
- highly stressful life events like isolation, violence and abuse may create a greater risk of alcohol abuse as a coping method.

Finally, research also shows that “. . . substance abuse frequently occurs within a social context characterized by social and economic disadvantage” (Single, 1999, p. 19). That is, people more often drink in problematic ways in situations of poverty and unemployment, low education level, unstable family conditions, unstable social environments, and lack of resources and supports. The connections are complex between alcohol abuse and these other factors that affect health. But it is likely that when individuals do not have the tools to make a meaningful life, feel a lack of secure rootedness in family and society, and/or do not have a sense of direction for a positive future, they may learn to use alcohol as a coping tool. This alcohol misuse then creates even more problems.

To a great extent, then, alcohol misuse and problems arise out of personal psychological factors, learned social patterns, the rewards a person gets from drinking, and the person’s expectations. Harmful and disadvantaged environmental, economic, and social conditions increase the likelihood that people will develop problems.

PROBLEM-RESOLUTION APPROACHES

Treatment is a word that is related to medicine and medical views of problems. In the North, the term is usually thought of as meaning help given in a treatment centre. Treatment centres are only one method of helping, but people are often not aware that there are other ways to reduce problems.

Experts agree that a complete community approach requires a continuum of services that includes several levels of programming (National Native Addictions Partnership Foundation, 2000). Primary services include general services that are factors in health (education, economic strategies, etc.) as well as alcohol-specific strategies such as alcohol education and control policies. Secondary services come into effect when there is evidence of alcohol abuse, but problems are not yet serious. These include screening and assessment as well as early intervention brief counselling that helps a person make changes before the problem gets worse. Third-level services provide treatment when definite problems have begun. Strategies include more intensive outpatient counselling programs and residential treatment programs. Treatment goals can include abstinence, moderation, or just less drinking. Relapse prevention services help people stay on track or get back on track, whatever their goal.

There are many ways of helping people who have alcohol problems. Research agrees there is no one way that works for everyone or that is appropriate for everyone. The National Native

Addictions Partnership Foundation in its NNADAP Renewal Framework report (2000, p. 41-42) says:

Recognition should be given to a variety of types and intensities of substance abuse problems. At least two decades of research have contradicted previous thinking that alcohol and drug abuse necessarily develops as one type of “disease” and follows, inevitably, through a specific, predictable, progressive set of stages of intensity. In fact, substance abuse takes many forms and does not necessarily move from one stage to another nor does it consistently worsen and create more intense personal problems over time . . . Each of the various categories across the continuum of problems . . . call for particular types of service responses.

Experts agree that abstinence is the best goal for those who are severely dependent/addicted—although the individual may not agree and must still be provided help at whatever level is possible. But alcohol abuse problems (including binge drinking) do not necessarily require abstinence and can be successfully changed by a variety of other methods. Counselling services that offer both reduced-drinking strategies and abstinence have higher success rates than those that offer abstinence only because clients can choose. A number of people who start off by cutting down end up deciding to be abstinent (Health Canada, 1998a; Health Canada 1998b; National Native Alcohol and Drug Abuse Program, 1998; Goldman, 2000; Government of Australia, 2003a; Hester and Miller, 1995).

Alcohol disorders are quite resistant to treatment until a person is ready to change. But most problem and dependent drinkers do change at some point, with or without treatment. Many people change even severe drinking problems with no help. As mentioned earlier, there are many more problem drinkers than addicts. Research shows that most people with alcohol disorders do not seek treatment, though they may recognize they have a problem. Often, this reluctance to ask for help is because people do not want to be labelled alcoholic or to quit drinking completely.

The purpose of alcohol prevention and treatment programs is to try to prevent problem drinking, provide help when problems occur and motivate change.

Unassisted Self-Change

Although most people do not realize this, researchers now know definitely that most people recover from problem or addictive drinking (and other addictive behaviours like smoking or gambling) on their own without formal help from counsellors, treatment programs, self-help groups, or the medical profession (Health Canada, 1998a; Sobell and Sobell, 1993; Hester and Miller, 1995). They simply either stop completely or reduce their use to a level that does not create problems. A major study on alcohol use by the National Institute on Alcohol Abuse and Alcoholism (1998) included information about 4,500 adults who had been alcohol dependent/addicted at one time (a year to 20 years previously). At the time of the study, 74 per cent of these previously dependent people were either abstinent or drinking without problems even though they had never received treatment. People with severe addiction problems always find recovery more difficult, even with treatment. Even so, a number manage on their own.

Sometimes people just start cutting down without giving it much thought. (For example, it is known that many people seem to change harmful drinking patterns as they get older.) Other times, they use a self-change process that is similar to treatment/counselling. That is, they start

thinking about their drinking, decide they do not want to keep drinking the way they have been, decide on what they would like to do instead, and then figure out their own ways of reaching that goal. The triggers for change can be varied: a new relationship, new job, one too many blackouts, fear of losing some important part of one's life, signs of physical problems, drinking just is not fun anymore, etc. People decide to change for their own reasons.

Assisted Change Models and Methods

There are several main methods that have been shown to be effective in helping people change harmful drinking behaviour. These helping methods (listed here alphabetically) can be made available in communities. Some require little professional supervision.

In both treatment centre programs and community intervention programs, methods that help people think about their drinking and develop new thoughts and behaviours have been shown to be very useful. These cognitive-behavioural strategies include things such as:

- learning about alcohol effects and consequences;
- analysing own drinking and consequences;
- analysing own drinking behaviour and trigger situations;
- gaining understanding about the reasons one drinks—the emotions, experiences and circumstances linked to the drinking; and
- learning new problem-solving, coping, interpersonal and thinking skills that lead to improved self-esteem, relationships, and competence.

Experts agree that clients need to be alcohol-free when they are assessed and making treatment plans. Assessing and planning requires the individual's participation. Research shows people do not or cannot give accurate information if they are under the influence of alcohol. This does not mean they must no longer be drinking. It just means they need to be completely sober during assessment and planning interviews.

Brief Intervention

Brief intervention means exactly that. Individuals are offered some basic practical advice about how to make sure they do not develop difficulties with alcohol problems. For example, this can be done routinely by health care providers when they first interview a patient or at any stage if they suspect risky drinking behaviour. Some doctors explain that in an initial examination with all patients, they automatically say something like, "If you drink, here are some guidelines for how to do it safely. . . ."

In addition to being a standard approach with all patients on a first visit, brief intervention can be used for any level of a drinking problem, from mild occasional problems to dependent drinkers who are not ready for abstinence or more intensive counselling.

Studies show that brief intervention can be extremely effective for those in the early stages of problem drinking. Evidence shows that many people make positive changes after just one session of basic advice (National Institute on Alcohol Abuse and Alcoholism, 2000). Alcohol-dependent people may not change but they may be better motivated to seek specialized treatment.

The simplest form of brief intervention consists of friendly, non-confrontational, matter-of-fact information about:

- alcohol effects (e.g., negatives such as liver and pancreas changes as well as positives such as feeling relaxed);

- practical advice about how to maintain safe drinking levels; and
- acknowledgment that the client can decide what to do.

Brief intervention is cheap to provide. It is especially effective as a preventive measure that helps people make changes in the early stages of risky drinking. Internationally, it is recommended that primary health care providers and social workers/counsellors should be using the simple process and strategies of this method. Various health organizations have developed guidelines, which can be obtained through the web links in Appendix 1.

Experts and policy-makers agree this kind of advice and help can and should be given by doctors, nurses, social workers, counsellors, community health representatives, and community wellness workers (Health Canada, 1998; Government of Australia, 2003a; Babor et al, 1998; National Institute on Alcohol Abuse and Alcoholism, 2000; National Native Alcohol and Drug Abuse Program, 1998). People are often embarrassed to voluntarily talk about their drinking and ask for help. They may not know about alcohol's effects, safe drinking levels, and simple, private ways to prevent problems. Health providers at all levels have an obligation to provide this information and suggestions for behaviour and lifestyle changes just as they do in cases of physical illnesses like heart disease and diabetes. Individuals cannot take control of their own health until they have the information they need.

Brief Counselling

For clients who are stable with few concurrent problems (no mental illness, major socio-economic problems, or major personal emotional issues, etc.) and have a mild or moderate problem, more directive brief counselling over three or four visits may be appropriate. This is basically a process of determining how much of a change the person wants to make and sharing some ideas for doing that. The counsellor will need to help the client work through to a specific goal rather than just cutting back. Specific goals include things like drinking only on weekends or only at the bar every day with the guys but not getting drunk.

The health care worker helps clients look at their drinking and learn some specific ways to prevent or change problems, such as:

- identifying current drinking levels and the risks and benefits;
- setting drinking limits (e.g., no more than three drinks);
- strategies for staying within limits (e.g., counting and spacing drinks);
- figuring out ways to cope with problems other than using alcohol
- learning how to say no without losing friends; and
- using self-help materials.

There are many simple self-help materials available that people can use on their own or with follow-up from the health care provider (for example, Sanchez-Craig, 1995; Rotgers et al., 2002; Alberta Alcohol and Drug Abuse Commission, 2004b). Similar structured brief counselling can be used with dependent drinkers as a first step to get them on the road to change with abstinence as the final goal.

Guided Self-Change

Guided self-change (Sobell and Sobell, 1993) is a structured brief counselling process that can be provided individually and in groups. It too is based on the belief that many people can solve their own problems if they are motivated, are given some guidance about what to do and

can work at change in their home and community. The usual number of sessions is about four, but can be more or less depending on the client's needs. The process is flexible and can be adapted to fit the needs of clients and communities. (The Centre for Addiction and Mental Health, the primary Canadian addictions research and treatment organization that is a partner of the World Health Organization, uses guided self-change as one of their primary treatment strategies.)

Guided self-change is intended to help people help themselves by:

- encouraging people to identify reasons for changing their drinking patterns;
- giving information about alcohol and advice about options; and
- teaching methods for achieving and maintaining change with a focus on each individual's personal strengths and resources.

The guided self-management approach must be explained to the client. Clients need to understand that they themselves will have to take a big share of the responsibility for deciding and acting on the treatment plan.

Clients are first assessed for the level of problem. Getting an accurate picture of the person's drinking behaviour is essential. This not only includes current patterns, but also information about the past. Sobell and Sobell recommend a thorough (25 questions), but easy-to-administer, assessment test like the Alcohol Dependence Scale (ADS). (A web source for this test is available in Appendix 1.) This measures if the person has some level of alcohol dependence. The Timeline FollowBack Method (Sobell and Sobell, 1996) is also used to get a full picture of the individual's drinking patterns day-by-day for a specific period. (This assessment tool and instructions for its use are available at the Centre for Addictions and Mental Health. A web link in Appendix 1 will show ordering information.) Other tools are used to assess the person's high-risk situations, strengths, types of coping skills, and confidence. (The counsellor needs to be non-judgmental about what is a strength, coping skill, etc. If something works for the client and s/he is comfortable using that strategy, it should be considered. For example, not everyone wants to talk about feelings. Some people prefer to withdraw and handle negative emotions privately. They should be allowed to do so unless they themselves want to talk.)

Results of assessments are honestly and respectfully discussed with the client. The treatment plan is then set up with client input involving goals, alcohol education, specific self-help and monitoring materials, homework assignments, etc. This plan may be different for each individual. It must be made according to the client's needs. At the regular meetings with the counsellor, the client will discuss how the plan is going, what the s/he has learned about his/her own drinking, what changes may need to be made, how s/he can keep positive changes going, etc. Follow-up and support can be made available after the last formal meeting. Clients may want to have support sessions or a support group available at least for a while.

Clients can also use simple assessment tools themselves if they are wondering about their own drinking (Klingerman et al., 2001). That is, they can privately answer the questions and make a decision about whether they need to change or seek help.

Harm Reduction Models

The harm reduction approach takes the holistic view that the essential goal of helping should be to decrease the "health and social problems associated with the use and control of alcohol and other drugs among all individuals, families and communities" (Canadian Centre on Substance Abuse, 1992, p. 1). It is a public health approach. Its goal is not necessarily to stop people from

drinking, but to teach them how to drink without creating physical, legal, financial, or social problems for themselves and others. Harm reduction is not one particular strategy. It encompasses a variety of methods to help individuals control their drinking or their desire to drink. It also builds in counselling for other client issues either directly or through referrals to other care providers.

Abstinence is not a requirement in harm reduction methods, but it is always presented as an option. It is a fact that alcohol provides pleasure in many ways and most people do not want to quit drinking completely or they have mixed feelings. It is also a fact that some people simply should not drink at all, either temporarily (e.g., during illness, pregnancy, on medications, etc.) or permanently (e.g., those who have developed serious alcohol dependency). But the harm reduction approach believes clients cannot be forced to do something they do not want to do, they have the right to choose what they want, and a reduction in problems is better than no change at all. The counsellor does not take the position of being the authority telling clients what to do. Instead, the counsellor sets up a respectful and collaborative relationship that acknowledges clients' right to participation, control, and ownership of their life decisions. Therefore, the counsellor helps clients determine what amount of change they want to accomplish (a specific cut-back level or abstinence) and then provides ideas and activities for reaching the goal. Clients' goals may change and their plans may change. There is much evidence that when people are allowed to make their own choices, quite a few in fact choose abstinence, sometimes immediately, sometimes later on. Furthermore, they will be more successful because they will be more committed to the goal. (This is true in many areas of life. When people are ordered to do something, they may resist.)

Harm reduction methods are also extremely useful in treatment aftercare, in helping clients manage drinking triggers and psychological habits.

Some question the harm reduction approach. They believe that if alcohol abusers are told they can learn to control their drinking, it will lead to increased drinking and eventual development of dependence. However, all the evidence shows just the opposite. Harm reduction can be highly successful in helping those with alcohol abuse disorders to reduce their drinking to levels that create no problems or at least fewer problems (Canadian Society of Addiction Medicine, 1999; Health Canada, 1998; Centre for Addiction and Mental Health, 2002a; National Native Alcohol and Drug Abuse Program, 1998; National Institute for Alcohol Abuse and Alcoholism, 2000). It has also been shown to be a useful middle step in helping alcohol dependent people become abstinent. People trying to change heavy drinking patterns or achieve abstinence are not often immediately successful. It can take time and several attempts. Harm reduction provides a less stressful, less guilt-producing path to change while reducing community, family, and individual physical and mental harm.

Harm reduction has been shown to be a powerful tool for change, but it must be presented appropriately. It is not enough to just tell people to cut down on their drinking or to stay away from alcohol. Alcohol misuse is not an isolated behaviour. Effective harm reduction counselling is a holistic process that helps people look at their whole lives and the role alcohol plays. Areas to be looked at include the following:

- assessing drinking levels and the possible future consequences of the risky drinking;
- assessing readiness to change;
- looking at underlying factors in the harmful drinking (e.g., drinking cues or triggers, self-esteem, family problems, past trauma, etc.);
- analysing the benefits and problems of current drinking;

- setting goals;
- preparing for possible positive and negative consequences of change;
- monitoring/managing drinking behaviour and/or desire to drink;
- learning new ways of handling problems, dealing with emotions, relating to others, finding peace, getting what one wants, etc.

A longer period of such outpatient treatment (e.g., 10 to 12 sessions) may be necessary for those with serious alcohol and/or personal problems.

Medical/Pharmacological

Until recently, the only medication available to help people with alcohol dependence was the drug disulfiram, known as Antabuse. Antabuse discourages drinking because it produces extremely unpleasant physical symptoms like strong vomiting if it is combined with even a small amount of alcohol. However, as scientists learn more about biological factors in alcohol misuse, they are developing new drugs that may be helpful in serious dependence. For example, some interfere with pleasure-producing, natural brain chemicals that may contribute to alcohol dependence. Some reduce craving. As well, when a person has an alcohol disorder and depression, the use of antidepressants may be useful in improving mood and reducing drinking.

Studies show, too, that medication alone is not enough. Drug therapy needs to be accompanied by effective counselling/psychological treatment that helps the individual take control of his/her drinking and the underlying issues.

A doctor must always supervise medication use.

Detoxification is the medical management and supervision of alcohol withdrawal. People severely physically dependent on alcohol suffer withdrawal symptoms. These can include seizures, hallucinations, and other life-threatening reactions. Detoxification is not a treatment. It is a first step in treatment for severely dependent individuals. Once withdrawal has been managed—once the person has “dried out”—the necessary counselling and treatment can begin.

Motivational Interviewing

Why does one session of basic advice work with some people and intensive treatment (even with aftercare) not work with others? As was mentioned before, alcohol misuse is resistant to change. Evidence now suggests that a person’s readiness to change is a major factor in success. No change is possible unless the person acknowledges a problem and wants to do something about it. As in other areas of life, people change only when they have decided there is a need to change.

Experts now agree that empathic (understanding) motivational interviewing is an effective treatment tool that helps clients come to their own realization of negative consequences and the need for change.

One model increasingly used by many alcohol treatment programs is the Stages of Change (Prochaska, Norcross and DiClemente, 1995). It was originally developed about 20 years ago to help people stop smoking, but has been found to be an effective tool in many kinds of change. (A web link to a self-help version is listed in Appendix 1.) This approach looks at behaviour change as a process that depends on the person’s thinking about alcohol use and problems. The process says any change follows five steps plus preparing for relapse.

- Precontemplation: There is some awareness and concern about drinking excessively/inappropriately, but not real acknowledgment of a problem. (E.g., bosses or family may have said something, the person may have gotten into a fight while drunk, etc.) S/he may think about changing sometime, but not in any definite way. Counsellors need to gently help the client come to the conclusion that maybe there is a reason to change.
- Contemplation: The person decides to do something, although there are probably mixed feelings. The person may be definite that s/he will change, but not yet. At this point, the person will be more willing to discuss the pros and cons and options.
- Preparation: An active decision is made and a commitment made to change. The counsellor helps the client gather information, assess options and considers positive and negative consequences of each option. This is an important stage because this is the beginning of a plan. The plan must be based on enough information and on the client's needs.
- Action: The client is fully committed and starts on the plan using strategies that will lead to achievement of the goal.
- Maintenance: The person is following the plan and using strategies to stay on track. New habits are practised.
- Relapse: New habits do not come easily. Most people will fall back into earlier patterns at least occasionally. It is important to help them understand that they may get off track, but they can plan how to get back on track. Relapses are excellent learning situations for examining what led this to happen and what can be done next time to prevent it from happening again.

People may go back and forth between stages several times before a change is complete. They should simply be helped to work through the issues and move on again.

A short version and a self-help version of the worksheets are available online and are listed in Appendix 1.

W.R. Miller and S. Rollnick (2002, p.36) describe four main principles that are essential in motivational interviewing.

- Express Empathy: This helps build a trusting relationship (respect, acceptance of what the client says and how s/he sees things, understanding of feelings and circumstances, encouragement of expression of thoughts and feelings, with no counsellor judgment).
- Develop Discrepancy: The counsellor helps clients who believe they do not have a problem to see that the belief does not fit with the facts of their lives. An example: the client says alcohol is not a problem . . . he has a job, his girlfriend does not mind his drinking, etc. But he also mentions that he is off work a couple of days a week because of hangovers and he and his girlfriend have been arguing a lot. The counsellor would ask some non-confrontational questions related to those events, which encourage the client to think about the situations and the possible role of alcohol. But the client needs to make the connections her/himself.
- Roll with Resistance: If the client denies problems though they may be obvious or resists looking at behaviour, the counsellor should not argue. Instead, the counsellor should eventually, gently turn that resistance back in a way that gets the client thinking again. (E.g., "OK, I know what you're saying. But there's something you mentioned last time that I don't understand. . . . Can you tell me more about . . . ?")

- Support Self-Efficacy: The counsellor should always make it clear that clients have the ability to make the changes they want, have control over their lives and have personal strengths and resources that make them capable. The counsellor believes in the client and the client learns to believe in him/herself.

Once clients themselves have decided that they may need to do something about their problem, the counsellor and client can move to the next stage—making a plan. Motivational interviewing is an important part of all helping strategies, from brief counselling to residential treatment.

Psychodynamic/Psychoanalytical Therapy

Psychodynamic therapy believes that present harmful or dysfunctional behaviour is based on past early negative experiences including those in the unconscious. The belief is that once clients have talked about painful past experiences, understood the connections between the past and the present, and expressed the emotions connected with those experiences, they will be able to change.

Studies that have evaluated psychodynamic approaches show that it is not an effective tool in substance abuse (Hester and Miller, 1995; Correctional Service Canada, 2003; World Health Organization, 1995). An important goal of alcohol counselling is to provide ways in which clients can start to deal with their drinking as quickly as possible. However, in psychodynamic therapy the goal is to achieve understanding and emotional healing first. Research shows that for effective alcohol change, counselling should first be focused on the alcohol problem. Past trauma and emotional issues need to be dealt with later (World Health Organization, 1995; Najavits, 2002; Selby, 2004). Psychodynamic counselling also takes time and great professional skill. The therapist must be able to safely guide the client through an examination of painful past experience. If this is not done knowledgeably, it can be harmful. Another problem is that counsellors who do not have strong training and experience in this may not know how to help clients move through. Clients can get stuck in a long cycle of repeated painful emotions and descriptions of the past. In groups, clients can trigger unsafe exploration and emotional cycles in each other.

However, some studies show that a psychodynamic element can be useful if it is part of a definite step-by-step process, focused on the present and future (rather than the past) and combined with cognitive-behavioural and other problem-solving strategies. That is, clients can talk briefly about painful experiences if they need to and are allowed to express those emotions briefly. However, they are then guided to plan what they can do to move on to a more positive future (Najavits, 2002 is an example). Allowing in-depth exploration may lead both client and counsellor into unsafe waters. During this process, the goal of reducing or quitting alcohol must remain the focus. Clients must be helped to plan alcohol management strategies even when they are working on solving other problems.

Screening Tools

Identifying or screening for risky drinking behaviour is now seen as an essential step in the prevention and reduction of alcohol problems. Screening tools are questionnaires that give quick information about a person's drinking behaviour. These are not diagnostic tools that will tell what level of problem a person has, but they help identify those who may be at risk of alcohol

disorders. They can be used by doctors, nurses, and other front-line health workers like community health representatives as well as by wellness and alcohol counsellors. Simple questions about frequency (“How often do you drink?”), quantity (“How many drinks do you usually have?”), and binge drinking (“How often do you have five or more drinks?”) can give useful information. If it seems the client is doing even mildly risky drinking (e.g., every day or any binge drinking), the health worker should follow through with friendly, non-confrontational, alcohol information and an offer of further helpful discussion.

Many organizations have developed screening tools. The National Institute on Alcohol (2000) Abuse and Alcoholism identifies some of the commonly used ones. Health workers should know how to present the questions and score the answers.

CAGE (Cut down, Annoyed, Guilty, Early-morning)

- Have you ever felt you should cut down on your drinking?
- Do you get annoyed at criticism of your drinking?
- Do you ever feel guilty about your drinking?
- Do you ever take an early-morning drink (eye-opener) first thing in the morning to get the day started or to eliminate the shakes?

A person who answers yes, sometimes or often to two or more of the questions may have a problem with alcohol. It is also suggested that just one yes answer may indicate a problem.

AUDIT (Alcohol Use Disorders Identification Test)

Developed by the World Health Organization (Babor, Higgins-Biddle et al, 2001) this test has 10 questions about frequency of drinking, amount of drinking and physical, emotional and social consequences in the past year. (See Appendix 1 for online information and a manual.)

- How often do you have a drink containing alcohol?
- How many units of alcohol do you drink on a typical day when you are drinking?
- How often do you have six or more units of alcohol on one occasion?
- How often during the last year have you found that you were not able to stop drinking once you had started?
- How often during the last year have you failed to do what was normally expected from you because of drinking?
- How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
- How often during the last year have you had a feeling of guilt or remorse after drinking?
- How often during the last year have you been unable to remember what happened the night before because you had been drinking?
- Have you or someone else been injured as a result of your drinking?
- Has a relative or friend or doctor or another health worker been concerned about your drinking or suggested you cut down?

RAPS4 (Rapid Alcohol Problems Screen)

- During the last year, have you had a feeling of guilt or remorse after drinking?
- During the last year, has a friend or a family member ever told you about things you said or did while you were drinking that you could not remember?

- During the last year, have you failed to do what was normally expected from you because of drinking?
 - Do you sometime take a drink when you first get up in the morning?
- Even one yes answer may indicate a drinking problem.

The following two tools were developed primarily for use with women and the criteria for tolerance is based on women's bodies. They have been shown to be useful in identifying harmful drinking in pregnant women.

T-ACE (Tolerance, Annoyance, Cut down, Eye-opener):

- How many drinks does it take to make you feel high? (two or less; more than two)
- Have people annoyed you by criticizing your drinking?
- Have you felt you should cut down or quit?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

A score of two or more indicates possible risk for pregnant women.

TWEAK (Tolerance, Worry, Eye-opener, Amnesia, Cut down):

- How many drinks does it take for you to get high? (Give score of two if she replies three or more)
- Have close friends or relatives worried or complained about your drinking in the past year?
- Do you sometimes have a drink in the morning when you first get up?
- Has anyone ever told you about things you said or did while you were drinking that you could not remember?
- Do you sometimes feel the need to cut down on your drinking?

A score of two or more indicates a probable problem that should be discussed.

Brief screening assessments have been found to be useful and effective because they are easy to administer, easy to acquire, free, and take only a few minutes. In fact, some studies have found that a single question such as "Have you ever had a drinking problem?" can result in more accurate and in-depth information than a complex screening test (Klingemann et al., 2001).

More in-depth interviewing after a brief assessment is recommended to determine readiness to change and plan directions. But even if a client does not want further discussion at the moment, the results of an assessment may be enough to get a client thinking about his/her drinking.

Self-Help

Self-help programs are not treatment programs. They are organized ways an individual can change without much professional help. Some self-help groups are run only by the members. Others are facilitated by someone with knowledge of certain techniques. Individual self-help means the person works alone on changes.

People tend to think of self-help as group activities like AA, but self-help can also be an individual process. Self-help groups provide opportunities to share experiences and emotions and get support and ideas from others. Individual self-help involves reading, thinking, and doing

structured activities on one's own. Some people need the support of a group. Others prefer to solve their problems in privacy.

Below is information (listed alphabetically) about some organized self-help methods. Only AA has been available in Northern communities. The other self-help organizations described below provide online meetings and/or materials. Web links are given in Appendix 2.

Alcoholics Anonymous (AA) (2004) was established in 1935 in Akron, Ohio, by two men who found it was easier for them to not drink when they met with other alcoholics to share stories and inspirational readings. AA now has many offshoots like Alanon and Alateen for family members of alcoholics, Narcotics Anonymous for drug-users, Gamblers Anonymous, and 12-step groups for those who consider themselves sex addicts, food addicts, etc.

Although many believe AA is the most effective form of help, research does not support that belief. Health Canada (1998a) and others point out that only a minority of people who have contact with AA stay in the group. Studies also show that AA membership ordered by courts or an employee assistance program has not produced positive outcomes (Hester and Miller, 1995). AA has, however, been helpful to people who can commit to abstinence, are willing to accept a lifetime identity of alcoholic, get benefits from the social and spiritual support, and believe in the AA view.

The main underlying beliefs and method of AA are:

- alcoholism is a spiritual illness over which the person has no personal control;
- life will become more and more unmanageable unless the person quits drinking completely;
- to quit, people must give themselves to God/a higher power and become spiritually healthy;
- the best way to sobriety is to fulfil a number of activities (the 12 steps) that will help lead to an abstinent, spiritually-healthy life;
- these goals can be more easily achieved with the help of others who are going/have gone through the same problems.

Controlled Drinking by Correspondence Program (Australian Centre for Addiction Research, 2004) is a new Australian online program intended to help problem drinkers living in isolated areas to reduce their drinking. This program is available only to Australians at present, but demonstrates a useful model that could be adapted.

Moderation Management (2004; Rotgers, Kern and Hoeltzel, 2002) provides self-help materials and group meetings that enable people either to cut down on their drinking or to become abstinent. It developed out of the observation that there are many treatment programs for severely dependent people, but few for problem drinkers who are not yet seriously addicted. They encourage people to recognize their own risky drinking and make changes before problems become serious. This includes recognizing if abstinence is a better goal than moderate drinking. Their point of view is that personal choice and responsibility are crucial for recovery and that members who help each other also help themselves. Self-esteem is essential for recovery and self-esteem grows when people learn to make good decisions and manage their own problems.

This nine-step program provides information about alcohol, guidelines for safer drinking and exercises/activities for assessment, goal-setting, and change. At the beginning of the change process, individuals are asked to be abstinent for 30 days to break old habits and think about

what drinking does for them. Members are encouraged to use the same basic process to find balance in other areas of their lives.

Moderation Management provides online information and meetings.

Rational Recovery (RR) (Trimpey, 1996) is an abstinence-based, self-help approach that was one of the first alternatives to AA. RR believes people talk themselves into drinking and believing certain things about alcohol (e.g., “It’ll help me forget my problems.”). The RR viewpoint emphasizes that people have control of their thoughts and lives and can take responsibility for changing. Its main strategy is to teach people to listen to their inner voice that tells them reasons to drink (which RR calls the Addictive Voice or Beast) and to find ways to cut off the Beast and develop more positive self-talk. In the beginning, RR volunteers ran group meetings. Today, RR believes groups can make recovery more difficult by encouraging people to develop an addict identity. They now encourage individual private change and offer a free course on the Internet. RR is helpful for people who do not want an identity built around being an alcoholic or do not believe they are powerless.

SMART Recovery (2004) is an abstinence-oriented, self-help group that is co-ordinated by trained volunteers. SMART stands for self-management and recovery training. The organization, like RR, believes people develop alcohol problems because of their beliefs and thoughts but have the power to change their emotions, beliefs, and actions. (The founder, well-known therapist Dr. Albert Ellis, was originally involved in the development of RR.) SMART has developed cognitive-behavioural strategies to help people achieve that change. Strategies for motivation (the stages of change approach), coping, problem-solving, and balance in life are taught. Members are not called alcoholics or addicts and are told they are not powerless. They are encouraged to attend for as long as they need support in establishing and maintaining new habits. SMART offers information and free scheduled support-group meetings on the Internet. They also offer structured programs for use in prisons.

Women for Sobriety (1999) is an international abstinence-based group only for women. It started in the 1970s. A trained moderator runs each group. It believes that ideas of powerlessness and identifying oneself permanently as an alcoholic keep women from recovering. They say women’s problems develop in the first place out of negative emotional states like loneliness, stress, and feelings of powerlessness. The focus is therefore on helping women change their thoughts, develop belief in their ability to take control of their lives and emotions, and take care of themselves through proper nutrition, etc. The program has 13 statements or affirmations:

- I have a life-threatening problem that once had me.
- Negative thoughts destroy only myself.
- Happiness is a habit I will develop.
- Problems bother me only to the degree I permit them to.
- I am what I think.
- Life can be ordinary or it can be great.
- Love can change the course of my world.
- The fundamental object of life is emotional and spiritual growth.
- The past is gone forever.
- All love given returns.
- Enthusiasm is my daily exercise.

- I am a competent woman and have much to give life.
- I am responsible for myself and my actions.

Women who do not have access to a group can still use the affirmations in their lives and they can meet with others online or through a pen pal program.

Doctors, public health workers, and community counsellors need to be aware of the different kinds of self-help so clients can have a choice. “Agencies. . . and interested non-government organizations could post lists of self-help organizations on their websites and/or provide links to [self-help] websites” (United States Department of Health and Social Services, 2003, p.24). All the research says self-help referrals should be made according to the needs and beliefs of the individual. For example, an abstinence group will not be helpful to someone who wants to learn or maintain controlled drinking and a moderation group will not be helpful to someone who wants to be only with other abstainers.

Skills Training

People with alcohol problems may lack psychological and social coping skills. In times of conflict, frustration, helplessness, etc., alcohol may be their easiest and most effective solution. Depending on the clients’ situations and needs, the following are examples of specific strategies that have been shown to be especially helpful:

- marital/couples counselling to help partners learn new communication, anger-management, parenting, and other relationship behaviours;
- social and coping skills training (interpersonal, employment, anger and stress management, resistance, etc.);
- strategies that build esteem, responsibility and good decision-making; and
- problem-solving skills.

Such skills training must also be part of effective community prevention programs. Opportunities to develop these skills are especially essential in programs aimed at youth.

Special Needs Groups

Women, youth, seniors, and those who are affected by fetal alcohol disorders may require specific approaches to prevention, counsellor interaction, goal-setting, etc. Web links to best practices for these groups are listed in Appendix 1.

Examples of issues to keep in mind when dealing with women include:

- women especially may feel generally powerless and insecure, so strategies that build a sense of personal choice and competence are important . . . esteem builds when a person has a say in decisions and sees s/he is able to solve problems;
- women at risk of having fetal alcohol spectrum disorder (FASD) children must be provided with harm reduction help even if they do not quit drinking completely, because any amount of cutting back may reduce the risk for their babies (Health Canada, 2000; Selby, 2004). Although an expectant mother, like any other person, may not be able to quit drinking completely, she may be able to reduce the amount she drinks. She will need non-judgmental guidance and support to do so.

Counsellors can provide encouragement and strategies for cutting down, information on nutrition, parenting training, etc. Women must be treated respectfully without being made to feel guilty, irresponsible, hopeless, etc.

Individuals affected by fetal alcohol who have alcohol problems themselves will have serious problems in understanding their own and others' behaviour; planning; understanding consequences; controlling behaviour and impulses; remembering and following directions; resisting peer pressure; etc. They may appear to understand and agree and plan, but the brain damage makes it difficult or impossible for real follow-through. Counselling needs to use simple, concrete, step-by-step language and strategies. Intensive continual support and supervision is necessary. Counsellors must be prepared for relapses and must understand that the person simply may not be able to change.

Effective prevention programs for youth must be practical, realistic, based on accurate and believable information about effects and choices, and must involve youth themselves. Getting youth involved in treatment requires outreach and youth-relevant environments and assessment/screening tools. Youth, like adults, must be allowed to participate in flexible decision-making and goal-setting. Effective programs involve family and include educational and leisure resources.

Alcohol abuse among seniors may involve mental health issues, losses (e.g., spouse, friends), interactions with medications, and effects of the aging process. Effective programs should include attention to physical health problems, understanding aging issues, outreach, and helpful support like transportation or home visits. Efforts should also include development of connectedness and social relationships. Harm reduction strategies and the senior's involvement in goal-setting and planning has been shown to be effective.

People who suffer from traumatic past issues will need counselling to help them move on. However, as was discussed in the section on psychodynamic counselling, it is crucial that alcohol problems be dealt with first. Trauma counselling will not be effective if the person continues drinking. Trauma counselling itself is not effective in changing alcohol problems.

Therapist Characteristics and Training

Studies show that the interpersonal qualities of the counsellor/helper are an essential factor in positive results. Kind and non-judgmental empathy (showing understanding of the person's feelings and circumstances) has been shown to be the most important quality underlying successful outcomes (Health Canada, 1998a; Hester and Miller, 1995; Miller and Rollnick 2002). Empathy does not mean effective counsellors must have had alcohol problems themselves. Empathy simply means the counsellor listens well, accepts what the client says, does not judge or deny the client's views, and helps clients understand themselves through their own words.

For many years, it was believed that strong confrontation by an intervention team was an effective technique for motivating people to recognize and change their alcohol problems. This approach is still used by some treatment centres. However, Health Canada and researchers now say confrontation is ineffective and detrimental. Studies have shown no positive outcomes for this method but rather that the more clients are confronted, the more likely they are to resist change.

In the past, North American treatment programs have also often believed the most effective help can only be provided by those who identify themselves as recovering alcoholics. However, a large number of studies have shown that counsellor-problem/recovery is not necessary, just as it is not necessary for any other personal, mental, or physical health problems. In fact, it can be detrimental if counsellors take the position that what worked for them personally is what is

necessary for clients (National Native Alcohol and Drug Abuse Program, 1998; Health Canada, 1998a; Miller and Willoughby, 2002).

It has been said that if clients did not accept they were alcoholics or did not follow certain treatment expectations, they were in denial. Experts now say this kind of client response is not necessarily an indication of unwillingness to acknowledge a problem. Instead, it may be an indication of defensiveness created by the wrong counsellor style and/or inappropriate treatment approach.

The most effective counsellors are able to build a strong positive relationship with clients based on empathy and a confident belief in the client's own ability to take control of his/her life. They are also able to create a treatment plan based on the client's needs and wants. In other words, counselling must be client-centred and respectful of the client's values, perceptions, wishes, goals, social environment, etc. while facilitating action on the alcohol problem. Counsellors must be competent and knowledgeable and able to give clients accurate and full information about alcohol, its effects, and various options. They must understand human development and psychology, the different kinds of alcohol problems and the different models and approaches to treatment. They must then be able to provide ideas and activities that are appropriate to the client's drinking patterns and goals.

To be effective, therefore, counsellors must have access to alcohol-specific knowledge and skills. Personal experience or general basic counselling skills are not enough. The Canadian and international addictions counselling certification organizations state competency is essential to prevent psychological and other harm to clients. Certification requires at least 270 hours of education with at least 80 hours of addictions-specific training and 200 to 300 hours of addictions-specific counselling practice under an expert's supervision.

Training programs for effective professional addictions counselling include courses in: screening and assessment; motivational/stages of change interviewing skills; client-centred treatment planning and case management; harm reduction strategies; brief counselling models; relapse prevention; and health promotion (as well as courses in family and group work, pharmacology, human development, etc.) (For examples, see Centre for Addiction and Mental Health, 2004; New Zealand School of the Addictions, 2004; New School University, 2004; and McMaster University, 2004.)

The Canadian Addictions Counsellors Certification Board says, "candidates for our certification must be able to demonstrate that they have full knowledge of all accepted treatment philosophies and modalities, including, harm reduction, brief, and motivational counselling. In addition they must demonstrate through a case study and written and oral exams that they are competent in proper Screening and Assessment, Treatment Planning and Referrals" (Wilbee, 2004).

Treatment Centre Model

Treatment centres are intended to help those with serious dependency problems. Short-term residential programs provide intensive treatment for a few weeks while the client lives at the treatment centre. Most North American programs have been based on what is called the Minnesota Model, developed at three disease-model programs (Pioneer House, Hazelden and Wilmar State Hospital) in Minnesota at the end of the 1940s. This model consists of a three- to six-week inpatient treatment phase in which the client is assessed (by a team including a psychologist, medical personnel and trained counsellors) before an individualized treatment plan

is developed. Treatment generally includes such things as individual, group, and family counselling; life skills and coping skills; and confrontational intervention. The Minnesota Model's philosophy is based on the AA 12-step approach with the goal of abstinence. Inpatient treatment is ideally followed by extended outpatient therapy and participation in an AA self-help group (Hazelden, 2004; Hester and Miller, 1995; National Institute on Drug Abuse, 2003).

A number of modern treatment centres, especially outside the United States, no longer use the 12-step approach, confrontation, nor even abstinence as the goal. But the Minnesota Model's intensive holistic approach remains the focus of treatment centre programs.

Some 12-step residential programs do not have multidisciplinary professional staff, but provide counselling by recovering alcoholics who have had 12-step counsellor training (Government of the Northwest Territories, 2002). Aboriginal residential treatment programs in Canada (most of which are First Nations) include cultural education and traditional activities (including traditional spiritual practices at First Nations centres) as part of their programs.

It is expensive to build, set up, adequately staff, maintain, and provide therapeutic activities in residential programs. Treatment centres also can only provide help for few people. For example, a program may run for a month, for 10 people each time. With training and set-up time between sessions, perhaps only 100 people can get treatment per year.

Research shows treatment centre outcomes are no better than good outpatient programs. Even severely dependent drinkers whose goal is abstinence do just as well (some studies say better) with outpatient programs. In fact, evidence shows treatment centre programs are generally successful only if there is a strong community aftercare program available. Outpatient community programs that provide ongoing contact and support therefore seem to be more helpful (Hester and Miller, 1995; Sobell and Sobell, 1993; National Institute on Alcohol Abuse and Alcoholism, 2000; Sanchez-Craig, 1996; Health Canada, 1998a; World Health Organization, 1995).

Evaluation

The National Native Alcohol and Drug Abuse Program (1998), the World Health Organization (Marsden et al, 2000) and others emphasize that rigorous evidence-based evaluation must be a part of treatment services and policies. Effective services can only be provided when identification of needs, treatment planning and effectiveness of strategies have been assessed through valid evaluation. Too often, treatment program statements of success have been based on personal experience or the opinions or statements of staff/management or clients. "The subjective impressions of providers and clients are notoriously inaccurate indicators of actual treatment outcomes" (Miller and Willoughby, 1997, p. 14). Success must be determined through well-developed outcome studies. Valid criteria for success must also be determined. Effectiveness cannot be measured by abstinence alone. Success, even for those coming out of treatment centres, may be indicated simply by a disappearance or reduction of problem drinking. As well, what works in one setting or for one individual may not work with others. Assumptions of effectiveness are not adequate.

Prevention

Prevention means taking steps to stop alcohol problems from happening. As was noted earlier, there are four levels of prevention (National Native Alcohol Prevention Foundation, 2000):

- **Primary:** Public health and government actions that are intended to provide the awareness, knowledge and social/economic conditions that make it possible for individuals and society to be free of alcohol-related problems;
- **Secondary:** Identifying risky drinking in the early stages and providing the guidance necessary for individuals to make changes before problems escalate (e.g., through brief intervention and early intervention);
- **Tertiary (third level):** Actual treatment, which may involve any of the helping methods described earlier, with the purpose of preventing continued problems;
- **Quaternary (fourth level):** Maintenance and relapse-prevention programs to prevent renewed problems in the lives of individuals who have achieved change.

Primary prevention on a population health model is the crucial element in reduction of alcohol-related problems. Prevention programs must include information/knowledge, public policies/practices, attitudes, and resources that build the capacity of individuals, families, and communities to take control of their lives and behaviours. This also requires an overall focus on strengthening and developing the socio-economic foundations that are known to affect population health. Government and organizational policies must therefore be directed at improving the socio-economic conditions that contribute to alcohol misuse such as marginalization, poverty, low levels of education, lack of employment opportunities, and lack of support structures. Only then can societies prevent or undo the conditions that can lead to alcohol-related problems and strengthen those elements that protect against harmful drinking (National Native Addictions Partnership Foundation, 2000; Government of British Columbia, 2001; World Health Organization, 1995, 2002; Health Canada, 1998a).

Generally, effective prevention activities therefore include:

- practical and realistic health and alcohol education campaigns (specific information about risks, safe drinking, lifestyle alternatives, strengthening coping skills, etc . . . similar to smoking, safe sex or diabetes education); (research has shown that abstinence-only programs do not work, especially with youth);
- policies and practices that recognize the importance of early intervention and harm reduction as preventive measures: emphasis on prevention of harmful drinking, not prevention of drinking;
- programs that develop healthy relationships and healthy families (e.g., problem-solving skills, effective parenting, family communications, social involvement);
- legislation (e.g., drunk driving penalties) and control policies (e.g., restrictions on access to alcohol; legal consequences for over-serving, etc.);³
- promotion of non-drinking and moderate drinking as positive behaviours;
- a variety of support systems for individuals and families based on a holistic view of needs and a co-operative multi-agency model; and

³ Evidence shows that age limits, restrictions on serving and selling (e.g., bar closing times, liquor store closing, etc.) and other limits on access reduce the amount of drinking generally. However, these have less effect on the problems produced by binge drinking. Binge drinkers drink too much when they have the opportunity. Prohibiting alcohol completely has generally not been effective because people find ways to make/acquire it.

- the development of community, media, institutional, and organizational environments that promote moderation and positive social norms, provide information and support, and strengthen the sense of connectedness and personal capacity.

Summary of Best Practices

Internationally, alcohol misuse is now seen as a high-priority population health issue (rather than medical/disease) that occurs in a social context. The focus, therefore, is to empower individuals, families, and communities to manage their own well-being. The objectives and goals of the World Health Organization and countries around the world are to reduce heavy drinking, especially the most socially harmful binge drinking and thus reduce the problems that alcohol causes. A major action focus is on primary prevention strategies as already described.

For the treatment of alcohol problems when they do occur, research shows the most successful and cost-effective treatment interventions are outpatient programs that build motivation and offer flexible goals in a way that does not interfere too much in a person's life. Addictions organizations and governments within Canada and internationally have identified elements of effective alcohol programs. The following evidence-based best practices for prevention and treatment are recommended even by those organizations that take the view that alcohol dependence is a primary chronic disease.

- Alcohol abuse and alcohol dependence must be looked at in the context of a biopsychosocial approach in which biology, emotions, spirit, personality, learning, environment, relationships, history, etc. may all play a role.
- A flexible range of harm-reduction strategies is essential to provide effective help for the wide variety of drinking problems and the greatest number of individuals. Goals should be individualized along a continuum from reducing use to abstinence. Harm reduction is not one particular method, but a plan worked out according to client needs. It can include a few brief counselling sessions, guided self-change programs, long-term help with specific issues, or intensive treatment for severe dependence. Group programs, couples' counselling and youth outreach are other examples of services that can be included in a harm-reduction approach.
- Early brief intervention by health care providers and wellness counsellors is low-cost and effective with many early-stage problem drinkers. Identifying possible risky drinking and providing information about alcohol effects, safe drinking guidelines and ideas for lifestyle changes enables people to make changes before they run into greater problems.
- Assessment that provides a picture of clients' alcohol use is necessary for effective intervention. Results of assessment must be shared with clients in a non-judgmental, non-confrontational way that allows them to decide on the next steps.
- Strategies for developing clients' motivation to change are crucial.
- A co-ordinated, multidisciplinary, community approach and community-based programs including outreach must be established. Community outpatient programs are as effective—possibly more effective—than inpatient residential treatment. They are especially helpful for those who are not severely dependent, but who may be heavily habituated or regular bingers. Community programs are more flexible and can adapt to individual needs/goals and problem levels. They are less intrusive in a client's life and can provide on-going aftercare/support. In addition to being effective, they are considerably less costly and provide flexible help to a much greater number of

individuals. Community programs can also be set up to fit with local community and/or cultural needs and resources. A multidisciplinary approach means services should include whatever is necessary for a specific client: care for mental illness, employment services, shelter, marital counselling, etc.

- Follow-up, aftercare and community supports are essential for many individuals, especially for those with serious problems or those coming out of intensive residential programs. If clients are sent to residential programs, extended home-community aftercare must be provided.
- To be effective, alcohol workers/counsellors must have appropriate training in basic assessment; harm reduction strategies; motivation-building strategies; and empathic, non-judgmental relationship and interviewing skills. Treatment planning and setting goals must be based on knowledge and the client's needs rather than the counsellor's personal experience or opinions.
- Valid and careful outcome evaluation is necessary to develop and maintain effective alcohol treatment programs. Abstinence cannot be the only criterion of success.
- Population health-based primary prevention strategies for reducing consumption are necessary.

To be most effective, services and programs must be respectful of culture, but built on recognition of differences among individuals.

Finally, public education, prevention and treatment measures will not be fully effective unless social and economic influences on problem drinking are addressed and social attitudes, policies and official practices promote the view that excessive drinking is not socially tolerated.

ALCOHOL AND ALCOHOL APPROACHES IN INUIT COMMUNITIES

*“In many communities, social use is abuse.”
Jeela Palluq at an Inuit-regions FASD workshop*

Many Inuit who drink, drink moderately. However, as discussed earlier, binge drinking is the prevalent pattern in Inuit communities across Canada. Studies show that although non-Inuit may drink more often than Inuit, Inuit drink much more heavily when they do drink, and this heavy drinking is on the rise (Government of the Northwest Territories, 1996, 2002). The problem is not frequency, but quantity at each drinking occasion. Much too often, the whole point of going to a bar or having access to alcohol is to drink as much as possible and as quickly as possible to get drunk. Much too often, drunkenness and its negative results are accepted as normal behaviour. Much too often, fights, blackouts or a night in a jail cell are accepted as normal outcomes of drinking. (It must be noted again that this is not a pattern only among Inuit. This pattern of binge drinking, with its subsequent personal and social problems, is seen as the primary alcohol problem in other countries such as Greenland, Australia, the United Kingdom, the Scandinavian countries, and among certain groups like college/university students.) Much of the violence, sexual assaults, employment problems, accidents and injuries, etc. in communities can be directly linked to binge consumption.

The Northern picture also shows that many families “are caught in a persisting cycle of substance abuse, family dysfunction (and sometimes family violence), parenting problems, problems of social adjustment in youth, and in turn substance abuse in the next generation”

(Hodgins, 1997, p. 107). Drinking has thus become both a source of problems and a strategy for coping with problems, especially those “associated with social dislocation and economic marginalization” (Thatcher, 2004).

Alcohol problems are obvious and prevalent. However, many people who binge do not drink to intoxication in all situations when alcohol is available. For example, a person may binge drink to blackout level on every visit to the local bar or tavern, yet drink moderately when out for dinner at a restaurant or at a social gathering where moderation is expected. This suggests, as discussed earlier, that learning and social expectations play a role. It may be that binge drinking is the common learned pattern and drunkenness perceived as normal in situations where the focus is on drinking (e.g., in a bar or when one’s alcohol delivery arrives in a restricted community). However, moderation is being increasingly learned as appropriate in other circumstances.

From many conversations and contacts over the years, it is also evident that a number of people either change heavy drinking patterns to moderate levels or quit completely without any counselling or other help. As is shown in research studies with other groups, Inuit individuals, too, make these self-changes for a variety of personal reasons. However, communities want and need more specialized help for the many who cannot change on their own or do not know how.

Existing Initiatives and Programs

Community Counselling

Alcohol counselling is generally done by community health representatives (CHRs), community wellness workers, community social workers, community healing groups, and friendship centre counsellors. Problems identified by workers in communities include staff burnout and turnover, lack of co-ordination and support among different health services, and lack of resources/information and education/training (Pauktuutit, 2001). From past and recent conversations with front-line workers and managers, it seems evident that in a number of communities, a major counsellor role with clients with alcohol problems is to make referrals to a treatment centre. Counsellors who have counsellor training help clients with personal problems. However, in terms of alcohol, the usual focus is to present the need for abstinence and residential treatment as the usual method for achieving that. M. Callaway and P. Suedfeld (1995) in their study of one community alcohol counselling program, state that while counsellors dealt with underlying issues (abuse, family violence), the clients’ alcohol abuse was not specifically discussed unless the client brought it up. A referral was then made to a treatment centre.

The National Native Alcohol and Drug Program (2000, p. 35) concludes that current “service delivery is inconsistent with the best prevention and intervention practices . . . not carefully linked to program methodologies identified in the research literature as being most effective.”

Labrador

Labrador has some CHRs with addictions training (Flowers, 2004). For example, one CHR in Hopedale did addictions training as part of her CHR program and now is the addictions resource person helping to train others. (At the time of writing, the CHR was on leave, so information about her work and training was not available.) Health Labrador Corporation’s (2004) website states that professional skills development, community prevention training, workplace

counselling programs, assessment, and outpatient counselling as well as treatment-centre aftercare (for two years) are elements of service.

Northwest Territories

Community programs in the Northwest Territories are generally based on abstinence. The role of community addictions counsellors in all areas of the Northwest Territories seems to be primarily to do referrals for treatment centre programs and to provide encouragement for abstinence. A comprehensive study commissioned by the Government of the Northwest Territories evaluated the effectiveness of 15 out of 27 NWT community addictions programs. Among those were Inuvik and Tuktoyaktok (Inuit-region communities). Both rated at the bottom of the scale at 1.2 and 1.3 (a score of one was inadequate and seven was excellent). Although there are a few certified addictions counsellors, the report, called State of Emergency, says,

There is an overall lack of expertise, knowledge and skill of the personnel involved in the delivery of addictions services in the NWT. This lack of clinical and policy expertise in the NWT includes: a definition of addictions, the treatment environment of addictions, and the complexity of the management of addictions from assessment to relapse prevention. There is little addictions knowledge and skill evident in the work of the addiction personnel from the community level to the level of Health and Social Services (Government of the Northwest Territories, 2002, p. 77).

The Northwest Territories did try a Mobile Addictions Programs for women and youth in 2000-2001. Inuvik region was one of the pilot programs with a mobile women's program. The project evaluation indicated major inadequacies in organization, content, and staff skills. Content varied in different locations, often not dealing with alcohol use at all. As well, the necessary community aftercare services were lacking.

In recognizing its community addictions counsellors are presented with a wide range of problems, the Northwest Territories' planned focus will be to train counsellors as community wellness workers with both alcohol-specific and general counselling skills.

The Inuvialuit Regional Corporation's Health Promotion Officer, Francene Ross (2003), has submitted a proposal for a pilot project in Tuktoyaktuk oriented to FASD prevention. The project would be an abuse/addiction prevention and intervention program based on community education, youth outreach, and the use of harm reduction strategies. The proposal recognizes the appropriateness of abstinence, especially its necessity during pregnancy. However, it emphasizes the need for practical, achievable, realistic change that will reduce the harm to mothers, children, and society.

Nunavik

Both harm reduction and sobriety interventions are available in Nunavik. Community practice, however, tends to favour an abstinence model. Community programs are provided through Nunaliutiqait Ikajuqatigituut (NI), a regional community substance abuse organization. NI provides counselling and support services to Nunavik residents and front-line community workers both on site and by telephone. With funding from the Aboriginal Healing Foundation, workshops dealing with trauma and grieving issues are being provided in communities. Counsellors also provide aftercare for those returning from treatment centres. Nunavik distinguishes between alcohol abuse and dependence. A research study currently underway, supported by the Nunavik Regional Board of Health and Social Services, will look at methods

for identifying the different types of problems and appropriate service. Goals for communities include better primary intervention as well as effective training for alcohol counsellors. (The eventual goal is university-level training adapted to Inuit needs.)

Nunavut

Nunavut has community wellness workers, who have some counsellor training, in all communities to deal with alcohol problems and make treatment referrals. (A number of counsellors have been trained in Reality/Choice Therapy.) (Community wellness workers provide counselling for other problems as well.) Friendship centres in some communities also provide counselling. Abstinence is the common goal of counselling practice, although evaluations have generally indicated ineffectiveness. An Addictions and Mental Health Framework (Government of Nunavut, 2002) cites Health Canada Best Practices. It recommends co-ordinated community-based programs with outreach, motivational and behavioural interventions as well as case management.⁴ A proposal through the Primary Health Care Transition Fund is intended to eventually provide integrated mental wellness/addictions services, although development of addictions programs has been left to some future date.

A group of concerned individuals from many organizations formed the Central Non-Government Wellness Organization for Nunavut (2002). Their goals are to promote wellness initiatives, build capacity, form links, and share resources in all parts of Nunavut. Their website (see Appendix 1) provides links to alcohol-related information and resources from Health Canada, Alberta Alcohol and Drug Abuse Commission, Hazelden, and others.

Counsellor Training

Pauktuutit (2001) reports that although most counsellors in Inuit communities have had some training relevant to their work, many expressed a great need for alcohol information/resources and for training in both counselling skills generally and alcohol-specific counselling. Of those interviewed, 95 per cent said professional and up-to-date information and resources were needed for themselves and for clients. Training itself seems to be inconsistent and varied. It ranges from a variety of certificate and diploma basic counselling programs to workshops and in-service programs, workshops and materials from the Nechi Institute⁵ (primarily a First Nations addictions organization) to gathering knowledge through self-education such as personal experience, networking contacts, books/pamphlets, or the Internet. A need for training in related, specific issues such as grief and abuse was also noted. The National Native Alcohol and Drug Abuse Program review (1998) highlights the need for standards and training in Aboriginal programs.

⁴ This strategy paper states that Health Canada recommends one model, the community reinforcement approach, as “one of the best approaches to help clients with alcohol problems,” and describes it as being “specifically geared towards abstinence...” (p. 13). However, Health Canada’s overall recommendation is for a variety of flexible services in which abstinence cannot be the only criteria of success.

⁵ The National Native Alcohol and Drug Addition Program review (1998) states that generally Aboriginal training programs need assistance to develop training that meets the standards required for certification. Unlike most professional addictions training programs today, the Nechi Training, Research and Health Promotions Institute program, which has been a common source of materials in the North, includes confrontational intervention as an effective motivator for change and other 12-step theories that were the prevailing view in the 1970s and ’80s. (See <http://www.nechi.com/Training/CAT.htm>.)

Labrador

As noted, at least some Labrador CHRs have received some degree of alcohol/drug training, although details were not available regarding content. In partnership with the Labrador Inuit Association, Memorial University offers a social work diploma program in Labrador when requested, but this has not included alcohol-specific training. However, each time the program is offered, it is developed according to the needs of the group requesting the training. Alcohol-related courses could therefore be included. Some individuals go out to southern university programs: university graduation information indicates that one Labrador Inuit Association-sponsored student completed a university addictions certificate in 2003 (Kettler, 2004).

Northwest Territories

The Government of the Northwest Territories (2002) recommends community counsellors, co-ordinators and managers be trained at post-secondary level in a holistic biopsychosocial approach with knowledge of the different treatment models (abstinence, harm reduction, etc.), basic screening skills, understanding of the possible role of mental health problems in addictions, and case management. (Ideally, they state the need for superior skills consisting of a social sciences university degree and specialized addictions training.) Aurora College in the Northwest Territories does have a counselling program, but does not teach specifically about alcohol or alcohol-related strategies. They are hoping to institute alcohol-specific courses in the future. The NWT government recommends the development of a comprehensive addictions training program in partnership with Aurora College.

Nunavik

Nunavik has required basic counsellor training for several years. In 1997, community counsellors participated in an Aboriginal/First Nations addictions training program through British Columbia's Nicola Valley Institute of Technology, a First Nations post-secondary college. Front-line counsellors are also participating in trauma training programs from British Columbia's Justice Institute. Social work/basic counselling training has also been available through McGill University. Nunavik is currently developing new connections with McGill University, Sherbrooke College, and other possible programs for alcohol-specific training that meets certification standards.

Nunavut

The Nunavut Department of Health and Social Services trained a number of social workers and community wellness workers (previously addictions counsellors were hired by hamlets) in Reality/Choice Therapy counselling a few years ago. The Ilisqsiq Society in Clyde River translated the training materials for use by communities. Nunavut Arctic College has an alcohol/drug counselling certificate program. Information about the content of the current program was not available for this paper; however, when the addictions-certificate program began in 1990, abstinence was mandated as the goal of intervention. The Nunavut Department of Health and Social Services is developing plans for a new alcohol/drug-specific training program possibly in partnership with Nunavut Arctic College.

Evaluation

The Government of the Northwest Territories report (2002) states that results-based evaluation was not evident in any of the 15 community addictions programs. Nunavik is in the process of developing evaluation strategies. Nunavut says evaluations of past programs have generally been inadequate or have indicated ineffectiveness. Labrador information states that program evaluations are conducted, but details were not available. The National Native Alcohol and Drug Abuse Program review (1998) states that evaluation processes have often been inadequate and must be based on realistic measurable client outcomes.

Prevention and Awareness

All Inuit regions have some alcohol awareness and prevention programs. These include visits to schools by counsellors, CHRs, other health staff, or RCMP to explain negative consequences of alcohol and addiction; pamphlets on alcohol and drug abuse; newspaper articles and radio spots; healthy lifestyle promotion; more intensive activities during the annual National Addictions Awareness Week; and workshops on personal issues. However, the consensus is that while such activities may reinforce awareness of alcohol as a problem, they do not seem to be especially effective in prevention or change.

In addition to now providing direct services by certified Inuit addiction counsellors, the Nunalituqait Ikajuqatiitut (NI) program in Nunavik has done prevention, education, and awareness work for 20 years. Nunavik, however, is the only region in Quebec that does not have a Regional Services Organization Plan for Drug and Alcohol Use. Although the Board of Health and Social Services was to begin work in 1996 with regional leaders to develop a full strategy for substance use and services, only a draft was completed in 1997. Further work has not taken place, although a new community mobilization approach is being planned in which community leaders will decide direction and activities. A research group is currently developing a study of alcohol problems in Nunavik. Part of their plan includes pilot projects aimed at helping youth and their families understand alcohol abuse and addiction. NI has safe drinking and moderation materials. However, abstinence is the focus of prevention work.

Pauktuutit's report (2001) shows that almost all counsellors needed more resources both for their own knowledge and for public education. Materials that can be used on radio or television were especially seen as necessary for public information initiatives.

Prevention efforts also include community bylaws and restrictions on access to alcohol.

Relapse Prevention

Because aftercare programs are lacking, little help is available for those who have been through treatment programs and who resumed drinking. Too often, both the individual and others take the view that nothing else can be done.

Restrictions on Alcohol

A number of communities have passed bylaws restricting alcohol access. Some are completely dry—no alcohol is permitted to be brought into the community under any

circumstances and charges can be laid if someone is caught importing alcohol. Other communities are restricted in various ways. Examples of restrictions include:

- No alcohol is sold in the community, but individuals can apply to community alcohol committees for permission to import a certain amount of alcohol at certain times. If their alcohol use creates problems, the hamlet can refuse their next application.
- Alcohol can be served in licensed locations like restaurants or bars, but no alcohol is sold in the community. Groups and individuals must get permits to buy/import.
- Alcohol is served only in hotels to hotel guests. Groups and individuals must get permits to buy/import.

Smuggling alcohol and bootlegging are common in dry and restricted communities and intoxication and alcohol-related problems continue to be problems.

Treatment Centres

Labrador

Labrador has a residential treatment centre with 12 beds and a six-week holistic program. There is also a four-week, land-based, family-focused program that includes family counselling as well as traditional skills and topics such as parenting (Labrador Inuit Health Commission, 1998).

Northwest Territories

The Northwest Territories Department of Health and Social Services funds a residential treatment centre at the Hay River Dene Reserve. Clients are also sent out of the territory to treatment centres in Alberta or elsewhere. Others access non-government programs such as Inuvik's Turning Point program, Salvation Army's Life Recovery Substance Abuse Treatment Program in Yellowknife, friendship centres, or programs and centres provided by First Nations groups (whose cultural content is inappropriate to Inuit). Severely addicted persons needing detoxification receive supervised withdrawal at the hospital in Yellowknife. Although there have been calls for Northwest Territories treatment centres (for example, see Unrau, 2003), health officials cite the need for effective aftercare. The goal is to develop effective community alcohol-counselling programs.

Nunavik

Nunavik has two residential treatment centres: an adult program in Kuujuaq and a youth centre in Inukjuak. Both offer a Minnesota-model holistic program that includes cultural activities. Attention is also given to past trauma as a source of problems. The Kuujuaq centre offers 10 four-week cycles a year for nine clients at a time under the direction of a certified addictions counsellor. About 60 per cent are from Nunavut and some from the Northwest Territories. Although abstinence is the goal of treatment, the program recognizes that minimizing the harm of a return to drinking may be the best they can do for some clients. The centres are currently being reorganized to meet Ministry of Social Services criteria for staff training and program needs. Lack of community aftercare is a major problem, so Nunavik is working to develop continuity of care with the goal of aftercare service in each community.

Nunavut

The only Nunavut-based residential treatment centre closed in 1998 after four years of operation. Not enough clients entered the program to warrant the costs of staff and program operation. Clients are now sent to the centre in Kuujjuaq, other residential programs in various provinces, and Tungasuvvingat Inuit's (TI) new residential program in Ottawa. Nunavut Tunngavik Incorporated (NTI) is studying the possibility of building a treatment centre in Nunavut in one region with one assessment and aftercare facility in each of the other two regions.

Ottawa

TI's Ottawa residential program requires abstinence during the length of residence. However, their general approach and their day program are based on a harm reduction model that allows clients to choose whether they want abstinence or controlled drinking. As part of early intervention and harm reduction, they provide educational materials like safe drinking guidelines and self-help materials. This is a holistic program oriented to clients' needs and lifestyle changes. They have an emphasis on healing from trauma and abuse. TI's counsellors have specialized addictions training.

Self-Help

Some, but not all, communities have AA groups. Other healing and support groups exist in communities. They are run by church members, mental health workers, friendship centre staff, and involved community members. Their success with alcohol abusers is variable.

Positives

There are good things happening with alcohol services for Inuit:

- great concern about and willingness to improve services;
- recognition by government, administrators and alcohol/wellness workers that there are great gaps in alcohol knowledge, skills and treatment approaches;
- recognition by all that alcohol-specific training is needed and an emphasis on at least basic counsellor training in some regions;
- government willingness to look at ways of funding new initiatives;
- four treatment centres specifically for Inuit—Labrador, Nunavik (adult and youth) and Ottawa;
- recognition of the dire need for effective community-based aftercare services for those returning from treatment;
- a structured harm reduction program for Inuit in Ottawa;
- knowledge of harm reduction/safe drinking materials in some areas (e.g. Nunavik);
- a few trained certified addictions counsellors;
- youth initiatives aimed at discouraging alcohol use;
- the National Native Addictions Prevention Foundation has started providing evidence-based training and best practices knowledge transfer for NNADAP workers; and
- increased intolerance of heavy drinking and its consequences among public officials.

Gaps

Community Services

Except for Northwest Territories officials, there is still a common perception that residential treatment programs are the necessary and effective treatment model. Community-based outpatient programs with flexible services that include both harm reduction and abstinence strategies and provide a wide range of individually-targeted help (issues, employment, etc.) are most successful. Residential treatment is expensive, intrusive, necessary only for some severely dependent clients, and thus serves a small percentage of those who have alcohol problems. Of most importance is recognition that the success of treatment centre programs depends on strong aftercare service in each client's home community. That crucial element is not available.

Interventions

Resolution of alcohol problems thus tends to be talked of in terms of residential treatment centres, abstinence as the counselling goal, AA groups, and prevention as a "Don't drink" message. These strategies simply do not work for many people whose problem drinking is based on various psychosocial factors or who do not want to be abstinent. Such approaches are also not necessary for many problem drinkers. As stated earlier, research shows these problem drinkers far outnumber those who are dependent/addicted or willing to commit to abstinence. Evidence also shows that the majority of problems are the result of binge drinking rather than those who are addicted/dependent. Yet, except for TI's outpatient addictions program in Ottawa, virtually nothing is yet available for Inuit to help problem drinkers learn to manage their drinking so it does not lead to problems in their families and in their communities.

Belief in the disease model or in abstinence as the best goal is not a problem in itself. Problems arise when people do not also recognize that:

- some individuals may not want or be able to commit to abstinence; but they are still entitled to help that may reduce the problems they or others are experiencing as a result of drinking;
- success should be measured in terms of a reduction in the number of alcohol-related problems rather than by the number of people who are abstinent;
- there are a wide variety of drinking problems for which a variety of options and strategies are necessary.

The National Native Alcohol and Drug Abuse Program (1998, p. 50-51) states that:

New research and treatment methodologies are presently available that are less defined, less dogmatic, and better suited for helping clients take control over their own lives . . . treatment centres need to keep abreast of the research and develop new approaches to helping clients deal with their problems and place less reliance on disease models of addiction.

Effective services also require valid outcome evaluation of programs and methods. Like in treatment practice elsewhere in Canada and internationally, this element is missing in Northern services.

Knowledge and Information

There is a general lack of evidence-based alcohol information. Knowledge about alcohol problems is centred on the concept of addiction/alcoholism as a single kind of disease, although there is recognition of the role of emotional and environmental problems (education, employment, culture loss, services, etc.). There is generally no distinction made between alcohol misuse/abuse and dependence, nor is there a recognition of the wide variety of problem patterns. When alcohol abuse is talked of in newspapers, for example, it is presented as equivalent to addiction/dependence.

Awareness and prevention materials such as safe drinking guidelines or self-help materials generally do not seem to be in use in most communities.

Prevention

Prevention seems based mainly on a simple “don’t drink” message, often illustrated by newspaper stories of recovery from worst-case consequences. There is at this point no co-ordinated community population health strategy that provides full and accurate alcohol information and advice, strengthens family and individual coping skills and resources, and uses early intervention strategies. There is also no acknowledgment that people in fact sometimes like to drink and therefore need a public and educational approach that teaches and enforces moderation.

Training

A major problem is a lack of alcohol-specific training for community workers. The quality of training is also a significant issue. Although the desire to change alcohol problems is great among counsellors, they have had few opportunities to develop the necessary knowledge and skills. General counselling skills are not sufficient; neither is issues-specific training like trauma counselling. Treatment centre referral is not a sufficient role for counsellors. Training that has been available has focused on an abstinence model that does not seem to have included updated knowledge of best practices evidence. Counsellors are not getting the content that is necessary for thorough helping nor for professional certification. The lack of training is also a major factor in inadequate aftercare services in communities for those returning home from treatment centres. The National Native Addictions Prevention Foundation’s training programs for NNADAP counsellors are an important step.

CONCLUSIONS

People drink. Some people drink too much. In Inuit communities, too many people drink too much, in a binge pattern that is both learned and a negative coping tool. Most alcohol-related personal, social, and family problems are the result of this periodic heavy consumption rather than addiction/dependence. TI is providing a full range of services according to best practices identified in the evidence. Generally, TI’s programs have only been available to Inuit in Ottawa. Even with their new residential program, only a few Inuit from other communities have access to their programs. In Inuit communities, there are almost no educational or counselling services to help people change their problem drinking or to help those who do not go into abstinence-based

residential programs. There is also little effective aftercare for those coming home from residential programs. Both resistance and lack of services seem based on a lack of knowledge. Community members and community helpers do not yet know what the options are and do not fully understand the purpose and process and meaning of flexible strategies and harm reduction. They may therefore be uncomfortable with these ideas, believing they just encourage problem drinking.

Around the world, including in Canada and in Aboriginal organizations, alcohol problems are now seen as a population health issue arising largely from psychosocial factors rather than within the narrow focus of a physical medical problem. Prevention and treatment policies and services should therefore be focused on information, lifestyle-change guidelines, and other strategies focussing on reduction of consumption and harm. The National Native Alcohol and Drug Abuse Program (1998, p. 82) concludes that,

There are real treatment needs within the community. Ignoring low-cost and evidence-proven early- and moderate-problem interventions like safe-drinking education, brief intervention, and harm reduction strategies means appropriate help is not being provided.

That is, clients must be given helpful options for preventing or reducing problems even if they do not want to quit drinking completely. It would be unacceptable for a doctor or public health worker to promote only sexual abstinence and refuse to provide safer sex information. Similarly, it is unacceptable to promote only alcohol abstinence and not provide other information and options.

Aqqaluk Lyngé, vice-president of the Inuit Circumpolar Conference, has said, “We need to focus on healthy lifestyles, rather than on curing the disease that follows unhealthy ones. We need to focus less on bringing [in] expensive repairmen . . . and more on developing cost-effective local human resources that promote health and prevent illness” (*Nunatsiaq News*, Sept. 19, 2003).

Evidence shows that:

- people need complete and accurate information to take charge of their own health and change;
- a higher degree of positive change is accomplished when individuals are provided with information, options and choices;
- in Inuit communities, binge drinking rather than alcohol dependence is the main problem; and
- abstinence-based programs benefit only a minority of these drinkers.

Funding is always an issue. Evidence shows money is best spent on effective community-based alcohol services that can provide early and flexible interventions (abstinence to cutting back strategies) as well as effective support for those coming from treatment centres. Evidence also shows not providing effective community-based, flexible help results in high costs in hospitalizations for injuries, accidents and violence as well as in incarceration, child welfare and social services, etc. However, although residential treatment centres have been generally shown to be no more successful than effective community programs, the existing Inuit-relevant centres are a positive service. Inuit clients may be more comfortable in a centre in an Inuit region and the centres are providing the most knowledgeable, trained help. The level of knowledge and skills necessary for effective community services is simply not yet available in communities. However, high quality flexible community services should be the major goal.

Community counsellors want training. Those who have taken courses believe they are getting good training. But evidence shows that as part of effective community-based programs, those responsible for alcohol counselling must be trained in different models of addiction and treatment, alcohol-specific interviewing, screening/basic assessment, and a variety of flexible intervention strategies. They must also be able to provide and explain such early intervention and prevention materials as safe drinking guidelines and self-help materials. Generally, Northern counsellors have not yet had opportunities for such training. Modern addictions workers in the south often have university education in psychology, counselling or related knowledge as well as in-depth specialization in addictions. However, such high-level professional training is not available and may not yet be possible for most community workers in the North. However, structured addictions training can and should be made available in addition to basic counselling skills. A program of solid, skills-based, alcohol-specific training is the minimum that is necessary. There are a number of manuals available that guide counsellors step-by-step through an addictions counselling process with activities for clients (for example, Najavits, 2002; Sanchez-Craig, 1996, 1995; Rotgers, Kern and Hoeltzel 2002; Leslie and Reynolds, 2002). Addictions workers can be trained in the use of these processes as well as effective, respectful interviewing skills. The Centre for Addiction and Mental Health and its partners offer professional training, including online courses. Correspondence course training is also available through McMaster University. (Some web links for training are in Appendix 1.) Community counsellors taking such courses would need skilled helpers to guide them through coursework and practice training under the supervision of a certified addictions specialist. The few existing certified specialists are an important resource. Work could also be done with existing online programs to adapt or develop new programs that would be appropriate to the needs of Northern counsellors while providing the necessary content.

Alcohol problems have a variety of roots, some of them requiring professional therapy and guidance. However, evidence shows past-issues counselling is not effective for alcohol change, but can follow alcohol intervention. Alcohol counsellors, even highly trained professionals, are not intended to provide a full package of services for mental health issues and are not qualified to provide therapy for deep emotional issues. Such expectations are especially inappropriate and unsafe in Northern communities where even basic training is limited. Inuit community wellness and addictions workers face every kind of problem. There is much emphasis currently on past painful experiences of various kinds (residential school, sexual abuse, etc.) as a factor in alcohol abuse. However, counselling for significant personal issues like abuse, with minimal knowledge, can be highly damaging to clients. This is truly an area where a little knowledge can be a dangerous thing. A workshop or short course in sexual abuse, for example, is not adequate training.⁶

Also, clients seeking alcohol counselling may be put into counselling for such issues whether or not that is what they want. The first rule of all counselling is that goals and strategies must fit the clients' wants and needs. Clients must not be made to fit into a certain viewpoint. It must not be assumed that clients have certain problems or that they must work on certain issues. Services should be set up so counsellors are able to focus on well-trained alcohol intervention and appropriate problem-solving counselling with referrals to other mental health services when necessary. The goal for effective community services must include access to such professionals.

⁶ Real-life example of harm: a client told that the problems she is having with her husband must be based on childhood sexual abuse by her [much loved] father ... although the client insisted no such thing had ever happened, she was devastated at being told that it must have.

However, managers must be aware that in order for counsellors to be effective, they must not only have skills and knowledge, but must also believe in the philosophy and usefulness of those skills. It is known that effective counselling depends on the counsellor's ability to instil hope and belief in the client. It is therefore likely that counsellors who, in spite of training, are personally strongly against moderation and harm reduction will not be able to use those strategies well. They will not be able to generate a feeling of confidence in their clients that it can work. They will also not be able to guide clients through the process convincingly and effectively. They may also not be comfortable providing the community with prevention information like safe drinking guidelines and knowledge of options. In hiring, departments of health and social services and helping organizations may therefore need to consider the possibility of both abstinence-model counsellors and harm reduction counsellors. (Abstinence-oriented counsellors must nevertheless be trained in a variety of methods to help people maintain abstinence or deal with relapse.) In terms of funding, it seems reasonable that those salary costs would eventually be offset by reductions in medical, justice and social services costs.

Evidence shows early and brief intervention by primary health care staff is useful for those in early stages of risky drinking. Although such brief alcohol intervention is becoming more known in medical training, many doctors, nurses, etc. may not yet use these measures or be comfortable in approaching patients about alcohol use. Departments of health and social services may wish to consider such training for primary care staff working in Northern communities.

Evidence shows public information and prevention measures should include:

- safe drinking guidelines;⁷
- public information and role model campaigns that show appropriate drinking behaviour for social learning;
- information about the different kinds of drinking problems;
- self-help ideas for assessing and changing drinking patterns;
- early identification of risky drinking coupled with brief intervention measures;
- programs such as relationship/life/coping skills; and
- programs that strengthen families.⁸

Information and prevention materials, for use by individuals privately and by counsellors working with clients or groups, have been shown to be useful and are easily available from many sources. Although these depend on reading English, such materials can be rewritten in plain English and translated into Inuktitut. As well, guidelines and change strategies can be easily communicated through public education strategies such as radio, television, video, community-relevant skits, songs, etc.

Evidence shows that governments and communities should also work towards a culture of moderation, emphasizing that drinking to the point of drunkenness is simply not acceptable and that intoxication is not tolerated as an excuse for violence or other problem behaviour. A culture of bingeing has developed in the North, in which intoxication is an expected and tolerated

⁷ A Centre for Addiction and Mental Health survey (2001) showed few people know about these guidelines. In those who did know, it led to less drinking in a few. "The guidelines may thus be exerting a modest beneficial effect... They show promise as a simple but useful adjunct to a systemic public health approach to alcohol problems, especially when promoted among high-risk drinkers" (p. 5-6).

⁸ The Centre for Addiction and Mental Health, in partnership with the University of Buffalo and the National Institute on Alcohol Abuse and Alcoholism, is in the third year of a five-year pilot program called Strengthening Families. Hundreds of families in which at least one parent has an alcohol problem are taking part. Preliminary evaluations are positive. A summary and detailed information can be obtained from CAMH.

outcome. That does not mean people approve of drunkenness and the negative behaviour. It just means that even extreme intoxication is seen as a normal and natural result of drinking, something to be expected whenever someone drinks. Though this may have historical roots in observations of whalers and explorers, the pattern can be changed. What is needed is a public and private shift in attitudes, a change to the belief that if people drink, they must drink moderately. Public health initiatives in Canada, Greenland, and elsewhere are working towards the development of strategies and behaviours that emphasize and demonstrate moderation.

Self-help and support groups have been shown to be necessary and helpful to many people. However, communities and helpers need to become knowledgeable about the variety of self-help groups that are available, in addition to AA. While it is unlikely that many different groups will develop in small communities, the North is now wired to the Internet and group interaction and self-help materials are available on the computer. Because it is difficult to keep problems private in small communities, people may prefer the privacy and confidentiality of an Internet group.

Evidence shows programs cannot be assumed to be effective. Neither can evaluation of effectiveness be based only on numbers of participants who pass through a program. Abstinence cannot be the only criteria of success. Valid evaluations must be conducted on the results of intervention. The results must measure reduction or elimination of problem drinking as well as abstinence.

There are many Inuit who drink appropriately, have changed from problem drinking to non-problem drinking, or have stopped drinking completely without help. They are a resource to communities and have helpful stories to tell in community meetings, newspaper articles and in research. They can give Inuit-relevant information about how to prevent and reduce problems.

Inuit communities and governments want to implement services that will effectively reduce the high numbers of individuals with social alcohol-related problems. Ownership, capacity-building, and control of drinking decisions fits with Inuit goals. Evidence shows individuals must also be provided the knowledge and opportunity for making informed decisions and choices about their own health goals and behaviours. Opportunities for new knowledge, minimum interference, personal responsibility, presentation of options, individual choice, analysis of consequences, practise of new skills, community support, acceptance of different paths for different people, and evaluations of effectiveness are all practices and values which guided traditional Inuit life. They are also the components of the best practices in alcohol approaches.

Counsellors and communities work hard to do the best they can. But counsellors can do their jobs most effectively when they have full knowledge and skills. Individuals with drinking problems can more successfully change their lives when they have choices and guidance. Communities can develop more effective programs and attitudes when they know what the choices are. Effectiveness of methods can be assessed if they have been tried and properly evaluated. The best decisions and programs can only be made with full and accurate knowledge based on evidence.

Finally, evidence shows that a successful, comprehensive, problem-reduction strategy also means governments, policy-makers, education systems, justice systems, employment programs, etc. must be active partners with community wellness systems. Those who are unemployed, have low education levels, and live in poorer areas are at greater risk of harmful drinking (Single et al., 1994). The long-term permanent reduction of alcohol problems depends on a population health model that provides individuals and families the means to feel safe, self-sufficient, capable, and competent in all aspects of their lives.

GLOSSARY OF TERMS

(Note: Many of these terms are also used in relation to other drugs/addictions, problem behaviours and helping strategies. The focus here is on alcohol.)

Aboriginal: Canada's *Constitution Act* of 1982 specifies that the Aboriginal Peoples in Canada consist of three groups – Indians, Inuit and Métis.

Abstain/abstinence/abstention: Not drinking any alcohol at all.

Addiction: A general term describing a compulsive, hard-to-control urge to use alcohol even though it is creating problems. Addiction refers medically to physical dependence, which includes an increased tolerance for alcohol (drinking more before showing effects) and physical and psychological withdrawal symptoms when the person stops using. However, it is commonly also used to refer to any on-going alcohol abuse.

Advice: A basic alcohol problem-prevention strategy that can be used by doctors, nurses and other general health providers with patients who show indications of possible harmful drinking, but who have not mentioned a need for counselling. (Patients may not realize they are drinking at harmful levels.) It involves providing non-judgmental, basic information about alcohol risks and safe limits as well as self-help pamphlets with tips for cutting down.

Aftercare: The ongoing counselling and help that is continued after a person has come out of a treatment program or detoxification centre.

Al-Anon: A self-help group for the families of people who have alcohol problems. It helps them learn to understand and cope with the behaviour of the drinker. Al-Anon is an offshoot of Alcoholics Anonymous. **Alateen** is a similar group for youth whose parent(s) have alcohol problems.

Alcohol abuse: Continued drinking despite recurring problems in a person's work and/or personal and/or social life. Someone who abuses alcohol is not necessarily dependent on or addicted to alcohol.

Alcohol dependence: (See also addiction and alcoholism.) A severe consequence of frequent heavy drinking in which a person:

- needs alcohol to feel and function normally;
- craves alcohol;
- has tried unsuccessfully to cut down or stop;
- has withdrawal symptoms when they don't have alcohol;
- has developed a tolerance—drinks more and more to feel the effects; and
- spends much time and effort obtaining, using, and recovering from alcohol.

Alcoholic: A general term for a person who is experiencing alcohol problems or dependence.

Alcoholism: A general term to mean drinking to the extent that it creates problems. The term is no longer formally used in medicine/psychiatry because not all problem drinkers are dependent on alcohol. The medical profession now refers to alcohol abuse and alcohol dependence rather than to alcoholism.

Assessment test: A short set of questions that can indicate whether or not a person may have a drinking problem or be developing a problem. Also called a screening test. Several different tests have been developed. These tests do not provide a full picture of the level of a problem. A detailed diagnosis is done by a doctor or other qualified health professional.

Behavioural therapy: Counselling methods focusing on helping a person learn new behaviours and coping skills that will lead to moderate drinking or abstinence. Training can include both drinking-related behaviours such as counting drinks and learning to refuse drinks as well as general coping skills such as stress reduction methods and effective communication skills.

Binge drinking: Episodes of heavy drinking followed by periods of abstinence or low consumption.

Biopsychosocial model: The view that alcohol problems are the result of a complex interaction of physical/biological, individual psychological, and social/environmental factors. For example, a person's alcohol problems may result from a combination of body chemistry, low self-esteem (see the definition), abuse, and drinking patterns that were learned from others. These biological, psychological and social factors are different for each person and must all be considered in successful treatment.

Brief counselling/brief therapy: This is a short-term helping style in which the trained counsellor helps clients assess motivation, recognize risky drinking patterns/situations, develop coping skills, set goals (abstinence or reduction), and develop ways of achieving the goal. This skills training/instruction occurs over a few sessions and emphasizes the client's own strengths, resources, and capabilities for change.

Brief intervention: Providing basic advice about alcohol effects and safe drinking strategies. This can be done by doctors/nurses, community health representatives, wellness workers, employers, etc.

Chronic: Long-lasting, continuing.

Client-centred counselling: A counselling method that respects the client's values, situation, beliefs and goals while setting up a treatment plan that fits with what the client thinks will work best.

Cognitive therapy/cognitive-behavioural therapy: Counselling approaches that help people analyse their experiences, thoughts, beliefs, consequences, emotions, etc., underlying

their drinking and to change their behaviour and reactions by learning new, more beneficial ways of thinking and behaving.

Concurrent problems: A term meaning problems happening at the same time. These are usually important, ongoing, mental health problems that have an effect on a person's alcohol problem (e.g., depression, anxiety). These concurrent problems must also be treated for alcohol treatment to be effective.

Continuum of services: A variety of different helping strategies for the different kinds of alcohol problems.

Detox/detoxification: A medically-supervised process for helping an alcohol-dependent person eliminate the toxic effects of alcohol from the body in a way that reduces withdrawal symptoms and risks.

Diagnose/diagnosis/diagnostic: To diagnose means to figure out what is wrong in a detailed and organized way. By identifying specific symptoms, events, and time factors, doctors can identify the level and seriousness of alcohol problems.

Disease concept: The view that alcoholism is a primary disease (that is, not just a symptom of some other disease or disorder) that is chronic (life-long), progressive, incurable, and may lead to death.

Dual diagnosis: (See also concurrent problems.) A person has both an alcohol problem and an emotional/psychiatric problem. Alcohol problems may be the result of mental health problems or vice versa.

Early intervention: Identifying and providing advice to people who are doing some risky drinking and showing some signs of problems, but who are not yet in serious trouble.

Empathy/empathic interviewing: A kind, non-judgmental interviewing process in which the counsellor shows that s/he understands the client's feelings, situation, etc.

Guided self-change: A counselling approach that helps clients take charge of their own changes by helping them assess, keep track of, set goals, and set up a plan for changing their drinking.

Habituation: A firmly set habit of using alcohol in a certain way in certain situations (for example, always drinking when under stress). Like with any other habit, people may have a difficult time changing that behaviour pattern.

Harmful drinking: (See also problem drinking.) A pattern of drinking that increases the likelihood of physical or social harm. It is a term that is beginning to replace the terms alcoholic, alcoholism and alcohol abuse because it is seen as less absolute, less labelling and more descriptive of the wide range of behaviours and problems

Harm reduction: An approach to alcohol treatment that uses strategies to reduce the amount of drinking and therefore its harm without necessarily requiring abstinence. The harm-reduction approach sees prevention and treatment as ranging from cutting back to abstinence, depending on the needs, wants, and goals of the person.

Holistic: Taking into consideration all aspects of a person's life (history, social, physical, emotions, spiritual, economic, etc.)

Inpatient treatment: A treatment program that entails living in a treatment centre while undergoing the treatment program. (See residential treatment.)

Intervention: Anything a counsellor does to help someone solve a problem or make a change.

Low-risk drinking: A level of drinking that is not likely to produce serious or on-going harm. Guidelines vary somewhat. Generally, in North America, no more than one or two drinks a day for women (no more than five to nine a week) and no more than two a day for men (no more than 14 a week) and at least one or two non-drinking days. For special groups (pregnant women, those on medications, those with serious past alcohol problems or certain illnesses, etc.), low-risk drinking means no drinking at all.

Mandated treatment: Alcohol treatment ordered by the court or other authority.

Moderate/moderation: Avoiding extremes; not drinking too much or too often. Moderate drinking is generally defined as drinking in a way that does not cause problems for self or society.

Moderate drinking programs: Programs that aim to help people reduce the amount they drink to levels that do not result in problems. They generally involve teaching people how to assess their own drinking patterns and develop strategies for keeping track of and controlling their alcohol use.

Motivational interviewing: A specific process that counsellors use to help people decide they should change their drinking. (See also Stages of Change.)

Outpatient treatment: Counselling that does not require an individual to live in a treatment centre. S/he attends appointments or programs during the day but lives at home.

Pharmacotherapy: Alcohol dependence treatment that includes the medically-supervised use of certain prescription drugs.

Problem drinking: Drinking that is causing one or more physical or social problems, but does not meet the criteria for dependence. It is a term that is replacing the terms alcoholic, alcoholism and alcohol abuse because it is seen as less absolute, less labelling and more descriptive of the wide range of behaviours and problems related to overuse of alcohol.

Psychodynamic model: Treatment based on the belief that alcohol abuse/dependence is a symptom of underlying emotional issues from the past as well as personality factors.

Psychosocial model: The view that alcohol addiction develops because of a variety of psychological and social reasons. These reasons can include lack of self-esteem, learning ways of drinking, influence of peer groups, alcohol use as a coping strategy, etc.

Recovery: Having been able to stop problem drinking. It is a term that has its roots in the disease/12-step model of alcohol problems and is often used to mean that the person has become abstinent. However, it can also mean that a person is no longer experiencing or creating problems with drinking, even if he/she still drinks sometimes (Hester and Miller, 1995; Ogilvie, 2001; Klingemann et al, 2001; Denning Little, and Glickman, 2004).

Relapse: Back to problem drinking. The term can mean a return to problem drinking (harm-reduction view) or a return to any drinking (abstinence-oriented /12-step view).

Residential treatment: An intensive treatment program that involves living in a treatment centre, usually for three to six weeks, generally followed by outpatient counselling and support.

Safe-drinking guidelines: See Low-risk drinking.

Screening test: See assessment test.

Self-change: Stopping one's own drinking problem without help from professionals or treatment.

Self-esteem: Self-esteem means feeling good and confident about oneself. But it is also used in terms like 'low self-esteem,' meaning the person does not like him/herself very much or does not feel confident about his/her abilities and personal qualities. People with self-esteem (or high self-esteem) like and respect themselves, and believe they are generally capable and likeable, even when they makes mistake or are not sure of something.

Self-help group: A group of people with alcohol problems who meet regularly to talk about their experiences and give each other support and ideas. The best-known self-help group is Alcoholics Anonymous, although there are others including some that do not have abstinence as the goal.

Self-instructional material: Materials such as charts, ideas and self-assessments that help a person evaluate his/her own drinking, set goals and develop/keep up a personal plan for eliminating drinking problems.

Stages of Change: A process of helping people change their behaviour that is based on the belief that change only happens when a person is ready to change. The person goes through several stages from not really seeing that there is a problem to actually following through

on a plan. The counsellor helps the person through the stages until s/he has accomplished the change s/he wanted.

Social drinking: Drinking patterns that are accepted by the society and controlled by social rules. North American examples are having wine with dinner or a drink after work with friends without getting drunk.

Sobriety/sober: Not under the influence of alcohol. Generally, not drinking to excess. In the disease/12-step model, sobriety is used as meaning abstinence.

Standard drink: The measure that is used in calculating the amount of alcohol a person consumes. A standard drink is one 12-ounce/341ml can or bottle of beer OR one five-ounce/142ml glass of wine OR 1.5 ounces/43ml of hard liquor. Each of these three drinks has the same amount of alcohol.

Tolerance: The person's physical/nervous system has gotten so used to alcohol that it takes more and more alcohol before the person shows the effects or feels different.

12-step program: Any treatment program that is based on the 12 steps that Alcoholics Anonymous developed as their path to recovery from severe alcohol problems.

Withdrawal: The physical consequences that happen when a dependent person does not have alcohol in the body. Withdrawal symptoms can range from shakes to hallucinations and seizures. Severely dependent drinkers need medical supervision when they are undergoing withdrawal.

APPENDICES

Useful links and basic information

Appendix 1: Web Links to Resources

Low-Risk Drinking Guidelines

Guidelines vary in different countries, but the Centre for Addiction and Mental Health (2000b) has set the following:

- 0—In some circumstances, it is unsafe to drink at all (e.g., pregnant women, mental illness, liver problems, alcohol dependence, etc.);
- 2—No more than two standard drinks on any given day;
- at least one non-drinking day per week;
- no more than one drink per hour;
- always have food with drinks;
- never drink to intoxication; and
- those who don't drink at all shouldn't start.

Read more at:

http://www.camh.net/about_addiction_mental_health/low_risk_drinking_guidelines.html.

Brief Intervention Guidelines

- The World Health Organization has developed a manual (Babor et al. 2001) available at http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf.
- The Government of Australia (2003a) has written brief clear guidelines available at http://www.health.gov.au/pubs/drug/alc_hand/alc_ch4.htm.
- The National Institute on Alcohol Abuse and Alcoholism (1999) describes the basic process of brief intervention at <http://www.niaaa.nih.gov/publications/aa43.htm> and provides a specific structure with care-giver statements and questions (Fleming et al. 1999) at <http://www.niaaa.nih.gov/publications/arh23-2/128-137.pdf>.

Stages of Change

- The Cancer Prevention Research Centre (2002) gives a short version of the Stages of Change scale at <http://www.uri.edu/research/cprc/Measures/Alcohol01.htm>.
- Addiction Alternatives (2003) has an online version that helps people assess their own stage and work through the process at http://www.aa2.org/tools/stages_changes/stageslinks.htm.

Screening and Assessment

- Aquarius Alcohol and Drug Services (2004) has a copy of the AUDIT Alcohol Use and Disorders Identification Test questions and scoring at <http://www.aquarius.org.uk/pdf/Audit.pdf>.
- A detailed manual (Babor et al, 2001) explaining its background, use and scoring is available at http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf.

- The National Institute of Alcohol Abuse and Alcoholism (no date) provides the ADS Alcohol Dependence Scale at <http://www.niaaa.nih.gov/publications/ads.pdf>. The test is published by and available from the Centre for Addiction and Mental Health (2004) at http://www.healthbehaviorchange.org/ai/ai_03.html.
- Timeline FollowBack (Sobell and Sobell, 1993) ordering information is available at <http://www.camh.net/publications/clinicaltoolsandassessments.html#timelinefollowback>.

Special Needs Resources

- Hospital for Sick Children's Motherisk (2001) program gives information about alcohol during pregnancy and breastfeeding. It is available at <http://www.motherisk.org>.
- A tool kit (Kacki et al, no date) including screening and counselling strategies for working with at-risk and pregnant women is available at <http://www.ccsa.ca/toolkit/introduction.htm>.
- Health Canada (2001a) has published best practices for counselling with women at <http://www.hc-sc.gc.ca/hecs-sesc/cds/pdf/women-e.pdf>.
- Health Canada (2001b) has published a best practices report on substance abuse prevention with youth at <http://www.hc-sc.gc.ca/hecs-sesc/cds/pdf/substanceyoungpeople.pdf>.
- Health Canada (2002b) best practices in work with seniors are available at <http://www.hc-sc.gc.ca/hecs-sesc/cds/pdf/Seniors.pdf>.
- Alberta Alcohol and Drug Abuse Commission (1998) explains the challenges of working with fetal alcohol individuals: http://corp.aadac.com/programsservices/developments/vol18_issue5.asp (scroll down to Counsellor Challenge).

Training

- Centre for Addition and Mental Health/The Alcohol and Drug Recovery Association of Ontario (2002) has training information at <http://www.apcampus.ca/Content/home.asp>.
- McMaster University (2004) has information available at <http://www.mcmaster.ca/conted/addictions.html>.
- The course calendar for professional education at the Centre for Addiction and Mental Health (2004) can be found at http://www.camh.net/pdf/eps_coursecalendar0304.pdf.

Appendix 2: Self-Help Organizations

These are links that give information and activities to help a person change drinking patterns. Some of these will focus on quitting completely. Others teach how to cut back on drinking. Some offer online group meetings for support. These strategies are different from the AA method.

- Alberta Alcohol and Drug Abuse Commission can be found at <http://www.zoot2.com/getitback/index.asp>.
- Alcoholics Anonymous Big Book is available at http://www.aa.org/bigbookonline/en_tableofcnt.cfm.
- Moderation Management (2004) is available online at <http://www.moderation.org/onlinegroups.htm>.
- Rational Recovery online course is offered at http://www.rational.org/html_public_area/course_avrt.html.
- SMART Recovery (2004) can be accessed at <http://www.smartrecovery.org/online/schedule.html>.
- Women for Sobriety (1999) is located at <http://www.womenforsobriety.org/> (click on New Life Program and Penpal Program).

Appendix 3: Simple Assessment Tests

CAGE (Cut down, Annoyed, Guilty, Early-morning)

- Have you ever felt you should cut down on your drinking?
- Do you get annoyed at criticism of your drinking?
- Do you ever feel guilty about your drinking?
- Do you ever take an early-morning drink (eye-opener) first thing in the morning to get the day started or to eliminate the shakes?

A person who answers yes, sometimes or often to two or more of the questions may have a problem with alcohol. It is also suggested that just one yes answer may indicate a problem.

RAPS4 (Rapid Alcohol Problems Screen)

- During the last year, have you had a feeling of guilt or remorse after drinking?
- During the last year, has a friend or a family member ever told you about things you said or did while you were drinking that you could not remember?
- During the last year, have you failed to do what was normally expected from you because of drinking?
- Do you sometime take a drink when you first get up in the morning?

Even one yes answer may indicate a drinking problem.

T-ACE for Women (Tolerance, Annoyance, Cut down, Eye-opener):

- How many drinks does it take to make you feel high? (two or less; more than two)
- Have people annoyed you by criticizing your drinking?
- Have you felt you should cut down or quit?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

A score of two or more indicates possible risk for pregnant women.

TWEAK for Women (Tolerance, Worry, Eye-opener, Amnesia, Cut down):

- How many drinks does it take for you to get high? (Give score of two if she replies three or more)
- Have close friends or relatives worried or complained about your drinking in the past year?
- Do you sometimes have a drink in the morning when you first get up?
- Has anyone ever told you about things you said or did while you were drinking that you could not remember?
- Do you sometimes feel the need to cut down on your drinking?

A score of two or more indicates a probable problem that should be discussed.

Appendix 4: Ideas for Safer Drinking

Most problems are caused by drinking too much in one occasion.

One beer every day will usually not create problems in your life. Pregnant women or women planning to get pregnant and people with certain illnesses or on certain medications (even things like cold medicines), etc. should not drink at all.

If you will be driving, snowmobiling, hunting, or boating, or other physical activities that need a sharp mind and body control, do not drink at all before or during these activities.

Three beers in an hour will affect your thinking and your body co-ordination . . . you'll be starting to be drunk.

One beer = one shot or mixed drink = one glass of wine
They all have the same amount of alcohol

General Guidelines

- Women should not drink more than two drinks a day.
- Men should not drink more than three drinks a day.
- Everyone should have some non-drinking days every week.

Drinking more than that in one day will increase the risk of liver and other health problems, and increase the risk of developing a habit of heavy drinking. Because women are smaller, alcohol affects them more quickly. Women also develop liver problems more quickly than men.

Avoiding Problem —Some Helpful Ideas

Start with a non-alcoholic drink and plan your drinking.

When you first go out to drink, have a pop first. Think about how long you are planning to be there and set yourself a safe limit. Keep in mind that you want to have fun but you do not want to do anything foolish. (Remember that once you get drunk, you will not be able to judge what is foolish or trouble. You will not know until the next day.) Then decide how you are going to space out those drinks. Do the same thing even when you are drinking at home with friends.

Drink slowly and do not drink more than one drink an hour.

It takes your liver about 1.5 hours to get rid of one drink. There is no way to make this happen faster. While your liver is working to get the alcohol out of your system, the alcohol is circulating through your body to the brain. The more alcohol you have in your body, the more it will affect the areas in your brain that control thinking and muscle movements.

It is easy to overload on alcohol without really realizing it:

If you start drinking at 8 p.m. and have three beers by 9 p.m., you will still have two drinks worth of alcohol in your body at 9:30 p.m. If you are a small woman, that is enough to be noticeably affected. If you are a large man, one or two more drinks will be enough to start being drunk even though you might not yet be stumbling and mumbling. Have more and you will be drunk fast.

Keep track of your drinks.

Count and watch the time. Be aware that once you have had two or three drinks pretty fast, it will be hard to remember how much you have had and you will start losing your ability to think clearly.

Take breaks between drinks. Have a non-alcoholic drink after every alcoholic drink.

If you have had a couple of drinks within an hour, drink pop or coffee for the next couple of rounds. Get up on the dance floor. Play a game.

Drinking water will help your liver and kidneys do their jobs better. Your liver needs water to do its work and alcohol pulls water out of your body, so drink water or other non-alcoholic liquids between alcoholic drinks. However, nothing will get that alcohol out of your body any faster. Drinking water or coffee won't help. Fresh air won't help. The only thing that works is time, so give your liver time to do its work.

Always eat before you drink and have something to eat while you drink.

If you drink on an empty stomach, the alcohol is absorbed into your blood right away. When the stomach is busy digesting food, the alcohol will not get into your bloodstream and brain as quickly.

Be especially careful with mixed drinks.

It is easy to drink too many rum and colas or rye and ginger ales because it tastes like you are just drinking pop.

Do not feel uncomfortable about saying no.

You may not want to drink at all when you are out socializing or you may not want to drink too much. Plan what you could say when someone wants you to have a drink but you do not want one. Remember that it is OK to say no.

When you get drunk, you are more likely to get into arguments and fights, get into accidents or dangerous situations, have unsafe sex, be unable to go to work or school the next day because of hangovers, forget to do what you were supposed to do, and get into other kinds of trouble.

Keep yourself and others safe.

Appendix 5: Alcohol and Your Body

Alcohol is absorbed into the bloodstream from the stomach and the upper intestine. It then circulates around the body to the brain.

Alcohol affects your brain. The first drink or two makes us feel good. This is because a little bit of alcohol speeds up your heart rate and other body systems. It also triggers the release of certain brain chemicals that make us feel good.

But alcohol is actually a depressant. This does not refer to emotional depression, although that can be a result of heavy drinking. What it means is that more alcohol slows down your body systems and affects the ability of your mind and body to function properly. It especially interferes with those parts of the brain that control thinking, memory, muscle movements, balance, and reaction time.

An example of reaction time: you're driving your snowmobile when suddenly someone drives fast out of a driveway, right in front of you. Without even thinking, you throw on the brakes and turn off to the side fast. When you have been drinking, you cannot think, react or coordinate your movements as quickly. This is why people have more accidents and injuries when they've been drinking.

The more alcohol you have circulating in your blood, the more trouble you will have thinking and doing things. Eventually your body shuts down and you pass out.

Drinking a lot of alcohol in a very short time causes alcohol poisoning and can kill a person. If a person passes out, there is also the danger of vomiting and choking to death while unconscious.

The liver produces a chemical that breaks down alcohol and gets it out of your body. But it takes the liver about an hour and a half to process one drink. So the more you drink, the more alcohol builds up in your blood. Many things influence how quickly alcohol affects a person: whether you've eaten and the kind of food you've eaten, your age, the amount of body fat, your physical health, etc.

Men and women process alcohol differently. (Rotgers, Kern, and Hoeltzel, 2002.)

- A large part of the body is water. The more you weigh, the more fluid (blood, water, etc.) you have in your body. The more fluid you have, the more the alcohol is diluted, so it doesn't have as big an effect as quickly.
- Women are smaller, so they have less fluid, so the alcohol circulating through them is more concentrated and affects them more quickly.
- Women also have less of the liver chemical that gets rid of alcohol.
- Generally, a 55-kilogram (120-pound) woman will definitely be affected negatively (thinking, co-ordination) if she has two drinks in an hour. An 82-kilogram (180-pound) man will show these effects if he has about 3.5 drinks in an hour. These effects quickly get worse if the person drinks more without giving the liver time to get rid of the alcohol that's already in the body.

If the liver has to process too much alcohol too often, it starts to get damaged.

- First, the liver starts to lose its ability to process the fat in food, so fat builds up in the liver.
- More drinking causes actual damage and liver chemicals start leaking out into your bloodstream. These liver chemicals can be found with blood tests. If your doctor says your blood test shows liver chemicals, it means you have some liver damage. Follow the

doctor's advice, make sure you get proper nutrition, which can help prevent further damage, and stop drinking.

- If you continue to drink heavily, the liver will start to form areas of hard scars. This is called cirrhosis. Eventually, the liver will be so damaged that it will be a hard lump that cannot do its job of processing nutrients and ridding your body of poisons. This leads to death.

An episode of heavy drinking can cause:

- hangover (headache, throwing up, shakiness)—this is the result of your body producing chemicals and using up water to try to get rid of an alcohol overdose
- diarrhea in the morning
- disturbed sleep—you wake up in the middle of the night and can't get back to sleep, or you sleep very restlessly and wake up tired

Heavy drinking can lead to:

- damage to the pancreas, which is an important part of processing food and other parts of the digestive system
- cancers (for example—mouth, throat, liver)
- high blood pressure
- heart problems
- strokes
- brain and nerve damage
- less sex hormone production
- physical and psychological dependence/addiction
- an increased risk of breast cancer in women

Heavy drinking can also cause changes in brain chemistry and nutritional deficiencies, which can lead to ongoing anxiety and depression. Even individual episodes of heavy drinking can end up in depression. First you feel high and good and then you crash. The depression and anxiety can be made even worse because you may feel bad about yourself for drinking too much.

Appendix 6: Types of Alcohol Problems

Alcohol Abuse

Alcohol abuse means drinking so much that it creates problems for yourself or others. This does not mean you're addicted. It means you're drinking in a very bad way. Signs of harmful drinking include:

- losing time off work or school, or being unable to do your work properly because of drinking during the day or hangovers;
- spending money on alcohol rather than on food, rent and other necessities; leaving children alone while you go out drinking; getting into arguments and fights because of drinking; friends or family members making comments that you drink too much;
- accidents, injuries and getting yourself into dangerous circumstances because of drinking (e.g., falling asleep with a cigarette burning or the stove on, falling down, going out into bad weather without proper clothes, etc.);
- problems with police because of drinking (drunk driving, spending a night in a jail cell, creating a disturbance or assaulting others when drunk, etc.);
- health problems because of heavy drinking (for example, stomach problems, hangovers);
- getting drunk every time you drink;
- not remembering what you did or said when you had been drinking;
- being embarrassed about something you said or did when you were drinking; and
- having thoughts that maybe you shouldn't drink so much.

If you have had even one of these things happen once, it means you had way too much to drink that time.

If you are having even one of these things happening more often, you need to take a close look at your drinking. These kinds of drinking consequences lead to even more problems in work, family relationships, and physical health. They will also affect your self-esteem and your reputation in the community.

If you do not want to give up drinking completely, you can learn to drink in a way that does not cause these consequences. But it means you really have to pay attention to your drinking. You may need to learn to say no to family, partners, and friends sometimes and plan some other ways to have fun and socialize.

Psychological Dependence/Drinking as a Habit

Often, we can get into the habit of drinking too much or too often. If someone started using drinking as a way to relax stress, it can be easy to start depending on that drink as the relaxation method. If someone has a lot of problems or feels depressed, s/he may depend on drinking as a way to forget problems and feel a little better for a while. If someone feels less shy when drinking, s/he may start using alcohol in situations that cause anxiety. If get-togethers with friends are usually at the bar, it's easy to get into the habit of thinking socializing means drinking. And it's easy to develop the habit of drinking way too much in these situations. (It's especially easy to drink too much when people around you are drinking a lot.)

Eventually, when you are in these situations, you may feel like you need to drink or you do it automatically. You have developed a psychological dependence on drinking. Habits get built into our brains psychologically and biologically, like a path that you walk regularly.

Any habit can be hard to break. It may be easier to get some help, even if it's just sharing ideas and plans with a friend. It's a good idea to pay attention to the situations in which you drink. Who am I with? How do I feel before I drink? How do I feel when I've had a couple? How often do I drink too much and in what situations? And so on. Once you have an idea of your own patterns, it will be easier to change the habit.

Binge Drinking

Binge drinking is a kind of alcohol abuse habit where you do not drink all the time. You may not drink for days, weeks or even months. However, when you do drink, you drink so much you get drunk.

Binge drinking is not addiction. But it is the worst way of drinking. This is the kind of alcohol abuse that leads to some of the most serious problems:

- fighting and violence at home or in the community
- spending a night in a jail cell or other trouble with the police
- getting hurt or having an accident
- being so hung over the next day you cannot get to work, school or hunting

You can change this way of drinking, although you will have to pay close attention to your own drinking and work actively to change the pattern. That is especially necessary if people around you are drinking heavily. It is easy to get caught up doing what everybody else is doing. Follow the guidelines for safe drinking.

Alcohol Dependence

Alcohol dependence is a serious addiction. It means that a person's body and brain need alcohol for the person to feel OK. A person can be mildly dependent or severely dependent.

A doctor can diagnose whether a person is dependent and at what level. There are a number of signs that doctors look for. In addition to other symptoms, dependence generally includes:

- Tolerance: People who are dependent have usually developed a higher tolerance for alcohol. This means that their bodies and brains are so used to the alcohol that they can now drink quite a bit more than other people before they start to show the effects.
- Withdrawal Symptoms: A sign of severe dependence is having withdrawal symptoms when the person stops drinking. Withdrawal symptoms can include things like shaking, hallucinations, and seizures. People who are dependent may have to have a drink in order to stop these things from happening.

If you think you may be dependent on alcohol, make arrangements to see a doctor rather than quitting drinking on your own. Withdrawing from severe dependence can be dangerous.

A person's body/brain will get over the physical dependence in a few days. But a person who has been dependent is at risk of starting to drink too much again. Maybe they began drinking as a regular way to relax. Perhaps heavy drinking was the accepted way of socializing with friends. Maybe it was a way of dealing with depression and life problems. If the person has used alcohol in these situations, s/he'll be tempted to use again in similar situations and may become dependent again.

Anyone in this situation should learn to recognize what the drinking triggers are. They should then develop ways of handling those situations without using alcohol.

Nobody really knows yet why some people get dependent. But dependence can happen when you regularly drink a lot. If you drink, you should follow the guidelines to keep your drinking low and reduce risk. If you do not drink, do not start.

However, not everyone who has drinking problems, even serious drinking problems, is dependent or progresses to dependence.

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