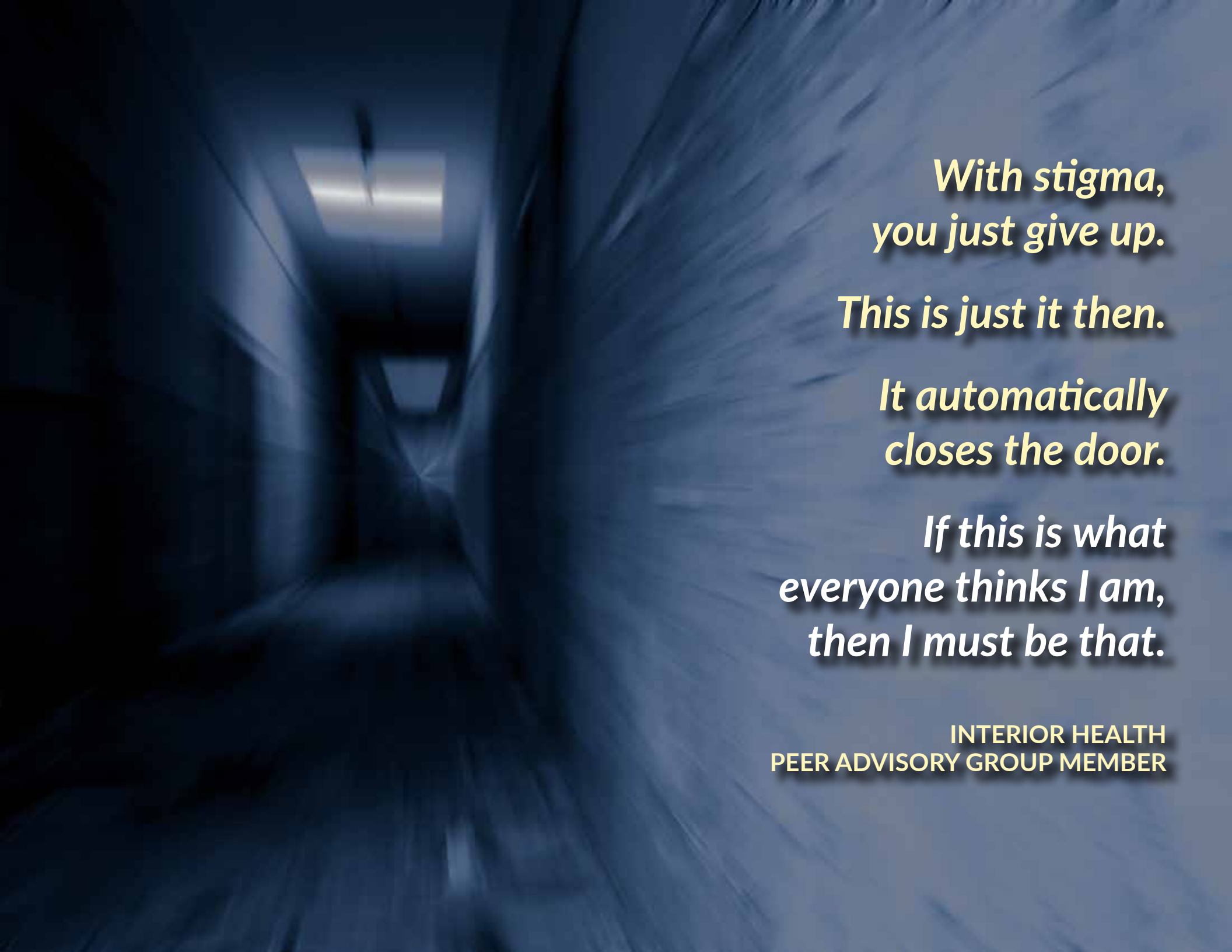
MEDICAL HEALTH OFFICER REPORT

2020

Alcohol and Health in B.C.'s Interior Region

Interior Health



With stigma,
you just give up.

This is just it then.

It automatically
closes the door.

If this is what
everyone thinks I am,
then I must be that.

INTERIOR HEALTH
PEER ADVISORY GROUP MEMBER

Contents

I wholeheartedly believe awareness and education around poverty , homelessness, different drugs, behavioural effects, concurrent conditions, trauma, race-related racisms ... is so, so, so important to be able to look at each and every individual as a human being worthy of care.

I am me,
I'm not defined
by my substance use.

INTERIOR HEALTH PEER ADVISORY GROUP MEMBER

Message from the Medical Health Officer

Dr. Silvina Mema

Alcohol is arguably the most socially acceptable of psychoactive substances. Drinking alcohol is socially acceptable and even an encouraged activity. Some individuals may feel pressured to drink during social gatherings. While social drinking may seem harmless, it can lead to alcohol misuse and addiction.

Many social and health harms can be directly or indirectly attributed to alcohol use. These include acute intoxication, injuries, intimate partner violence, high-risk sexual behaviour, and absence from work. Alcohol can also lead to many chronic diseases, including alcohol use disorder and cancer. Alcohol was present in over 25 per cent of the 6565 illicit drug toxicity deaths that occurred in British Columbia between 2016 and November 2020.

Sadly, addiction to alcohol and other psychoactive substances is surrounded by stigma. Many still consider these a moral failing or due to a weakness of character as opposed to a chronic disease of the brain.

In the past decade, alcohol consumption rates have been higher in the Interior Health region than the rest of the province, as noted in the 2019 Interior Health Medical Health Officer Report.[1]

From 2007 to 2018, the Interior Health region had the highest per capita rate of alcohol consumption in B.C., and this trend was increasing. Furthermore, the overall rate of hospitalizations for conditions related to alcohol was also increasing.

The COVID-19 pandemic has influenced social norms and alcohol use. Approximately 30 per cent of British Columbians have reported increased use of alcohol since the start of the pandemic. Some local governments have considered bylaws or pilot projects to allow consumption of alcohol in public spaces, as an attempt to boost the economy. At the same time, provincial orders have brought in more stringent restrictions to limit alcohol consumption at pubs and other venues in an attempt to prevent transmission of COVID-19.

It is important to keep in mind that liquor production is an important economic and touristic draw for the Interior region. In 2015, the wine industry tourism generated $246 million in revenue for the broader British Columbia economy. In addition, there are 12,000 full time jobs in B.C. as a result of the wine and grape industry, which is primarily concentrated in the Interior region.

With this report, I aim to shed light on measures of alcohol-related health outcomes and reflect the perspectives of stakeholders who can influence these outcomes. After all, a public health approach to alcohol seeks to strike a balance that maximizes social and economic benefits while preventing and mitigating health and social harms.

Highlights

- Alcohol is generally a socially acceptable psychoactive substance and its use is widespread in Canada. While the use of alcohol can have social and economic benefits, alcohol is also responsible for a large burden of health and social harms. Alcohol use is a leading cause of injury and death.
- Canada's Low-Risk Drinking Guidelines define limits that aim to reduce (but not eliminate) the risk of health related harms. At least 20 per cent of Canadians consume amounts above Canada's Low-Risk Alcohol Drinking Guidelines.
- The level of alcohol consumption that minimizes health loss is zero.
- The Interior region has the highest rate of licensed liquor establishments per capita in the province. Wine tastings and wine tours at the region's many wineries attract tourists from all over Canada and abroad.
- BC's alcohol industry contributes $2.4 billion annually to the provinces economy. The Okanagan Valley accounts for more than 80% of all wine produced in British Columbia.
- Per capita alcohol consumption in the Interior region is the highest of the five regional health authorities. On average, residents in the Interior region consumed four litres of absolute alcohol per year more than the provincial average in 2018.
- During the first three months of the COVID-19 pandemic, 30 per cent of all individuals surveyed in British Columbia reported increased alcohol consumption; among young adults that number was up to 40 per cent.
- The alcohol-related hospitalization rate is higher in the Interior Health region than the provincial average. There were 589 deaths related to alcohol in in 2017 and 5,090 alcohol-related hospitalizations in 2018.
- Alcohol Use Disorder is a significantly under-treated condition across Canada with less than one per cent of people having access to effective pharmacotherapy treatments. The prevailing stigma around addiction contributes to the failure of providers to recognize and treat this disorder.
- An Interior Health-wide framework has been developed to create a comprehensive, connected healthcare system whereby all people affected by substance use can receive safe, effective, and compassionate person-centred care and treatment when and where they need it.
- Local governments are uniquely situated to influence a culture of moderation in their communities. Through healthy public policies and partnerships, it is possible to both support the economic and social benefits of alcohol, and reduce the negative health impacts.
- Traditional public health approaches to respond to the health needs of Aboriginal peoples can be harmful and re-traumatizing. A new partnership approach is needed that rests on solid relationships and emphasizing strengths, assets and resilience.

Acknowledgements

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Alcohol and the Social Determinants of Health

In 2015, the Chief Public Health Officer's report on the state of public health in Canada focused on Alcohol Consumption. [2] The report recognized that there are a variety of factors that can play a role on whether alcohol will have a harmful impact for individuals and communities. **These factors are known as the social determinants of health and encompass the socioeconomic, environmental and cultural context of individuals. The social determinants of health can influence or determine health outcomes by protecting or creating risk for individuals and populations.**

The alcohol paradox provides an illustration of the complex interrelation between health and risk factors. According to the Canadian Institute for Health Information, **Canadians with the lowest incomes report less heavy drinking than those in the higher incomes, but are more than twice as likely to be hospitalized for conditions caused by alcohol.** [3] Possible reasons for this are higher stress levels, limited social supports, and poor diet and physical inactivity.

Interrelated social, political and economic factors that create the conditions in which people live, learn, work and play are known as the social determinants of health. Income, employment, education, discrimination and a history of trauma are some examples of social determinants of health. **In fact, socio-economic factors account for 50 per cent of all health outcomes, while health-care, genetics, and physical environment account for 25 per cent, 15 per cent, and 10 per cent of health outcomes, respectively.** [4]

Health is a state of total well-being—physical, mental and social—helping us both survive and thrive in our everyday lives. The factors that influence health are present at every level of society, from the individual through family and community, to a national and even global scale. Rather than protecting people from specific disease or harm, health promotion is the process of enabling people to increase control over their health and wellness, and reach their full potential. Effective health promotion strikes a balance between personal choice and social responsibility, promoting healthy behaviours, creating supportive environments, and encouraging healthy public policies.

With this in mind, the burden of negative health outcomes related to alcohol cannot solely lie in the hands of the health care sector. Only a collective effort across sectors can prevent poor health outcomes from alcohol and other substances in our communities.

Introduction

Alcohol is a socially acceptable psychoactive substance and its use is widespread in Canada [2]. While use of alcohol can have social and economic benefits, **alcohol is responsible for a large burden of health and social harms**. Short-term health risks of excessive alcohol use include injuries and violence, alcohol poisoning, and risky sexual behaviour, among others.

Alcohol use during pregnancy can result in miscarriage, stillbirth or fetal alcohol spectrum disorders. Long-term health impacts of alcohol use include increased risk of cardiovascular disease, cancer, and mental health problems, such as impaired memory, dementia, depression, anxiety, and alcohol dependence/alcohol use disorder. Social problems associated with high-risk drinking include lost productivity, challenging relations with family and friends, and unemployment.

In 2017, the Canadian Institute for Health Information (CIHI) reported staggering statistics in relation to alcohol-related harm in Canada [5]:

- Up to 18 per cent of Canadians aged 15 years or older have met the clinical criteria for Alcohol Use Disorder at some point during their lifetime.
- Currently, approximately 20 per cent of Canadians drink in excess of the recommended daily or weekly limits.
- During the 2015-2016 fiscal year, hospitalizations directly related to alcohol exceeded hospitalizations for heart attacks in Canada (212 vs 205 admissions/day).
- Alcohol use is linked to eight per cent of all deaths in Canada, and accounts for eight per cent of all potential years of life lost for people younger than age 65.

Higher amounts of alcohol consumption are associated with greater alcohol-related harms. The Canadian Centre for Substance Use and Addiction (CCSA) Low-Risk Drinking Guidelines [6] provide health drinking limits for Canadians. **It is important to note that these drinking limits aim to reduce, but do not eliminate, the health risks of alcohol (Figure 1)**:

- For men, the maximum alcohol consumption under the Low-Risk Drinking Guidelines is 15 standard drinks per week with no more than three drinks a day on most days.
- For women, the maximum is 10 standard drinks per week, with no more than two drinks a day on most days.
- For certain individuals, including those who are pregnant and people living with alcohol use disorder, driving a vehicle, making important decisions or responsible for the safety of others, are recommended to avoid alcohol altogether.

The Canadian Cancer Society sets more stringent recommendations for those who wish **to further reduce the health risk of alcohol-related cancer**: two standard drinks per day for men and one standard drink per day for women. These guidelines are particularly important for people who use tobacco, because the use of both tobacco and alcohol has a synergistic effect on increasing cancer risk. [7]

Past research suggested that low levels of alcohol consumption can have a protective effect on some health conditions such as heart disease. Recent studies, however, have defied this evidence and established that any protective factors derived from alcohol are offset when overall health risks are considered. As such, **the level of alcohol consumption that minimizes health loss is zero**.

A population health effort to prevent and mitigate alcohol-related harms requires a cross-sector approach (**Figure 2**) that fosters a culture of moderation, early detection and management, and specialized care. Specific actions, strategies and target groups for each goal are detailed in **Table 1**.

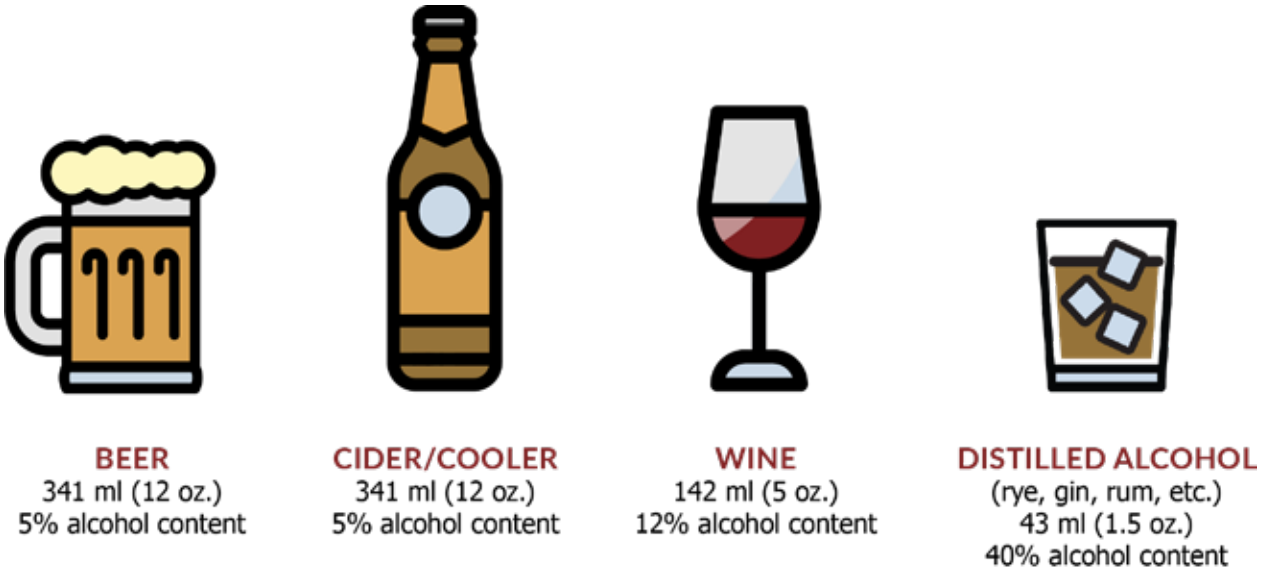

Figure 1. Meaning of a "drink" in Canada's Low-Risk Alcohol Drinking Guidelines [6] *Source:* Canadian Centre for Substance Use and Addiction (CCSA)

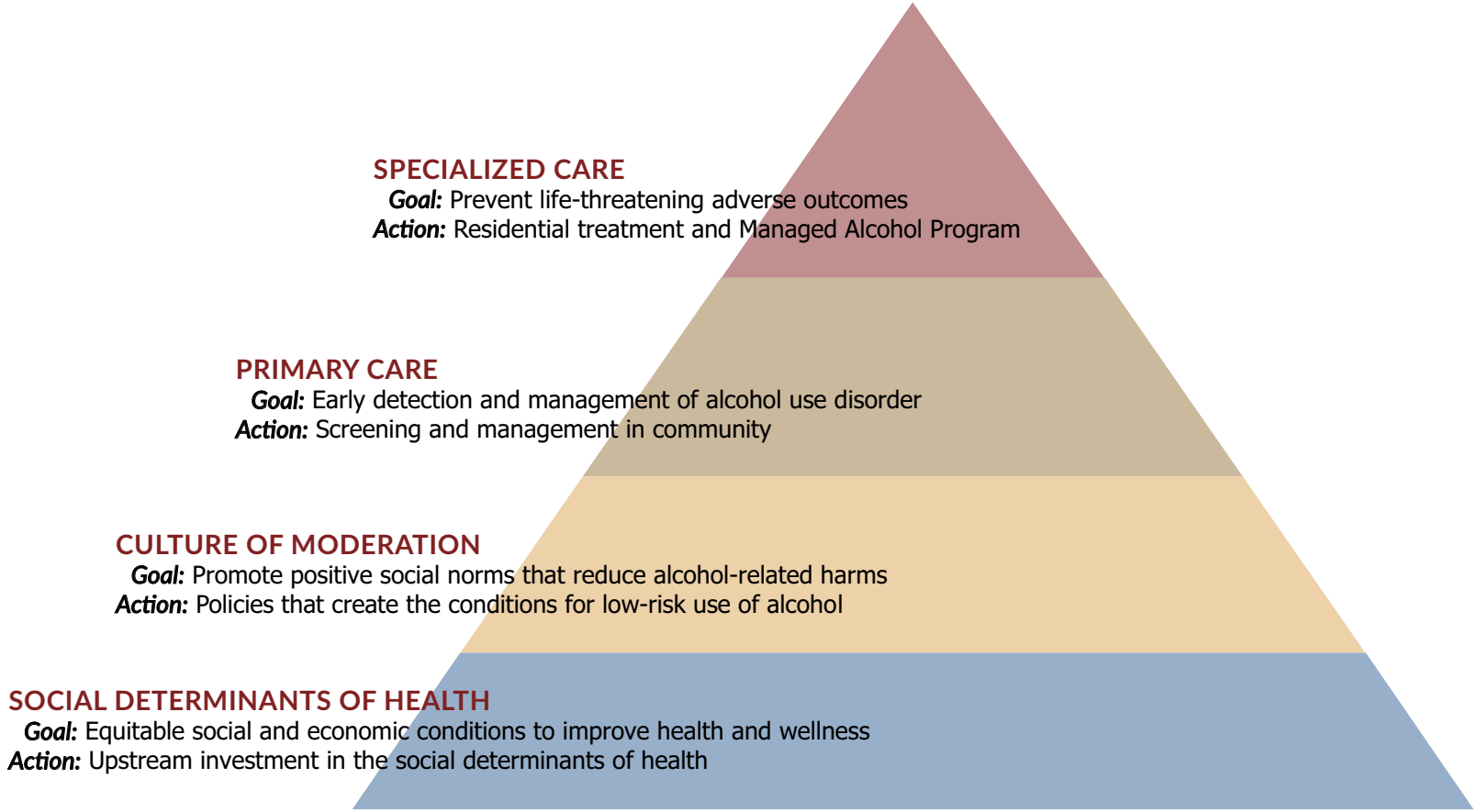

Figure 2. Comprehensive approach to prevention and mitigation of alcohol harms.

No Safe Level of Drinking Alcohol

"Our results show that the safest level of drinking is none. This level is in conflict with most health guidelines, which espouse health benefits associated with consuming up to two drinks per day."

From "Alcohol use and burden for 195 countries and territories, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016," *The Lancet*, 2018. [8]

GOAL	ACTION	EXAMPLES OF STRATEGIES	TARGET GROUP
Equitable social and economic conditions to improve health and wellness *(primordial prevention)*	Upstream investment in the social determinants of health	• Reduce socio-economic inequalities • Investment in early childhood development and care • Develop personal and community resiliency • Promote mental wellness	Population as a whole
Promote positive social norms that delay use, prevent misuse, and reduce harms of alcohol *(prevention)*	Create a culture of moderation with social norms and policies that enable the conditions for low-risk use of alcohol	• Education (i.e. health promoting schools) • Social marketing, role model • Enforcement • Age restrictions • Taxation • Liquor licensing • Limited advertising • Harm reduction	Youth, individuals who drink moderately, individuals with high-risk drinking behaviour, individuals at risk of alcohol use disorder
Early detection and management of high-risk drinking and alcohol use disorder *(risk mitigation and treatment)*	Primary Care for screening and management in community. Integration between primary and specialized care such as residential treatment or managed alcohol programs	• Address stigma by normalizing addiction as a chronic condition vs moral failing • Cultural safety • Screening and referral • Availability of specialized care (e.g. managed withdrawal, crisis response, outreach, counselling, managed alcohol programs, phamacotherapy) • Non-specialist support (e.g. aftercare programs, peer networks, sobering centres, housing support)	Individuals with high-risk drinking behaviour, individuals at risk or with a diagnosis of alcohol use disorder
Prevent life-threatening adverse outcomes *(rehabilitation)*			Individuals with alcohol use disorder

Table 1. Goals, Actions, Strategies and Target Groups.

The climate of much of the Interior region is well-suited to growing grapes and other fruit for use in the production of wine and cider and this industry plays an important role in the local and provincial economy. The wine industry employs thousands of workers across the Okanagan, Similkameen, Kootenays, Lillooet, Thompson Valley, and Shuswap. Products are not only consumed locally but also exported to countries like China, the United States, and others. Wineries of the Interior region are also a tourist draw in their own right, with wine tastings and wine tours proving a desirable destination for thousands of travellers. Cideries, breweries, distilleries, and even meaderies provide similar experiences for tourists who prefer other forms of alcohol.

This report aims to shed light on the status of alcohol consumption and alcohol-related harms in the Interior region. The report provides a snapshot of the impacts of the COVID-19 pandemic on alcohol consumption and services available for individuals with alcohol use disorder. The report concludes with an outline of public policies and the role of local governments in enabling a culture of moderation, and makes broad recommendations to advance prevention, treatment and recovery of individuals who are negatively impacted by alcohol in the Interior region.

Alcohol Epidemiology in the Interior Region

It is important to note that there currently is very little data specific to alcohol being collected by Interior Health. **Data on alcohol and other substance use is often combined, making it difficult to clearly and consistently distinguish alcohol-specific clients or outcomes.** Improved data collection such as separating alcohol from other substances in the health record would help better understand the health impacts of alcohol use among Interior Health residents.

This section describes trends in alcohol consumption, alcohol harms and deaths using data from external sources, including opportunistic studies like the B.C. SPEAK COVID-19 survey and the B.C. Adolescent Health Survey, and other provincial data sources such as Canadian Institute of Substance Use Research at University of Victoria.

Alcohol Consumption

Data from the annual Canadian Community Health Survey can help estimate the prevalence of heavy drinking. The survey defines heavy drinking as five or more drinks for males or four or more drinks for females on one occasion at least once a month in the past year. **Since 2015, approximately 16 to 20 per cent of B.C. respondents have reported heavy drinking, with younger age groups more likely to report heavy drinking (Figure 3).** [9] A higher rate of heavy drinking was observed among males compared to females (data not shown).

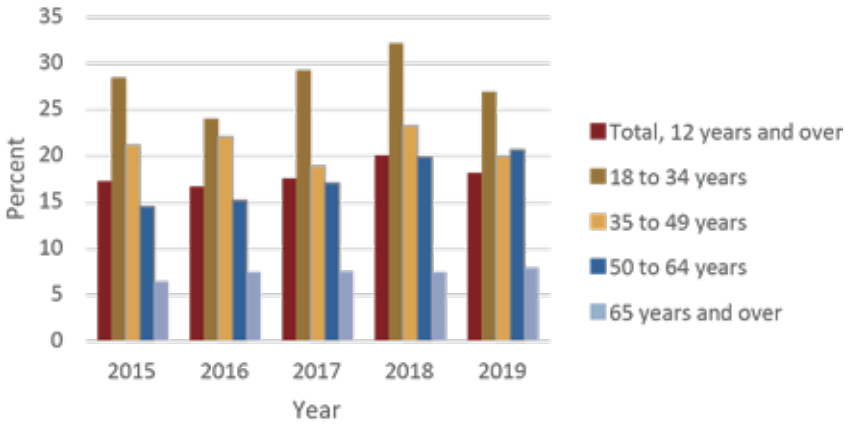

Figure 3. Per cent of B.C. CCHS respondents identified as heavy drinkers, 2015 to 2019. *Notes:* The percentage of respondents aged 12 to 17 years of age are available through the CCHS, but was not reported in this figure because estimates were noted to be used with caution for that age group. *Source:* Statistics Canada [9]

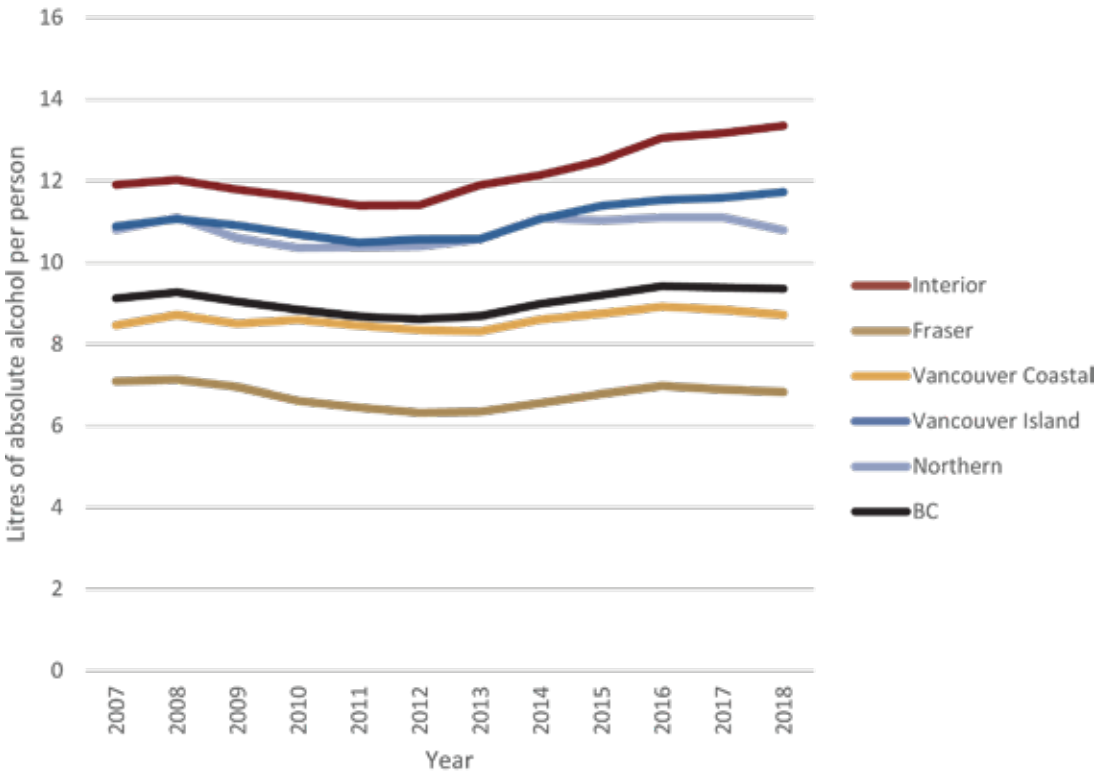

Figure 4. Per capita alcohol consumption, 2007 to 2018 B.C. and Regional Health Authorities. *Notes:* The estimates of total absolute alcohol consumption for health regions in B.C. were obtained from two data sources: the BC Liquor Distribution Branch sale alcohol data and the Ubrew/Uvin data from the B.C. Liquor Control and Licensing Branch. For more information, please see https://www.uvic.ca/research/centres/cisur/projects/aod-monitoring/alcohol-consumption/index.php *Source:* Canadian Institute of Substance Use Research University of Victoria.

Alcohol sales data is used as a proxy for alcohol consumption because it tends to be more accurate than population surveys, which underestimate alcohol consumption. [5] [10] [11] [12] Limitations of using alcohol sales data as a proxy for alcohol consumption are the inability to account for alcohol obtained from other sources, including alcohol produced at home, bought on the black market or across borders, and also the assumption that all alcohol is consumed in the same area it was purchased. [12] **As such, alcohol sales data may overestimate consumption in the Interior region, where alcohol is produced and sold to visitors from other jurisdictions.** For the purpose of this report however, alcohol sales are reported as alcohol consumption.

Between 2007 and 2018, average alcohol consumption per person in the Interior Health region was higher than the provincial average and the highest of the five regional health authorities. Interior Health residents consumed between 2.8 to 4 liters of absolute alcohol more per person each year than their provincial counterparts. While per capita alcohol alcohol consumption remained relatively constant across B.C., **the Interior Health region saw an increase in consumption between 2012 and 2018 from 11.4 to 13.4 liters of alcohol per person respectively (Figure 4).**

Within the Interior region, the four Health Service Delivery Areas (HSDAs) followed a similar trend in alcohol consumption between 2007 and 2018. The East Kootenay had the highest alcohol consumption followed by the Okanagan, Kootenay Boundary, and Thompson Cariboo Shuswap. **Compared to Thompson Cariboo Shuswap, the population of East Kootenay on average consumed an additional 2 liters of alcohol per person per year (Figure 5).** The reason for the spike in alcohol consumption in the East Kootenay during 2013 is not known.

Licensed Liquor Establishments in B.C. and the Interior

Alcohol policy in Canada is mainly a provincial issue. In B.C., the Liquor Control and Licensing Act establishes the issuing of alcohol licences and permits, and associated supervision and enforcement. [15] The Liquor Distribution Act establishes manufacturing, distribution and sales of liquor. [16] There are three main categories of licences for liquor establishments in B.C.; Liquor Primary, Food Primary and Manufacturer licence.

Liquor Primary are for businesses wanting to offer liquor as their primary focus (e.g. bars, pubs, nightclubs) or where liquor is sold as an additional service (e.g. spa or art gallery). Private and B.C. Government Liquor Stores are locations where liquor is sold to be consumed outside of the location, such as licensee retail stores, wine stores, and UBrew or UVin locations. **Food Primary** licences apply to locations where the primary focus of the establishment is food service, but liquor is also sold (e.g. restaurants, bistros, cafes and other businesses). Liquor is commonly sold to be consumed onsite, such as at restaurants, bars or nightclubs. Finally, **Manufacturer liquor licences** apply to establishments where alcohol is produced or manufactured, including wineries, breweries and distilleries.

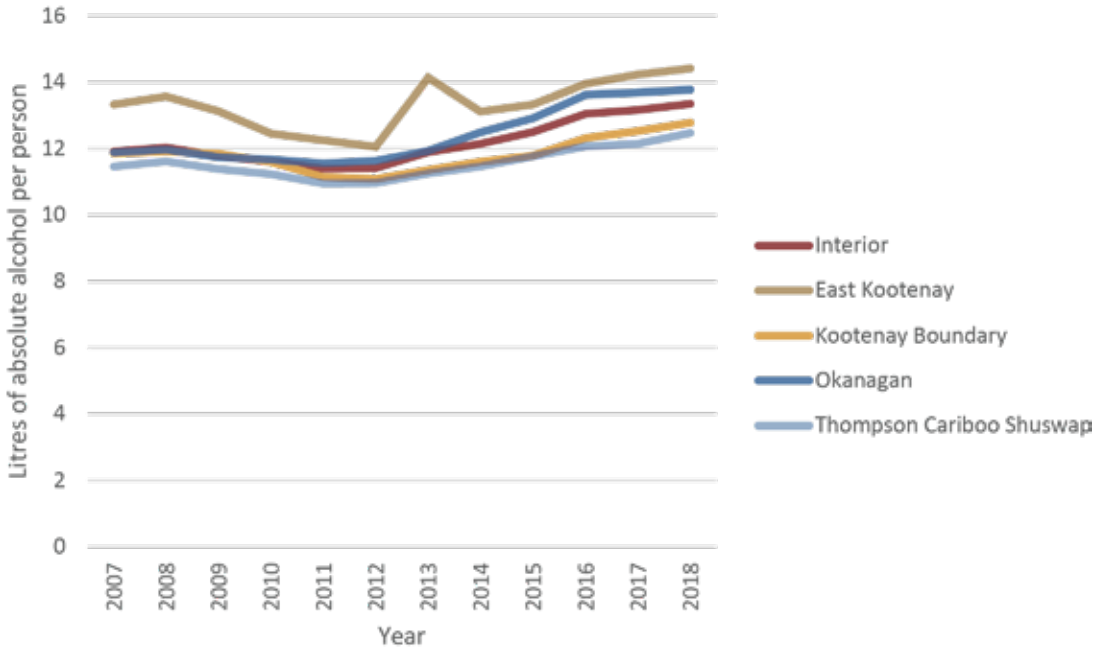

Figure 5. Per capita alcohol consumption, 2007 to 2018, Interior Health HSDAs. *Notes:* The estimates of total absolute alcohol consumption for health regions in B.C. were obtained from two data sources: the B.C..Liquor Distribution Branch sale alcohol data and the Ubrew/Uvin data from the B.C. Liquor Control and Licensing Branch. For more information, please see https://www.uvic.ca/research/centres/cisur/projects/aod-monitoring/alcohol-consumption/index.php *Source:* Canadian Institute of Substance Use Research University of Victoria.

The Cost of Alcohol in British Columbia

In 2014, the direct societal costs of alcohol in B.C. due to health care and enforcement costs and lost productivity was $1.9 billion. The government revenue from alcohol was $1.6 billion, creating a net negative balance. These costs are experienced by communities through the money required for policing alcohol-related community disruption from violence to property damage, as well as the social costs of disability, injuries from impaired driving, domestic violence, and lost work time and productivity. [13] The good news is that upstream public health measures can have a significant return on investment. [14]

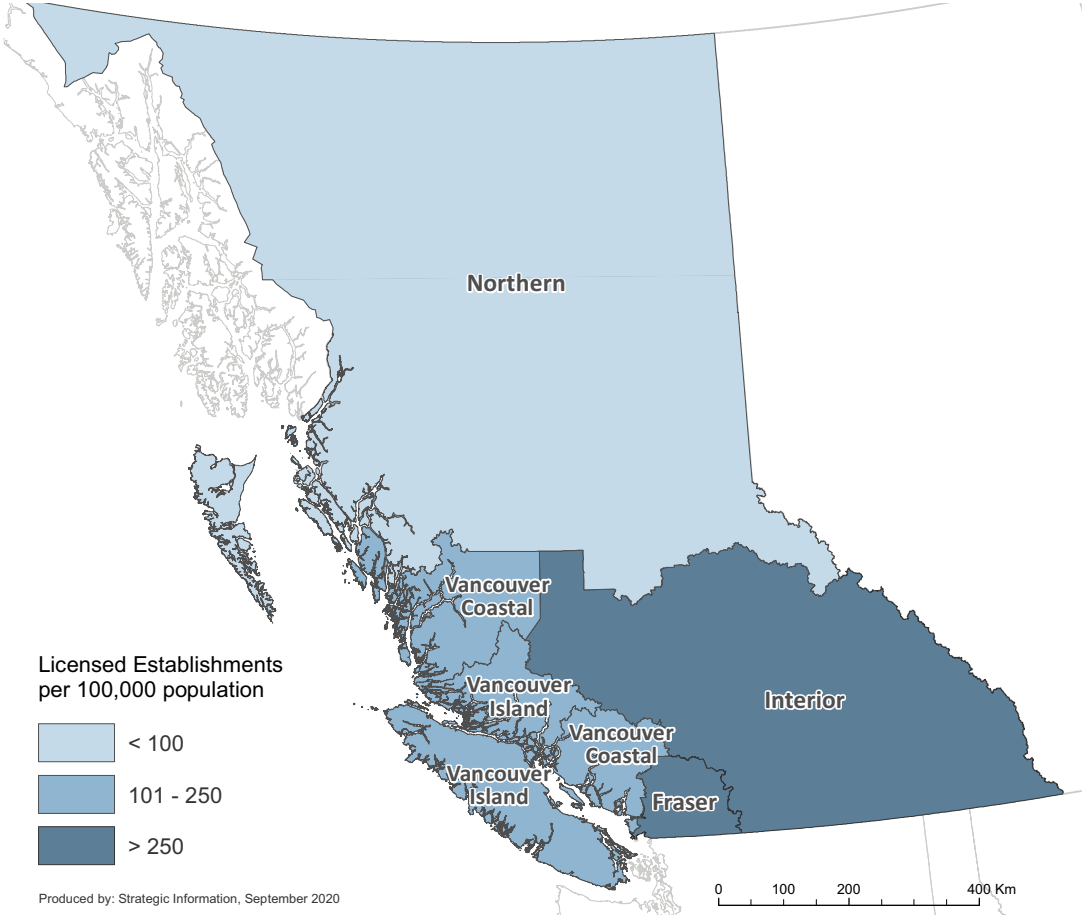

Figure 6. B.C Liquor licence rates per health authority and per 100,000 population. *Note:* Liquor licence rates include all forms of liquor licences, including food primary licences. *Source:* Government of B.C. https://www2.gov.bc.ca/gov/content/employment-business/business/liquor-regulation-licensing/liquor-licence-permits/liquor-resources-information/bc-liquor-licensed-establishment-locations

The Interior Health region has the highest rate of licensed liquor establishments in the province **(Figure 6 and Table 2)**. There are 290.1 licences per 100,000 population in the Interior Health region, followed by the Fraser Health region with 251.7 licences per 100,000 population **(Figure 6)**. The total number of liquor establishments in the Interior Health region is 2,407; the second highest in the province, surpassed only by the Vancouver Coastal Health region with 2,785 establishments (data not shown).

Table 2 provides the overall rates of licensed liquor establishments per 100,000 population, as well as the three liquor licence types related primarily to the creation and purchase of alcohol – liquor primary, food primary and manufacturer licence. **As expected, the rate of establishments with manufacturer liquor licences is substantially higher in the Interior – more than three times higher than the provincial rate of licensed liquor manufacturers.**

HA	Rate of licensed liquor establishments per 100,000 population		
	All Licences	Liquor Primary	Manufacturer
B.C.	192.7	13.2	14.0
Interior	290.9	18.6	42.7
Fraser	251.7	9.8	5.8
Northern	80.9	24.3	6.0
Vancouver Coastal	233.3	9.2	9.0
Vancouver Island	212.7	17.6	14.3

Abbreviations: B.C. – British Columbia; HA – health authority

Table 2. Rate per 100,000 population of licensed liquor establishments in B.C., stratified by health authority and liquor licence type (not including food primary). *Note:* This table presents the rates of selected liquor licences. Food primary, catering, UBrew/UVin and wine store licences are not included. *Source:* Government of B.C. https://www2.gov.bc.ca/gov/content/employment-business/business/liquor-regulation-licensing/liquor-licence-permits/liquor-resources-information/bc-liquor-licensed-establishment-locations

HSDA	Rate of licensed liquor establishments per 100,000 population		
	All Licences	Liquor Primary	Manufacturer
Interior	290.9	18.6	42.7
East Kootenay	401.7	138.4	20.3
Kootenay Boundary	307.3	112.0	19.4
Okanagan	286.4	57.2	71.4
Thompson Cariboo Shuswap	252.5	77.1	12.4

Abbreviations: HSDA – health service delivery area; TCS – Thompson Cariboo Shuswap

Table 3. Rate per 100,000 population of licensed liquor establishments in the Interior Health region, stratified by HSDA and liquor licence type. *Note:* This table present the rates of selected liquor licences. Food primary, catering, UBrew/UVin and wine store licences are not included. *Source:* Government of B.C. *https://www2.gov.bc.ca/gov/content/employment-business/business/liquor-regulation-licensing/liquor-licence-permits/liquor-resources-information/bc-liquor-licensed-establishment-locations*

Within the Interior Heath region, the rate of liquor licences was highest in the East Kootenay, followed by the Kootenay Boundary (**Figure 7** and **Table 3**). The Okanagan region had the highest rate of manufacturer licences.

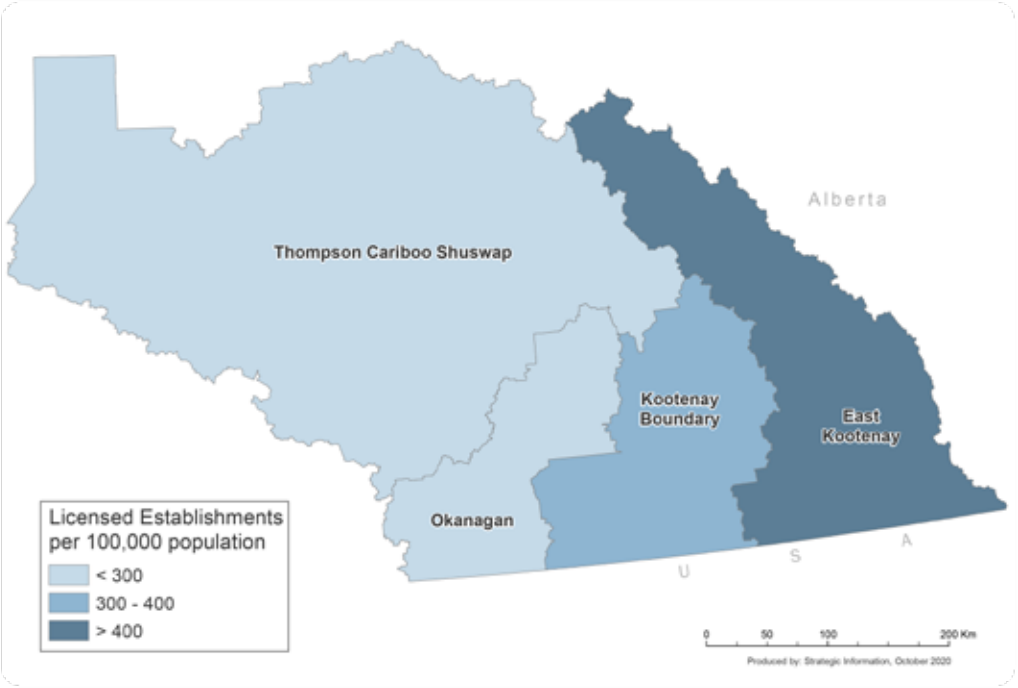

Figure 7. Alcohol density map of the Interior Health region and HSDAs per 100,000 population. *Note:* Liquor licence rates include all forms of liquor licences, including food primary licences. *Source:* Government of B.C. https://www2.gov.bc.ca/gov/content/employment-business/business/liquor-regulation-licensing/liquor-licence-permits/liquor-resources-information/bc-liquor-licensed-establishment-locations

Alcohol and Youth: Findings from the 2018 B.C. Adolescent Health Survey

The B.C. Adolescent Health Survey is a province-wide survey administered to youth in Grade 7- 12 every five years since 1992. The survey gives an evidence base of youth health trends, emerging issues, and risk and protective factors for healthy development. **In 2018,** [17] **44 per cent of youth ages 12-19 reported having had a drink of alcohol.** The most common age for youth to have their first drink of alcohol was 14 years. Females were slightly more likely than males to have tried alcohol (45 per cent of females vs 43 per cent of males). **Among youth who had tried alcohol, 64 per cent had at least one drink in the past month.**

On the Saturday before taking the survey, 15 per cent of all B.C. students had at least one drink. Among students who drank on the Saturday before, 61 per cent engaged in binge drinking. Binge drinking for males was defined as the consumption of four or more alcoholic drinks within a couple of hours, and for females, the consumption of three or more drinks. Females were more likely than males to binge drink (63 vs 59 per cent). Among all B.C. students, five per cent used both alcohol and marijuana on the Saturday before.

When asked about where youth got their alcohol last time, the most common source was an adult, followed by sourcing it at a party and giving someone money to buy it for them proxy-purchase. Respondents often identified more than one source. **The most common reasons youth gave for using alcohol or other substances were wanting to have fun, friends were doing it, and wanting to experiment.** Other reasons were stress, feeling down or sad, feeling that there was nothing else to do, and to manage physical pain. Note that respondents often identified more than one reason.

A little over half of youth who used alcohol or other substances in the past year reported negative consequences. Females were more likely than males to experience negative consequences of their substance use. The most common negative consequences were being told they did something they could not remember, passing out, arguing with family members, and getting injured. Other negative consequences were school work or grades changed, negative impact on relationships with friends or significant other, damaged property, getting into a fight, and having sex when they didn't want to.

Preventure

Preventure is a school-based substance use prevention program developed by the University of Montreal to address adolescent drug and alcohol use in "high-risk teenagers." It has been shown to reduce the likelihood of youth initiating substance use, as well as reduce the frequency of use. The program identifies students with "high-risk" personality characteristics through a survey, and then targets these students with group psychoeducation to provide strategies for managing their specific emotional and behavioural challenges.

Over the last four years, Interior Health has engaged various school districts and other internal and external partners to support the delivery of Preventure. This engagement includes supporting UBC Okanagan's clinical trials with the school district of Vernon and working to increase awareness of the program though presentations and advocacy.

In 2019, Interior Health worked closely with school districts in Revelstoke, Merritt/Princeton and Ashcroft to implement the program for Grade 8 students. Support to these school districts included ongoing engagement with school district administration staff, facilitation of a monthly community of practice, and support with group facilitation. Interior Health has provided updates on the program to the Regional Child and Youth MHSU Steering Committee, the Health Promoting Schools meeting, and the School District Regional Meeting.

Alcohol-Related Hospitalizations and Deaths

The next sections of the report describe health-related harms such as hospitalizations and deaths using counts and age-standardized rates. Counts reflect the actual number of individuals who experienced the harm and give a sense of the demand on health care and other public services. Age-standardized rates allow populations to be compared across geographic regions by removing differences in population size and age profile.

Between 2007 and 2018 age-standardized hospitalization rates in the Interior Heath region were consistently higher than the provincial average, with an increasing trend from 2010 to 2018 of 520 to 580 hospitalizations per 100,000 population (Figure 8).

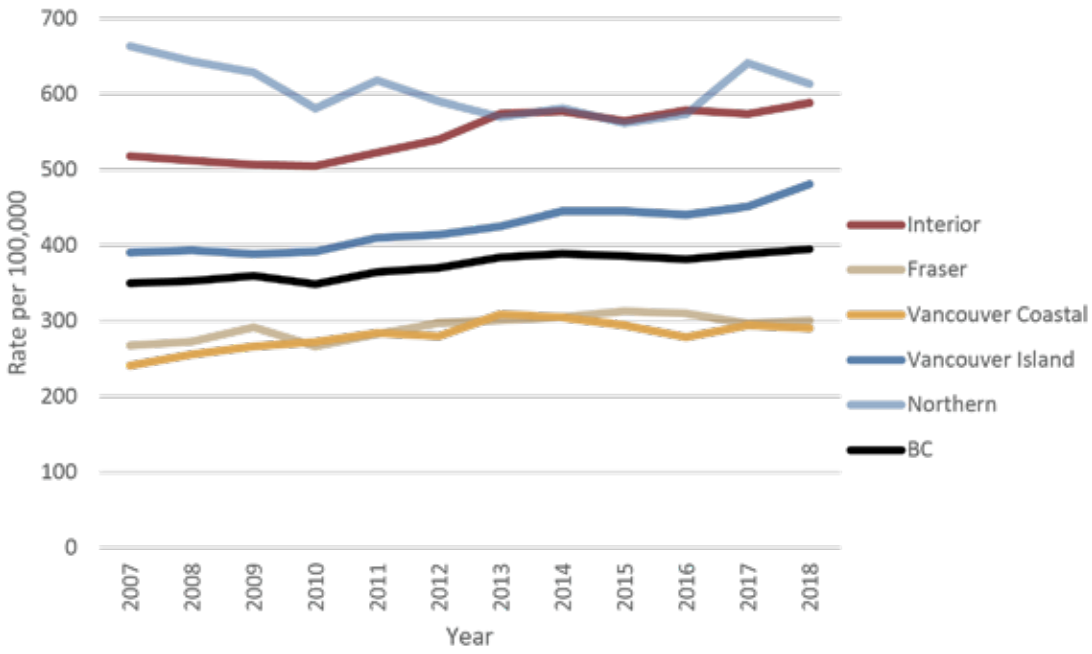

Figure 8. Age-standardized alcohol-related hospitalization in B.C. health authorities, 2007 to 2018. *Note:* Hospitalization data obtained from the B.C. Ministry of Health Discharge Abstracts Database. *Source:* Canadian Institute of Substance Use Research University of Victoria.

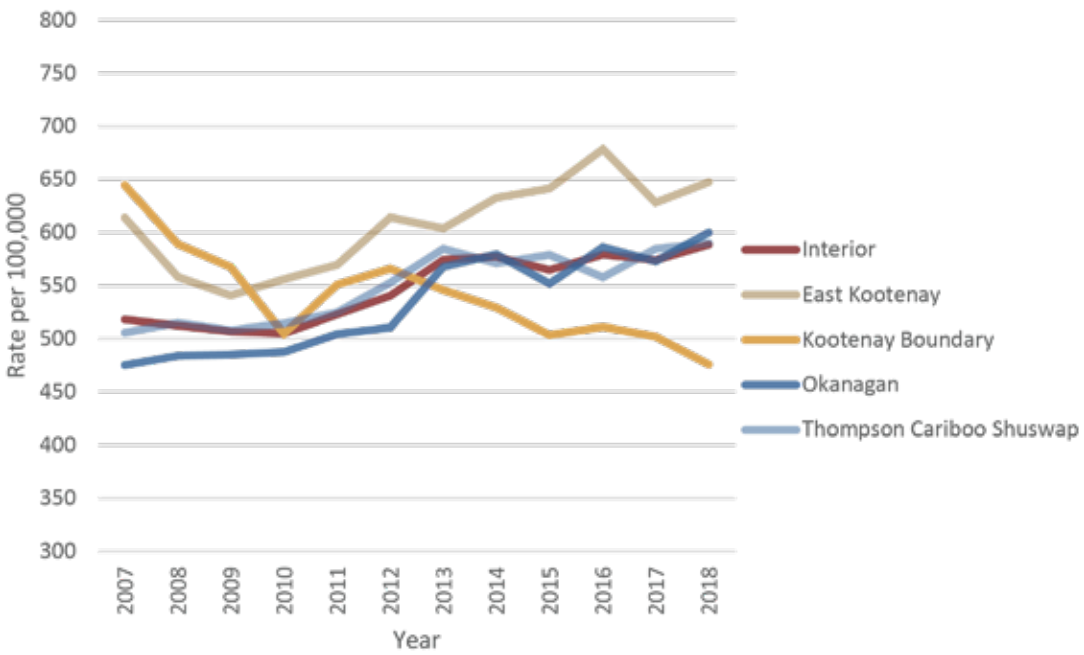

Figure 9. Age-standardized alcohol-related hospitalization in IH HSDAs, 2007 to 2018. *Note:* Hospitalization data obtained from the B.C. Ministry of Health Discharge Abstracts Database. *Source:* Canadian Institute of Substance Use Research University of Victoria.

Within the Interior region, the Okanagan, Thompson Cariboo Shuswap, and East Kootenay have generally seen an increase in age-standardized alcohol-related hospitalizations, with the East Kootenay consistently showing the highest rates (Figure 9). In contrast, the Kootenay Boundary saw a decrease. Figure 10 presents the average alcohol-related hospitalizations from 2009 to 2013 and 2014 to 2018, by local health area (LHA).

While age-standardized rates allow for comparisons between geographic regions, by removing differences in population size and age profile, case counts provide a more accurate sense of the demand on health care and other public services. **The number of people hospitalized due to alcohol in the Interior Health region between 2007-2018 was the second highest in the province (Figure 11).** The highest number of hospitalizations took place in the Okanagan, followed by Thompson Cariboo Shuswap. Both the Okanagan and Thompson Cariboo Shuswap saw an increase in the number of hospitalizations over time, while hospitalizations in the East Kootenay and Kootenay Boundary regions remained stable.

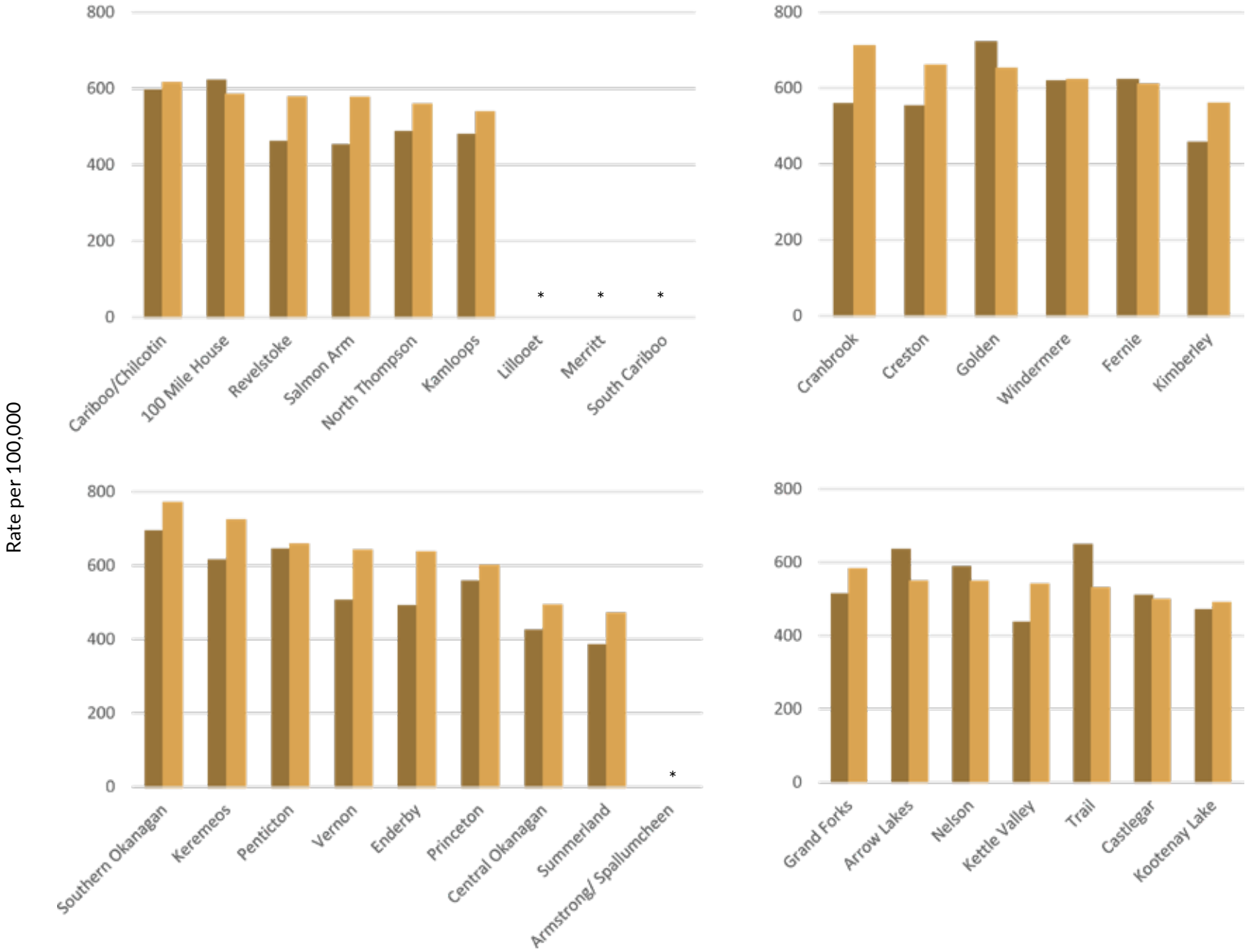

Figure 10. Age-standardized alcohol-related hospitalization in IH LHAs, 2009 to 2018.
Note: Hospitalization data obtained from the B.C. Ministry of Health Discharge Abstracts Database. *Note:* Rates are suppressed for LHAs denoted with a *, due to recommendations and agreements in place with First Nations Health Authority. *Source:* Canadian Institute of Substance Use Research University of Victoria.

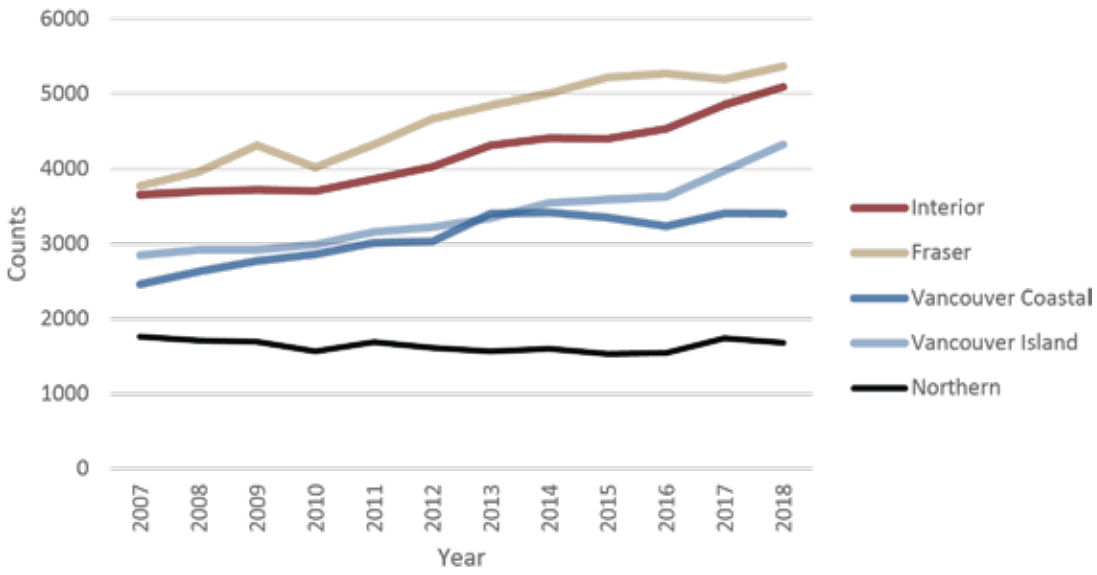

Figure 11. Alcohol-related hospitalization in B.C. health authorities, 2007 to 2018. *Note:* Hospitalization data obtained from the B.C. Ministry of Health Discharge Abstracts Database. *Source:* Canadian Institute of Substance Use Research University of Victoria.

Alcohol-related deaths typically arise from complications of alcohol use itself (e.g. liver cirrhosis) or alcohol related injuries (e.g. motor vehicle accident, drowning). The B.C. Coroner's Service reports on alcohol-related mortality in three different categories: transport, suicide and drowning. These data are extracted from the B.C. Vital Statistics registry. [18]

The age-standardized alcohol-related mortality rate in the Interior region surpassed the provincial average between 2007-2018 (Figure 12). While the rate was relatively stable between 2007 and 2012, it has been increasing since then for B.C. as a whole and in the Interior region in particular. Alcohol-related mortality rates were similar within Interior region HSDAs (data not shown). **In 2017, there were 589 alcohol-related deaths in the Interior Health region (Figure 13).**

Alcohol-related transport mortality has been consistently higher in the Interior region compared to the provincial average, contributing to the higher than average alcohol mortality observed in the region. This mortality has declined over time with the difference between the Interior region and the province narrowing. In 2007, mortality-related to transport in the Interior Health region was 6.6 per 100,000 compared to 3.0 per 100,000 for the province, whereas in 2017, the rates had declined to 1.3 and 0.7 per 100,000 respectively.

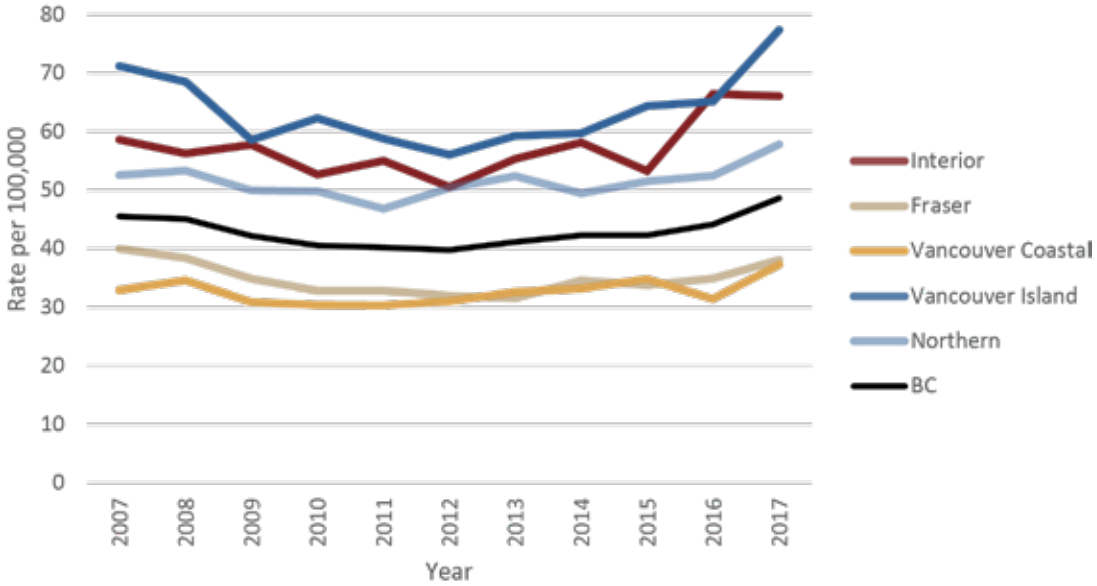

Figure 12. Age-Standardized alcohol-related mortality, 2007 to 2017, B.C. and Regional Health Authorities. *Source:* Canadian Institute of Substance Use Research University of Victoria. *Note:* Hospitalization data obtained from the B.C. Ministry of Health Vital Statistics Death database.

Age-standardized alcohol-related suicide death rate in the Interior Health region has declined from about four deaths per 100,000 in 2014 to slightly below two per 100,000 in 2017, which was similar to the provincial average. Drowning deaths related to alcohol in the Interior Health region are difficult to interpret due to small or suppressed numbers available between 2007 and 2017. Where reported, the rates ranged from 1.8 deaths per 100,000 people in 2010 to 0.6 deaths per 100,000 people in 2017; in terms of counts, these rates translate into 12 deaths and five deaths, respectively. Overall, the trend in B.C. is a decrease in alcohol-related drownings over time.

Age-standardized alcohol-related premature mortality-related to alcohol reflects the people who died during their productive years (before age 75). **Between 2007-2018, the premature mortality rate for the Interior Health region was consistently higher than the B.C. average.**

Health and Social Support Services Available in the Interior Region

Alcohol use encompasses a continuum of behaviours with varying degrees of harm. As such, a broad range of programs and interventions are necessary along the continuum to reduce risk and harm at all stages. It is important to note that harmful alcohol use is a complex and multi-faceted issue that can be influenced by trauma, racism, peer pressure, social determinants of health and issues relating to health equity and social justice. **Focusing on the alcohol use alone without addressing these broader issues is likely to be insufficient.**

A Harm Reduction Approach to Alcohol Use

Harm reduction is a pragmatic approach that focuses preventing death, disease and injury associated with risky behaviours. [19] Emphasis is placed on personal choice "starting where a person is at". With its foundation in human rights, a harm reduction approach accepts an individual's right to self-determination and supports informed decision making. Harm reduction is an integral component of the continuum between health promotion, illness prevention, treatment and recovery.

The harm reduction philosophy can be applied to the full range of the services from alcohol prevention programs to delay onset of alcohol use, education programs on safer alcohol and other drug use, and impaired driving prevention programs. Harm reduction supports the implementation of evidence-based treatment approaches that do not require abstinence such Managed Alcohol Programs, pharmacological approaches and the provison of safe and inclusive spaces for people who are impaired and at risk of harm.

An Interior Health harm reduction policy would help the organization to standardize and foster a culture of reduced harms in all aspects of client and family/partner-in-care interactions with the health system. Training in harm reduction is critical for workers who may interphase with clients facing conditions that are traditionally stigmatized, such as alcohol misuse and illicit substance use. **Meaningful interactions with staff can translate in an opportunity for engagement, with clients choosing to access necessary health services and receiving appropriate care.**

Stigma and Substance Use

Perceived stigma and self-stigma, the internalization of negative societal attitudes about mental illness, prevent individuals from seeking support for alcohol misuse. Stigma creates barriers to service access and engagement with treatment, and contributes to decreased care retention and poorer health outcomes. Stigma amplifies racism and other forms of discrimination that increase health and social inequalities, and contributes to the ongoing marginalization of people affected by substance use.

A small number of initiatives aimed at decreasing stigma at Interior Health are underway. These include the development of an Addressing Stigma Toolkit , a digital 'end stigma' campaign and a 'words matter' initiative. There is an opportunity to amplify this work by creating an organization-wide strategy that includes targeted interventions, measurement, policies, and training.

Primary Care

Despite the significant burden of disease, social harms and economic costs attributed to alcohol, high- risk drinking and alcohol use disorder frequently go unrecognized and untreated in the health care system. **Rather than preventing or reducing harm through early intervention and treatment, providers are often left managing the negative consequences of alcohol use.** Simplified screening tools such as the *Modified Single Alcohol Screening Questionnaire* can readily identify at risk individuals.

Even when recognized, alcohol use disorder is a significantly under-treated condition across Canada, with a sizable gap between what is scientifically known and current treatment approaches. Most individuals can be effectively managed in the outpatient primary care setting. **Effective medical treatments include four medications that provide hope and reduce suffering, yet less than one per cent of people with alcohol use disorder have access to effective pharmacotherapy treatments.** The new B.C. Centre for Substance Use (BCCSU) Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder [20] highlights and supports the use of evidence-based treatments, such as safe and effective pharmacotherapies that help manage alcohol withdrawal, reduce alcohol consumption and prevent relapse (Appendix 1).

An important barrier that hinders the widespread use of pharmacotherapy for alcohol use disorder is that many care providers, patients and members of the public still consider this brain disorder to be a moral failing or due to a weakness of character. As such, they remain unaware of the existence of effective medical therapies resulting in patient options and therapies based on outdated information. Compounding this knowledge gap, alcohol use disorder is still largely viewed with stigma rather than with compassion.

Specialized Care

In Interior Health, addressing alcohol related harms is part of a comprehensive and integrated system of substance use and mental health care that spans primary care, acute services, and specialized substance use treatment, as well as contracted services and community agencies. This system aims to ensure people can access effective supports and treatment that meet their needs.

As part of this system, Interior Health provides substance use services for youth and adults across the region including [21] outreach services and overdose prevention services to reduce barriers for clients to engage in services; treatment options including counselling, day treatment programs, facility-based treatment; withdrawal management services to support clients through acute stages of withdrawal in an inpatient or home-based setting, substance use connections; and wellbeing and relapse prevention including long term support such as support recovery. Additional information on location and description of each of the services can be found here.

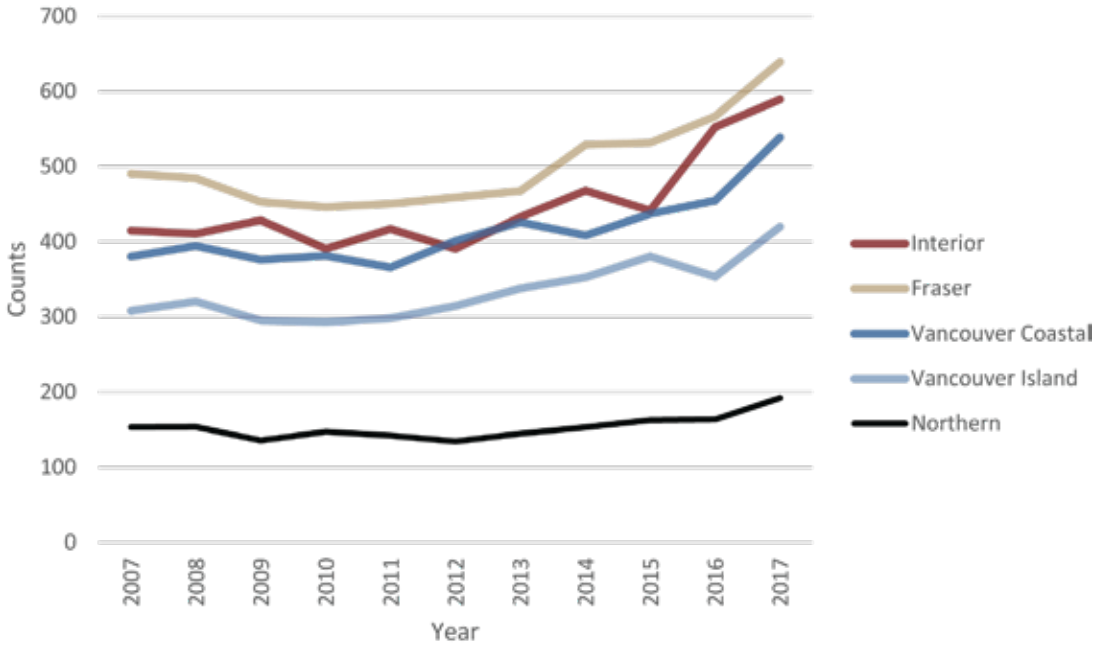

Figure 13. Alcohol-related deaths 2007-2017, B.C. and Regional Health Authorities. *Source:* Canadian Institute of Substance Use Research University of Victoria. *Note:* Hospitalization data obtained from the B.C. Ministry of Health Vital Statistics Death database.

Strengthening Our System

The MHSU System of Substance Use Care Model (**Figure 14**) outlines the major system components involved in delivering substance use care and the essential functions provided in comprehensive systems of care, and highlights system characteristics critical to reducing barriers to care. Its primary function is to inform system planning and transformation.

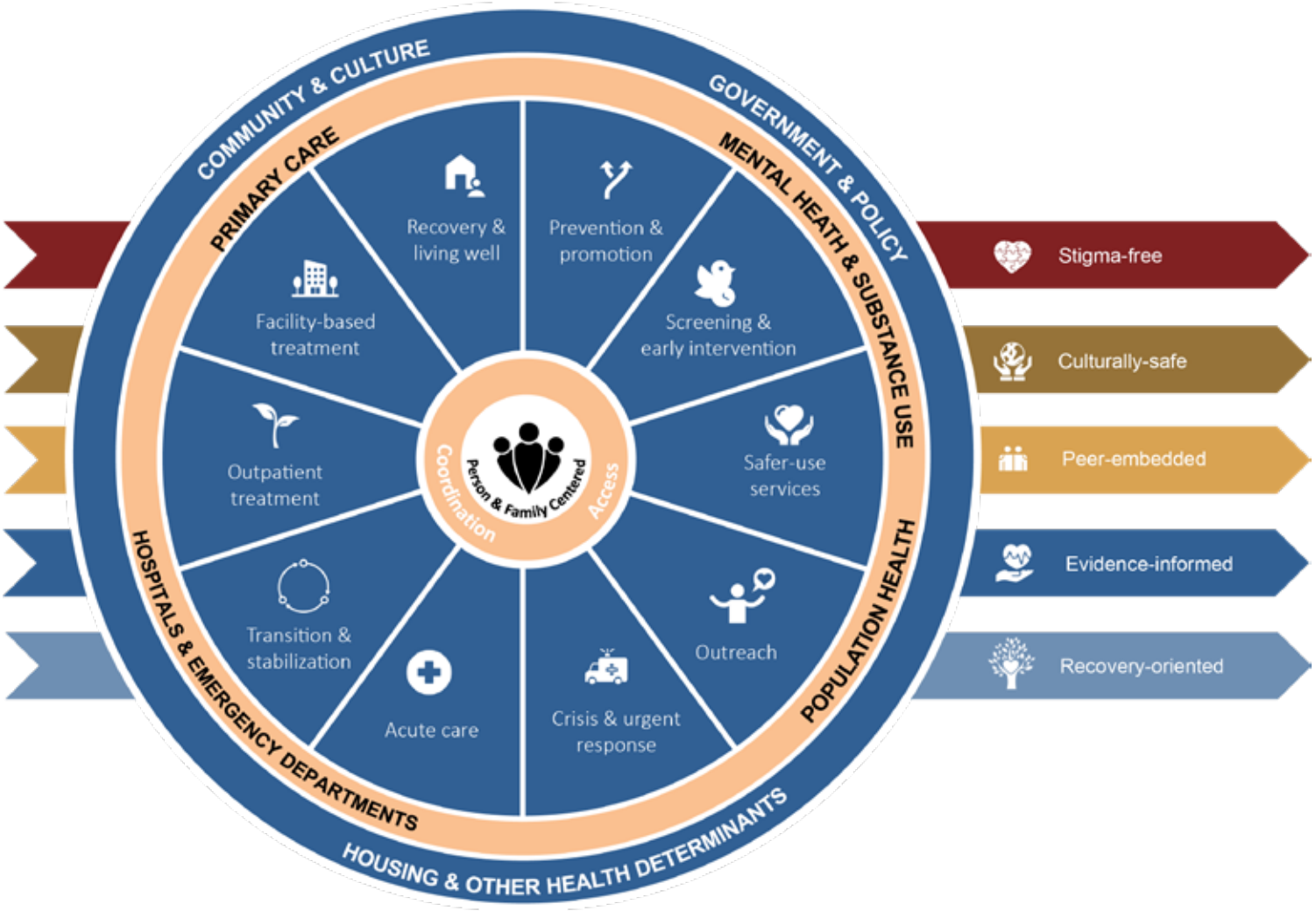

Figure 14. The MHSU System of Substance Use Care Model

Interior Health has a dedicated Substance Use Team within the Mental Health & Substance Use Network. This team is focused on ensuring that **all people who use substances have access to safe, effective, and compassionate person-centered care, when and where they need it.** Working with community partners, this team is improving the quality and consistency of substance use treatment and services throughout the region and expanding access to evidence-informed substance use care.

A recent system gap analysis, *Time for Change: Interior Health Substance Use System of Care Gap Analysis and Service Inventory (2020)* conducted by the MHSU Network identified several opportunities to strengthen the system of care and better meet the needs of people who experience high-risk drinking. Opportunities to strengthen quality of services include: 1) integrating screening and early intervention process in general care settings across all leves of care; 2) application of evidence-based pharmacotherapies for alcohol use disorder in general care settings across primary care, acute care and urgent primary care centres [22]; 3) implementation of home-based withdrawal management services, and 4) expanded access to community and acute-managed alcohol programs

In respose to the system gap analysis, an Interior Health-wide framework, *Ensuring Every Person Matters: A Collective Framework for Strengthening Substance Use Care Across Interior Health*, and workplan has been developed. This framework is intended to create a comprehensive, connected healthcare system whereby all people affected by substance use can receive safe, effective, and compassionate person-centred care and treatment when and where they need it.

Provincial Context

A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia lays out the B.C. government's 10-year vision for mental wellness with the purpose to improve mental health care and establish an effective substance use prevention, addictions treatment and recovery system. [23] Initial priority actions in the three-year plan include:

1. Improved Wellness For Children,Youth And Young Adults
2. Supporting Aboriginal-Led Solutions
3. Substance Use: Better Care, Saving Lives
4. Improved Access, Better Quality

Specifically, the plan highlights the major toll of substance use on physical and mental health, with alcohol use being the leading risk factor globally for death and disability in people aged 15 to 49 years. Increasing rates of alcohol-related hospitalizations and deaths have coincided with the emergence of fentanyl in the illicit drug supply to heighten demand for addiction prevention, treatment and recovery services. An integrated system of care must address alcohol use in the context of the opioid overdose crisis, and incorporate standards, best practices, and meaningful Aboriginal cultural humility and safety training.

First Nations, Métis, and Inuit Peoples

In developing this report, it was recognized that a conventional approach to health needs assessment may not encompass the unique and historical influences on substance use when considering alcohol and Aboriginal peoples. A new partnership approach is needed, which is collaborative in nature, rests on solid relationships with Aboriginal partners, and serves to emphasize strengths, assets,and resilience. Any approach needs to be based on an understanding of the how alcohol use relates to ongoing complex trauma impacts, racism, power imbalances and colonization.

We briefly discussed the development of this report with Interior First Nation and Métis Nation British Columbia representatives, which reaffirmed that approaches moving forward need to be grounded in understanding the colonial narrative and colonial trauma, self determination and be action oriented. Interior Health remains committed to taking action and working in partnership with Aboriginal partners to enhance the health and wellness of Aboriginal peoples and communities (Figure 15).

Specific considerations include:

Understanding the colonial narrative:

- Prior to European contact, Aboriginal people practised fishing, hunting and gathering of traditional foods and medicines that led to an active and healthy lifestyle enriched by ceremonial and cultural practices.
- Colonization introduced devastating impacts to Aboriginal peoples' health through forced displacement from their land, disconnection from culture, family and community, language, ceremony and traditions.
- Alcohol was introduced by European colonizers as a tool to manipulate Aboriginal peoples in a variety of ways including to purposefully breakdown family structures, alliances and kinship ties to lower their defences as a tactic to negotiate and encouraged excessive and abusive consumption.
- Aboriginal people were subject to prohibitory alcohol laws (including but not limited to the Indian Act of 1876), as an attempt on the part of the Canadian government to facilitate assimilation.
- The direct linkage between colonization with the historical origins of alcohol use in Aboriginal populations, and the current effects of anti-Aboriginal racism and colonial trauma continue to perpetuate barriers to relevant and appropriate care.
- Being respectful of the lived experiences of Aboriginal partners. A well-intended conventional public health approach can be harmful and re-traumatizing when focused only on deficits, without adequately recognizing historical and current context, and the direct links with health inequity.
- Work that examines the drivers of alcohol and other substance misuse, and that attempts to reduce or eliminate these drivers, will inevitably involve examining: the colonial structures of power, relevancy and cultural safety of services and approaches; systemic and individual racism; and the adverse social determinants of health, including basic services (e.g. water, sewage, education, internet access etc), as well as the geographical location of services.

Self-determination:

- First Nations, Métis and Inuit communities are not a single entity, and that distinction-based approaches are required, as approaches to and perspectives on alcohol and other substances will vary between communities and Aboriginal partners.
- An approach grounded in human rights and committed to the self-determination of Aboriginal partners, with respect to the development and delivery of process, policy, services and governance, may be more helpful than a conventional, deficit-based data gathering approach.
- If indicators are to be used, wellness indicators developed with Aboriginal partners would be more appropriate.

Action-oriented:

- There should be concrete timelines for achieving tangible deliverables, in terms of resource allocation, service improvement and self-determination. This involves the transfer of resources to Nations and the relinquishment of power and control by regional and provincial authorities.
- Further work with Aboriginal partners, to understand the issues and explore solutions, needs to be properly resourced at a level that respects people's time, effort and lived experience. Primary care may also be a key partner in this work.
- Ongoing engagement efforts with Aboriginal partners, to further health authority understanding of the issues and explore meaningful approaches to resolution.
- As well, there is required commitment from Interior Health and the Mental Health and Substance Use Network and Operations for ongoing meaningful engagement of Aboriginal partners in any substance use service planning as determined by Aboriginal partners.
- Within the Substance Use Strategic Framework under development, additional consultation with Aboriginal partners and consideration of Interior Health actions related to the In Plain Sight report is required to determine specific actions.

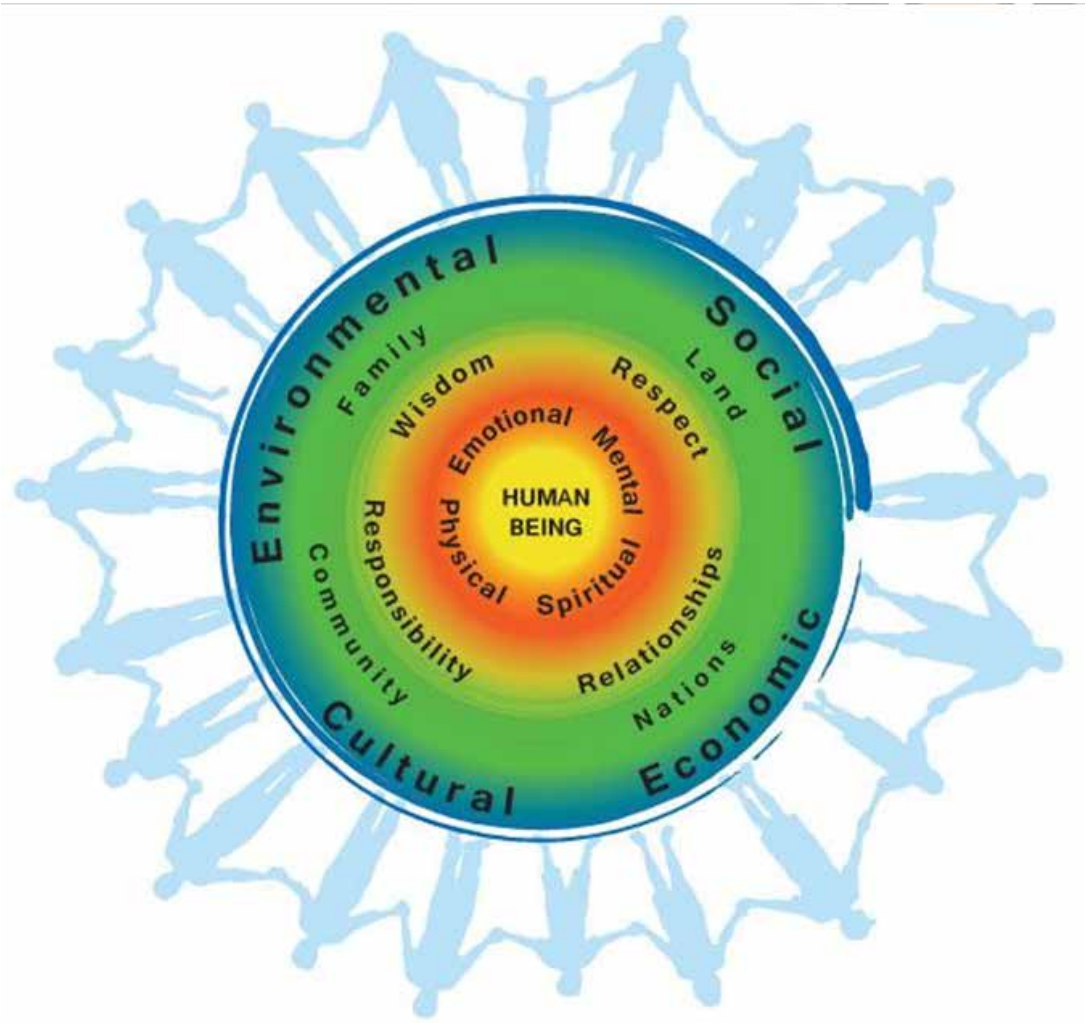

Figure 15. First Nations Perspective on Health and Wellness. *Source:* First Nations Health Authority Policy on Mental Health and Wellness [24]

COVID-19 Pandemic Impacts on Alcohol Use

A COVID-19 pandemic was declared by the World Health Organization on March 11, 2020, and a provincial emergency was declared in B.C. six days later prompting stringent control measures to reduce social contact. Preliminary data shows pandemic restrictions have lead to increased stress, worsened mental health and increased substance use with disproportionate effects on vulnerable groups. **Notably, the incidence of overdose deaths in the province and the Interior Health region increased dramatically during the pandemic, and 2020 is positioned to be a tragic, record-breaking year for lives lost due to overdose.** Adverse outcomes related to substance use are likely rooted in a combination of factors such as increased use of substances as a coping mechanism to reduce stress, and reduced health and social supports during lockdowns.

The B.C. COVID-19 SPEAK survey was a web-based population health survey designed to elicit B.C. residents experience, knowledge and behaviours during the COVID-19 pandemic. The purpose of the survey was to shed light on the impacts of COVID-19 and inform approaches for future public health measures. The survey ran for two weeks during May 2020, the target population for the survey was residents of B.C. who were 18 years of age or older.

A total of 394,382 people responded provincially, with 56,501 surveys completed in the Interior region. The response rate in the Interior was higher than initially anticipated; however, certain demographic groups may be underrepresented in the results. Adjusted analyses were conducted to address under represented groups.

The survey results showed that alcohol consumption increased during the first three months of the COVID-19 pandemic. Twenty seven per cent of respondents reported increasing their alcohol consumption in the province. In the Interior Health region, the increase in alcohol consumption was similar to the provincial average, with 26 per cent of respondents reporting increased alcohol consumption (**Figure 16**). Across the region's HSDAs, those reporting increased alcohol consumption ranged from 24 per cent of respondents in the East Kootenay region to 27 per cent in the Okanagan.

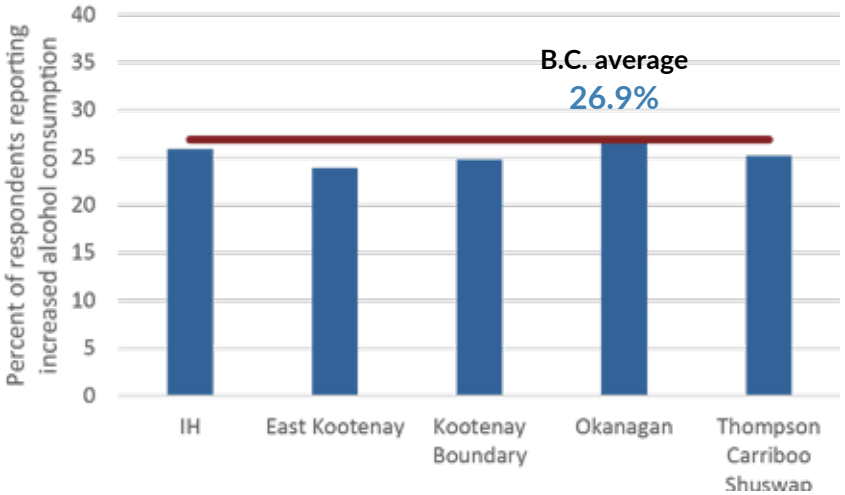

Figure 16. Increased alcohol consumption in IH HSDAs, results of B.C. COVID-19 SPEAK survey. *Source:* B.C. COVID-19 SPEAK results [25]

More younger individuals reported increasing their alcohol consumption during the pandemic (Figure 17). In the Interior Health region the percentage of adults under 50 years who reported increased alcohol consumption was slighly higher than the B.C. average. Conversely, a lower percentage of adults over age 50 reported increased consumption compared to the B.C. average, with the exception of adults over age 80.

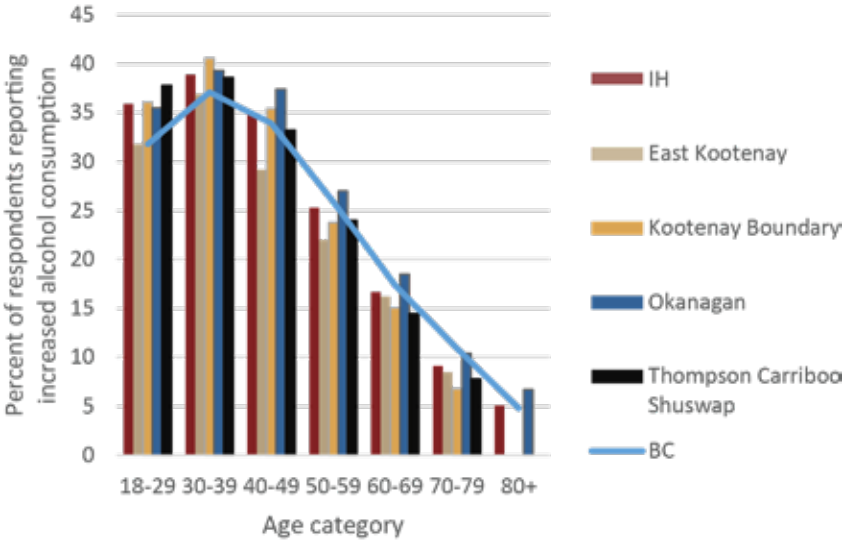

Figure 17. Increased alcohol consumption in IH HSDAs by age category, results of B.C. COVID-19 SPEAK survey. *Source:* B.C. COVID-19 SPEAK results [25]

Interior Health's Managed Alcohol Program During the COVID-19 Pandemic

An important control measure to prevent the spread of COVID-19 is the self-isolation of cases and contacts. Individuals who struggle with alcohol dependence may struggle to comply with isolation recommendations due to their need to access alcohol to prevent withdrawal which can be life-threatening.

Managed Alcohol Programs are evidence based intervention that allow individuals who meet certain criteria to access a regular dose of alcohol, typically at a shelter-based harm reduction centre. The purpose of such programs are to mitigate health and social harms such as drinking non-beverage alcohol and criminal activity to access alcohol. Provision of managed alcohol may be appropriate for individuals with alcohol use disorder who are not retained or have declined treatment and are unable to safely obtain alcohol.

Interior Health implemented a managed alcohol programs for vulnerable populations during the pandemic in order to support clients to comply with self isolation protocols. The program was rolled out through Mental Health and Substance Use in partnership with housing or shelter providers in Kelowna, Kamloops, Penticton, Vernon, Williams Lake, Trail, Grand Forks and Nelson. Additionally, a COVID-19 Managed Alcohol Program pre-printed order was developed at Kelowna General Hospital to support the admission of acute inpatients with moderate to severe alcohol use disorder.

Public Policy and Alcohol

The Canadian National Alcohol Strategy, launched in 2007, provides 41 recommendations for action across four strategic areas: health promotion, prevention and education; health impacts and treatment; availability of alcohol; and safer communities. [26] The notion of sensible alcohol use, or developing a culture where moderation is the goal, underpins the Strategy. A status report update in 2017 demonstrated significant progress had been made in the implementation of the strategy. [27]

A culture of moderation, "…signals a new way of thinking about alcohol use that includes an understanding of when, when not and how much to drink, appropriate motivations for drinking and settings in which responsible drinking should take place." As such, developing a culture of moderation to reduce alcohol-related harm requires an understanding of the different risks involved in drinking how to minimize these risks. [26]

Public policies can support create and maintain a culture of moderation. Some evidence-based, effective policy practices to reduce the societal and health harms of alcohol include pricing, restricting consumer access to alcohol, limiting marketing and sponsorship, and enforcement activities among others. [28] Provinces and territories develop their own alcohol policies that define the legal drinking age in that jurisdiction. This dictates who can purchase, possess, consume and supply alcohol.

Local governments can have an influence on how alcohol is consumed in their communities while balancing the need to support the local alcohol industry. A culture of moderation can be reinforced through bylaws and and advocacy by elected officials. Zoning, special event bylaws, increased enforcement of drinking and driving legislation are examples of interventions that can be advanced at the community level.

Local governments can consider developing a municipal alcohol policy with input from the public and including considerations from the business sectors and community. Such a policy can help clarify and strengthen policies that are already in place, but that may not be consistently upheld. Several communities in B.C. have developed municipal alcohol policies, such as West Vancouver, Prince George, Fort St. John, Fort St. James, Kitimat, and Pemberton.

It is important to note that policies and programs that target alcohol use can have a disproportional impact on under-served, marginalized, and diverse individuals and groups. An equity lens can be useful in analyzing or diagnosing the impact of alcohol policies on different populations. For example, minimum pricing policies can be effective in reducing alcohol related mortality by increasing alcohol price. Expensive alcohol beverages however may push low income alcohol dependent individuals to use toxic non-beverage alcohol such as hand sanitizer, engage in criminal activity to be able to afford alcohol, or turn to illicit substances. [29]. Another example are policies that criminalize public drinking and intoxication, which tend to be disproportionally enforced against marginalized populations.

Sobering centres are operated in several communities across the province to provide a health-focused alternative to the criminalization of public intoxication. Sobering centres offer a non-judgemental and safe space for people under the influence of alcohol or drugs (as opposed to police cells or public spaces) and linkages to appropriate medical care, treatment and housing supports. Evidence indicates that sobering sites have a positive impact on court time, domestic violence and demand on health and emergency medical services. [30]

Finally, social marketing campaigns with mass media messages to reduce alcohol consumption and related harms have been effective in changing knowledge, attitudes and beliefs about alcohol. Given the range of factors that influence alcohol use, social marketing campaigns need to be part of a multi-level approach to addressing alcohol-related harm, reinforce a culture of moderation, and have a positive influence on behaviour change.

Seeking Input from Local Governments

A focus group with local governments was held in October 2020 to hear concerns and suggestions regarding alcohol use in IH communities. **This is what we heard:**

What are your concerns?

Public drinking *is an issue. Policing services cannot "arrest people out of their dependence on alcohol."*

Rural communities ***perceive a lack of or gap in services*** *and programming for treatment and detox of alcohol.*

Drinking and driving. ***Limited transit services*** *within communities and road safety concerns for peole walking or biking after drinking*

Any local initiatives?

The ***Responsible Liquor Consumption in Designated Public Places – Pilot Project*** *in Penticton was implemented in 2020 to allow consumption of alcohol in designated public parks and beaches. An evaluation conducted by city staff a month later considered the pilot successful with little disruption and no added costs to enforcement. City staff recommended that a similar bylaw be created in 2021.*

What would be helpful?

Community grants *have been helpful in advancing local issues such as alcohol. Grants have allowed* ***convening a cross-sectoral table*** *including Interior Health, non-profit organizations, policing services among others.*

Community grants have also been useful to ***action community plans*** *and create a safer built environment. This has allowed giving safer active transportation options to community members such as better street lighting and bicycle infrastructure to prevent drinking and driving.*

The ***role of the liquor inspectors*** *could expand from strictly enforcement to include education and awareness to reinforce a culture of moderation.*

Participants expressed interest in understanding targeted services and interventions for ***alcohol dependency among those who are homeless, precariously housed, or low income****.*

Finally, there was desire by several rural community participants ***to collaborate with Interior Health to advocate for local services and programming****.*

Recommendations

1. Implement improvements to the substance use system of care that will:

a. Increase access to specialized substance use treatment by expanding current services and introducing new, evidence-informed models of care.

b. Enhance care effectiveness by integrating standardized and evidence based approaches to substance use care throughout Interior Health.

c. Create safer services for people who use substances by reducing stigma and discrimination throughout the system, and ensuring that services are culturally-safe and trauma-informed.

2. Approval and implementation of an integrated approach to harm reduction across Interior Health, in order to ensure:

a. IH services provide an evidence-based approach to alcohol-related care, treating all clients and families/partners-in-care with dignity, compassion and in a non-judgemental manner.

b. Staff acknowledges that among people who use substances (PWUS), abstinence may not always be the goal and that the commitment to permanent or temporary (while in care) abstinence is not a requirement for receiving care or treatment. This may mean provision of alcohol or alcohol replacements as the client may need.

c. Staff shall be aware of and will not use or perpetuate stigmatizing, stereotyping and racist language, attitudes and behaviours.

3. Working across Interior Health, to further strengthen relationships and collaborative action with local governments and other community partners to address the determinants of health by:

a. Balancing risk prevention and health promotion by informing policies that reduce alcohol related harms and promote a culture of alcohol moderation.

b. Translating knowledge to inform evidence based interventions.

c. Helping to strengthen protective factors that improve wellness and resilience.

d. Mobilizing collective action to promote, improve and protect community health and wellness.

e. Integrating equity within the social and built environments, leading to improved health outcomes for everyone.

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Appendix 1. Guideline for Clinical Management of High-Risk Drinking and Alcohol Use Disorder.

In 2019, the BCCSU published A Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder for the optimal screening, diagnosis, treatment, and care of individuals drinking above low-risk limits. [20] The guideline sets out 13 recommendations that are supported by high-quality, current, and rigorously reviewed evidence.

Screening and Brief Intervention

1. Clinicians should provide education about Canada's Low-Risk Alcohol Drinking Guidelines to all adult and youth patients.
2. All adult and youth patients should be screened annually for alcohol use above low-risk limits.
3. All patients who are drinking alcohol above low-risk limits but do not have an AUD should receive a brief counselling intervention.

Withdrawal Management

4. Clinicians should use the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) to assess the risk of severe complications of alcohol withdrawal in patients with AUD, in order to select the most appropriate withdrawal management pathway.
5. Patients at low risk of severe complications of alcohol withdrawal (PAWSS<4) who have no other concurrent condition that would require inpatient management should be offered outpatient withdrawal management.
6. Clinicians should consider prescribing non-benzodiazepine medications, such as gabapentin, carbamazepine, orclonidine, for the outpatient management of patients at low risk of severe complications of alcohol withdrawal.
7. Patients at high risk of severe complications of withdrawal (PAWSS ≥ 4) should be referred to an inpatient facility (i.e., withdrawal management facility or hospital) where they can receive a benzodiazepine treatment regimen under close observation, and emergency care can be administered immediately if needed.
8. All patients who complete withdrawal management should be connected to continuing AUD care.

Continuing Care

9. Adult patients with moderate to severe AUD should be offered naltrexone or acamprosate as a first-line pharmacotherapy to support achievement of patient-identified treatment goals..

a. Naltrexone is recommended for patients who have a treatment goal of either abstinence or a reduction in alcohol consumption.

b. Acamprosate is recommended for patients who have a treatment goal of abstinence.

10. Adult patients with moderate to severe AUD who do not benefit from, have contraindications to, or express a preference for an alternative to first-line medications, can be offered topiramate or gabapentin.
11. Clinicians should provide motivational interviewing-based counselling to all patients with mild to severe AUD to support achievement of treatment goals.
12. All patients with mild to severe AUD can be provided with information about and referrals to specialist-led psychosocial treatment interventions.
13. All patients with mild to severe AUD can be provided with information about and referrals to peer-support groups and other recovery-oriented services in the community.


Interior Health