Health Canada Santé Canada

Report from

WORKING TOGETHER: A National Workshop for Action on Women and Substance Use

Health Canada
February 22–24, 1994
Ottawa, Ontario

Canada

This report summarizes the work that took place at "Working Together: A National Workshop for Action on Women and Substance Use", hosted by the Alcohol and Other Drugs Unit, Health Programs and Services Branch, Health Canada, as part of Canada's Drug Strategy. The workshop as held in Ottawa from February 22 to 24, 1994, and comprised 66 participants from across Canada involved in women's health, substance use, and other related areas.

Health Canada would like to thank all the people who helped to plan the workshop and the participants who made the workshop a success.

canada's drug strategy

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Introduction

"... we thank you for the powerful words we have heard here. Please guide them so they will be heard by the people who make decisions ..."

—prayer by Anishinabeg elder, Dorothy Meness

Background

Working Together: A National Workshop for Action on Women and Substance Use was held in Ottawa from February 22 to 24, 1994. Participants included 66 people from across Canada who represented non-governmental agencies and government departments involved in women's health, substance use and related areas. Please refer to Appendix A for a list of participants.

This workshop was the third in a series of national events on women and substance use and abuse. Two roundtables were held prior to the national workshop: one involved federal officials involved in the area, and the other included experts from across the country who helped to plan the national workshop. Participants in the second roundtable identified priority issues to be addressed at the national workshop and made suggestions on the design of the meeting. A Planning Committee then built on this work to pull together the agenda for *Working Together*.

The objectives of *Working Together: A National Workshop for Action on Women and Substance Use* were:

1. To identify key strategies and set a collaborative cross-Canada, health promotion agenda on women and problem substance use.

2. To synthesize and share knowledge and information about issues and strategies related to women and substance use, misuse and abuse in Canada. This includes identified trends, patterns of use and relative risk, especially as they relate to critical life factors, such as age, women's roles and status in society, income, social support and other environmental factors.

3. To encourage links and collaboration among all groups working in women and problem substance use and related issues (e.g. violence, HIV and AIDS, mental health).

Special Features of the National Workshop

In addition to the use of plenary and small group discussions, the national workshop agenda included a number of special features that were designed to increase participation, networking and interest. Please refer to Appendix A for a copy of the agenda.

Showcase

An exhibition area was set up in an area adjoining the meeting room to provide participants with the opportunity to share resources and information about their organizations and areas of expertise. An *Expressions* Board in the Showcase area was available for posting creative work: poems, drawings and thoughts (please see Appendix C-1). Twenty-five groups participated in the showcase. For a list of exhibitors, please refer to Appendix A.

Herstories

Three conference participants shared their personal experiences with problem substance use to help illustrate the situations faced by many women. For details of their stories, please refer to Appendix C-2.

Drama

As part of the first day, a professional acting troupe was invited to perform five short skits, written for the workshop by Beverly Wolfe of Ottawa. Each skit was designed to give a real-life portrayal of the issues and substance abuse problems which can be experienced by women within the context of five life stages: childhood, adolescence, young adulthood, mid-adulthood and senior adulthood. For example, the adolescence skit depicted the relationship of alcohol, tobacco and street drug use to issues such as body image, feeling left out, peer pressure, rebellion and ease of access to drugs.

Opening and Closing Prayers

The meeting was opened and closed with prayers from Anishinabeg elder, Dorothy Meness.

Expectations

At the beginning of the workshop, participants were asked for a brief list of expectations. The following main points were raised:

- to find better strategies for prevention, treatment and promotion
- to explore links between substance abuse and violence, mental health, and HIV/AIDS
- to share expertise, ideas and perspectives
- to network
- to set a clear direction for the future
- to make things happen: to take action
- to recognize and support the needs of front-line workers
- to increase the visibility of women and substance abuse as an issue—with the government and media
- to explore the needs of different sub-groups of women, including Aboriginals, immigrants, lesbians and women with disabilities.

Speech on Behalf of the Minister

Dawn Walker, A/Director, Programs Division, Health Promotion Directorate, Health Canada, delivered a welcoming speech on behalf of the Honourable Diane Marleau, Minister of Health Canada (Appendix B).

Guiding Principles

These principles reflect an approach which is sensitive to women. It acknowledges the diversity of women's experience based on race, culture, sexual orientation, socio-economic status, spiritual beliefs and abilities. The interrelationships of substance abuse and poverty, violence, and other forms of abuse that affect women's lives are recognized.

Women from across Canada have been involved in developing the following statements which guide our efforts.

WE BELIEVE:

→ that women's needs are different than men's, and therefore, alternative approaches are required

→ that we need to proactively address the broader social context of women's lives and the underlying issues which influence their use and abuse of substances

→ that women's substance use and abuse may be a way of coping which eventually diminishes their power, choices and abilities

→ that women have the right to explore and choose healthy ways of living

→ that actively listening to all women is the basis for action

→ that we need to conduct participatory research that reflects women's experience

→ that we need appropriate, accessible and accountable programming and policies that support a continuum of services sensitive to women, their diversity and their life experiences

→ in the strength of partnerships and the need to support collaborative efforts

→ that each step along the path is an important one and needs to be celebrated

Trends in Substance Use by Women

Patricia MacNeil is a project manager in the Health Promotion Studies Unit of the Health Promotion Directorate of Health Canada. Her presentation focused on the need for research that is specific to women and their life situations.

Underlying assumptions about the issue of women and substance use and abuse include:

- patterns and extent of use for most drugs differ between the sexes
- there are different drug use practices associated with different stages of life
- existing general population surveys are based on assumptions most relevant to men, especially those in younger age groups
- research largely ignores the use of psychoactive substances among women in later life.

Research on substance use and misuse needs to be gender-specific because of differences in:

- physiology
- social stigma
- reasons for use
- patterns of use
- outcomes of use and abuse
- support from others
- the incidence of dual disorders
- the incidence of physical and sexual abuse
- morbidity and mortality patterns
- reproductive functions (fetal alcohol syndrome and fetal alcohol effects [FAS/E])
- vulnerability to HIV and AIDS
- prevention and treatment needs

All of the above can be seen as primary issues relating to women and substance abuse.

In the past, research on women and substance use was based on a less than perfect reflection of reality. A male norm was assumed as "standard" for questionnaires, interpretations, and treatment. Women were largely viewed as a subpopulation of homemakers who were sicker, less receptive to treatment, and more difficult to treat. In the 1980s, new research approaches began to emerge that took into consideration some of the many social, economic and political factors affecting women's lives. Attempts must continue to be made to take a more holistic and multidisciplinary approach to research and to identify trends among sub-populations of women according to age, ethnicity, socio-economic status, history of abuse, and sexual preference. Future research should focus on heavy use of alcohol, as well as tobacco and medication use. Women's only surveys should be a priority, as should longitudinal studies, follow-up procedures and general population surveys that include women's issues within the context of their life experience. Other issues to be considered include the female lifecycle, social support, multiple drug use, self-medication, and prescribing and help-seeking practices.

Although some information about trends for women and substance abuse can be extracted by breaking down general population surveys, specialized research is required in addition to this (Please refer to charts in Appendix D-1, prepared by Patricia MacNeil, Florence Andrews and Virginia Carver). The ultimate goal is for a research model that represents the reality in women's lives.

During the question period following the presentation, one participant suggested that opportunities for collaborative research among members of high-risk professions and subgroups such as nurses, nuns and airline workers would be explored.

Issues and Trends Panel

Sexism and the Devaluing of Women

Abby Hoffman is Director General of the Women's Health Bureau, Health Canada.

In Canada today, being female means being less equal. This inequality takes different forms for different groups, based on how society responds to each group's unique characteristics and life situations and how it accommodates or fails to accommodate its particular needs. Ultimately, gender is one of the most significant variables when it comes to health. To understand any aspect of women's health, we have to understand what it means to be female from both a biological and social standpoint. Gender bias tends to appear in one of two forms:

(i) the inappropriate application of programs, interventions, etc. based on male experience to women; and/or

(ii) programs which purport to be specifically tailored to women but which are laden with stereotypes about women's physiology, psychology and behaviour.

Statistics give us a picture of the economic, political and social inequality that women face (see Appendix D-2). In many respects, this has not improved: stress and strain on women has increased in many ways, and a shift in the division of labour within families is badly needed.

Body image and the persistence of socially-defined images of what is desirable and acceptable is also a key issue. Women have a love-hate relationship with their own bodies, the pressure of which has enormous health effects, including anorexia and bulimia, smoking to maintain or lose weight, and the fact that chronic self-hatred may set a pattern for other health-destroying behaviours.

Some factors leading to differences in women's and men's health include:

- biological differences
- some diseases/conditions occur in both men and women but unique, gender-specific aspects are not studied nor understood
- some diseases/conditions occur only or primarily among women (i.e., breast cancer) and have been under-researched
- some aspects of women's health have been over-medicated
- women predominate numerically in the formal, paid health field, but tend to occupy the positions with least influence
- women predominate as the informal care-givers and source of health-related information and guidance in society.

What we can conclude from all of this is that:

1. Gender counts

2. Women’s health—including their patterns of substance abuse—is a function of their social, economic, political and cultural context, and particularly of inequality. We have to work on both fronts—equality in the health system and equality in society.

3. We have to adapt to the reality of women themselves. We must listen to what they have to say, be responsive to their realities, and work with them to change those realities if we can, or find some meaningful methods of adapting or coping if we can’t.

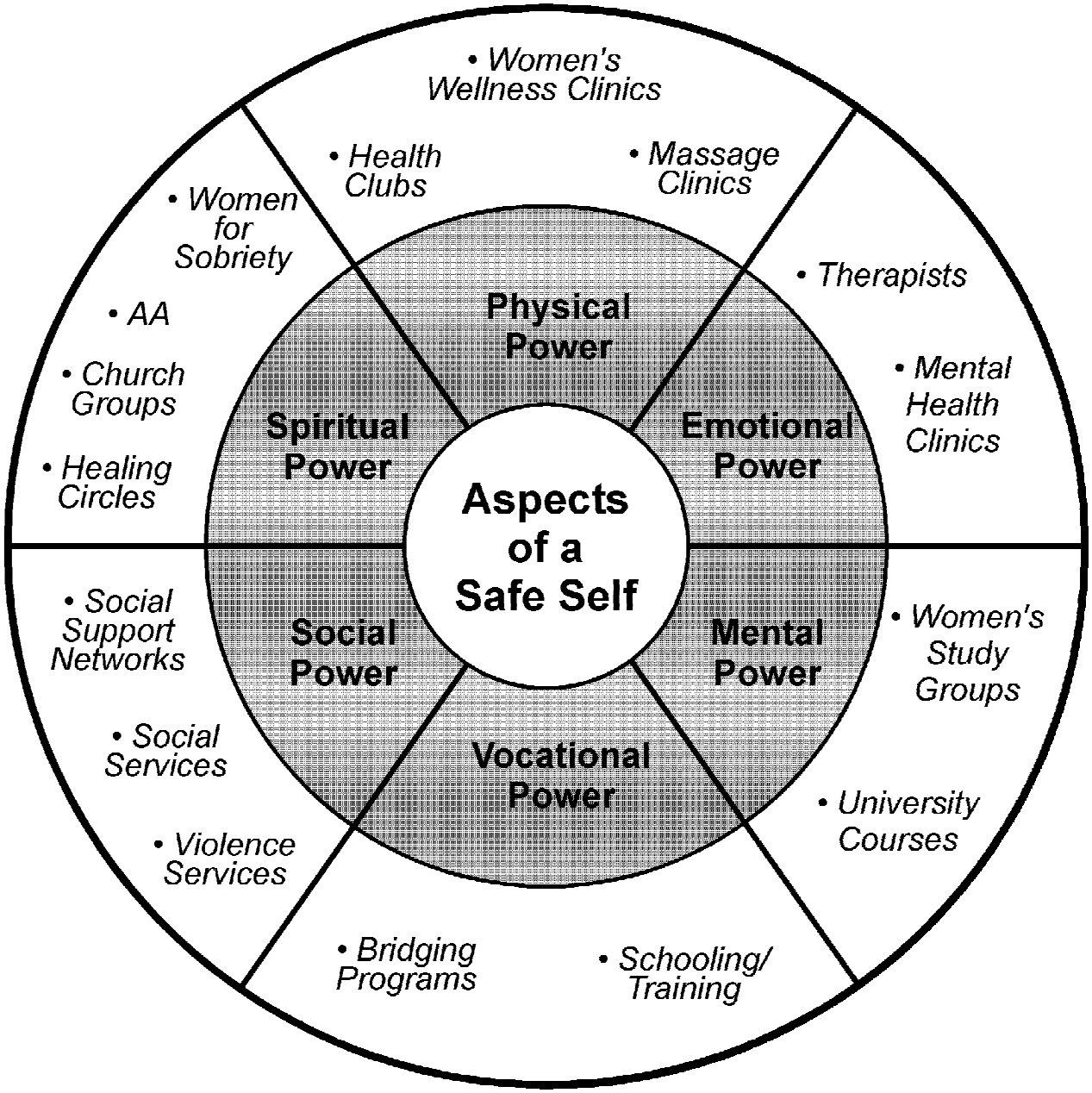
Health Service Issues versus a Feminist Model of Treatment

Miki Hansen is currently the Acting Director of Alcohol and Drug Clinical Services, Ministry of Health and Ministry Responsible for Seniors, British Columbia.

Although we tend to operate from an "us" and "them" standpoint when talking about governments, it is important to remember that bureaucrats are also people. It is also important to acknowledge that some men have great contributions to offer and should not be excluded from this process.

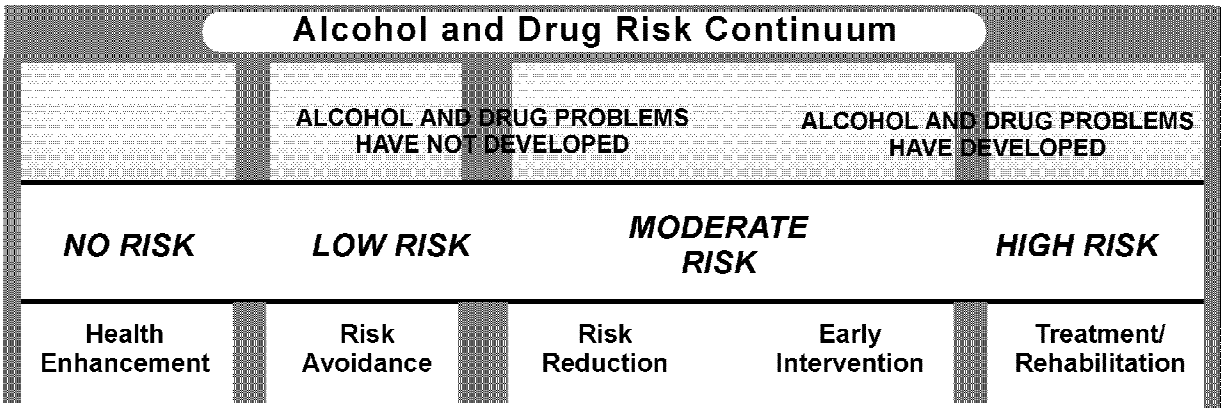
The concept of the Whole Person Wheel was developed as a means of determining how well we are linking women to the community and how well different aspects of their lives are being enriched. The inner ring of the wheel represents the different aspects of a "safe self"—physical, emotional, mental, vocational, spiritual and social power. The outside represents program opportunities to enrich these powers, and illustrates how professionals from a wide range of areas must come together to form a complete service delivery system for women.

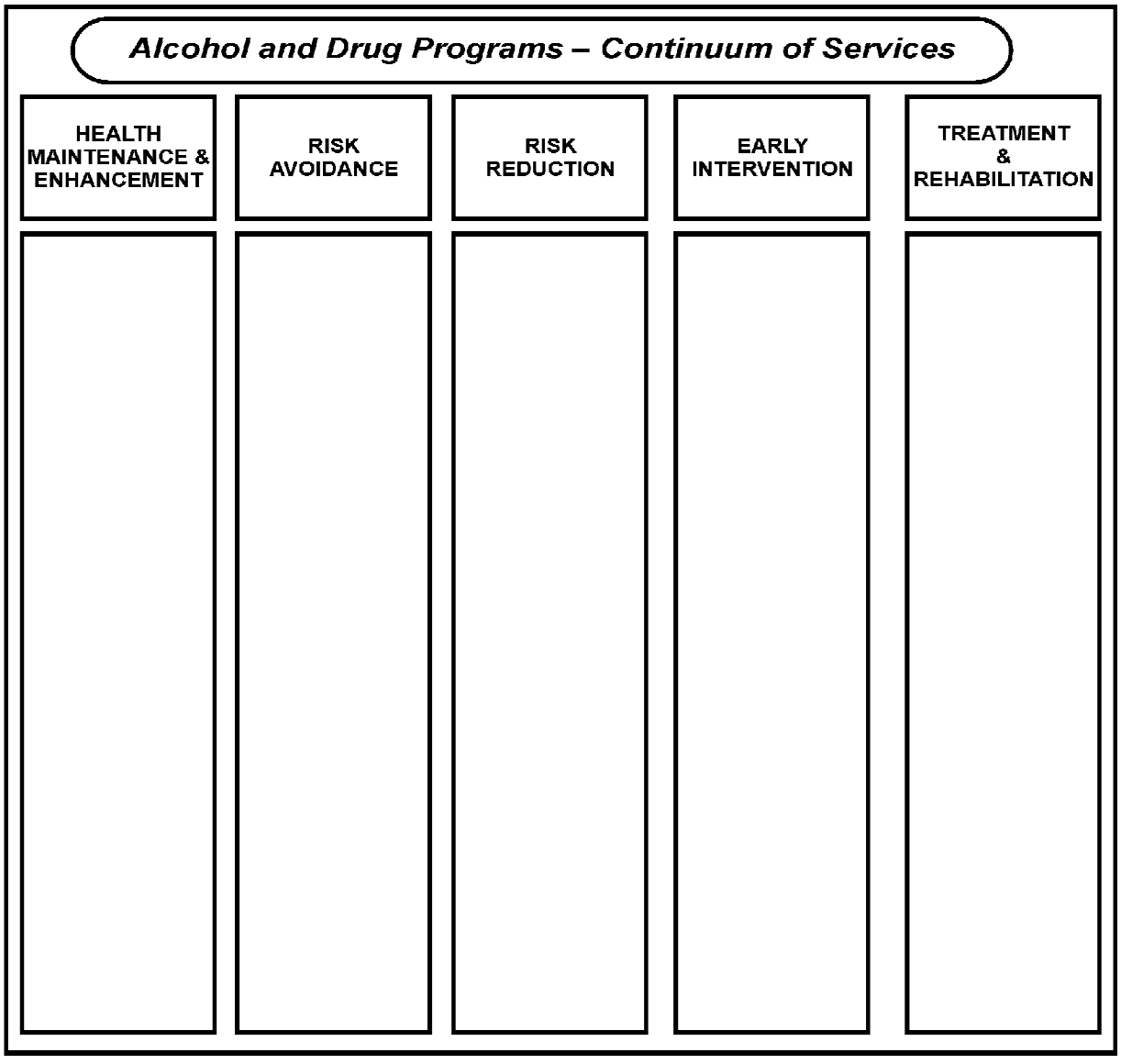
Whole Person Wheel



In British Columbia, we created a committee to examine barriers to program access for women and came up with 26 recommendations for addressing these barriers. We valued the process as much as the outcome: it enabled us to ask women in the community what their needs are and to clarify our understanding of the system of care in the province. We did this by using the Alcohol & Drug Continuum of Services chart to identify the different programs required for each different level of risk—from health maintenance and enhancement to treatment and rehabilitation.

We need to target women as a primary group and give them as many tools as possible. We must address the issue of day-programming; we're currently field-testing a model that is flexible enough for rural women as well. We've created statements about addiction and violence that have been a powerful tool in approaching other groups, and have seen many co-ed residential services in British Columbia become women-only as a result of our efforts.


Alcohol and Drug Risk Continuum
ALCOHOL AND DRUG PROBLEMS HAVE NOT DEVELOPED
ALCOHOL AND DRUG PROBLEMS HAVE DEVELOPED
NO RISK
LOW RISK
MODERATE RISK
HIGH RISK
Health Enhancement
Risk Avoidance
Risk Reduction
Early Intervention
Treatment/ Rehabilitation


Alcohol and Drug Programs – Continuum of Services
HEALTH MAINTENANCE & ENHANCEMENT
RISK AVOIDANCE
RISK REDUCTION
EARLY INTERVENTION
TREATMENT & REHABILITATION

An Aboriginal Perspective

Maggie Hodgson is Director of the Nechi Institute on Alcohol and Drug Education, Alberta.

The challenge is how we can move forward as women; to look at our commonalities and differences, and work together. Change is important. We need to acknowledge that individuals are linked to families, friends, agencies, governments and the outside world. All of these form a part of an individual's support system. In most cases, the primary motivator for an individual seeking treatment is either a spouse or child—with health representatives and addiction counsellors second and third in line. Yet there are very few efforts directed towards accessing these catalysts (significant others). We need to repriorize our existing programs to address this need and opportunity.

There are several issues of importance with regard to substance use problems and Aboriginal women. The first is that prescription drugs are free for Aboriginals, so we're seeing drug use go up as alcohol use decreases. Although we need better data on this, we have some statistics that illustrate a major problem for incarcerated women. In one study, incarcerated men were found to average 19 prescriptions per year, while women in prison averaged 71 per year.

We are also doing a study to see how many reformed Aboriginal substance abusers have become gambling addicts. If they are just changing their addictions, we are missing something that should be taken care of at the treatment stage.

We have also seen the average age of treatment go down from 40 to 23—for many a history of substance abuse goes back to their pre-teen years. Also, there is a pattern among users that indicates that many go from smoking to drinking to smoking marijuana—yet very few treatment or prevention programs are directed at the latter. There is a strong need to rebuild our traditional ceremonies and rituals as part of the process of dealing with all of these issues.

Strategies: Tackling Substance Abuse in Different Life Stages

On the second day, symposium participants were asked to join a small group to discuss the primary issues facing women at one of five life stages and to report back with a list of activities or "must do's" to address the issues identified in the skits the previous day. A summary of the presentations made by each group follows:

Children (0–12)

A primary issue at this stage is prenatal health and FAE/FAS/NAS: women who do not start off as healthy children may have problems that multiply at later stages of life. Childhood is also the stage in which there is the greatest involvement by others—role models can have a strong impact on children, who may learn early on to use medication whenever they don't feel well (cough drops are just one example of over-the-counter drugs that are widely accessible to children).

Other concerns for this age group are the use of barbiturates to solve behavioural disorders, concerns about body image, non-selective time spent watching TV, and the absence of legislation regarding the use by children of .05 alcohol beverages.

Must Do's:

1. Create "women and children first" policies at all levels of government.

2. Continue to act on recommendations developed in 1992 by the Standing Committee on Health and Welfare on FAS and FAE.

3. Support grassroots-level development in programming for children.

4. Enact a national day care policy and address issues of latch-key children or those who have unsupervised access to substances.

5. Undertake more research on why some children get involved with drugs and others do not (resiliency).

Adolescents

Communities and individuals often fear teenagers. There is little tolerance and high expectations for girls in this life stage: they are too old to act like children and too young to be treated as adults. Adolescence is a time of transition: of learning, growing and experimentation. It is during this stage that women undertake their quest for autonomy and socialization—a quest to be accepted and liked. Although all young women are at risk of becoming substance abusers due to the pressure of body image concerns, high-risk groups include those from isolated communities and areas of high unemployment, runaways, and young women involved in the criminal justice system as witnesses, victims or perpetrators. Cigarettes, alcohol and over-the-counter drugs are the substances of choice in this age group.

More needs to be done to support families and to counteract the unrealistic portrayal of young women by the media. Sexuality needs to be celebrated during this life stage, while recognizing the importance of preventing sexually transmitted diseases, HIV and AIDS and unwanted pregnancy. We need to break down barriers between young and adult women by accepting adolescents and recognizing the importance of their contributions (perhaps through the creation of a youth forum). Feminists must be patient with the views of young women in this age group and remember that their own ideals grew out of experience.

Must Do's:

1. Start with where young women are at. Work in safety and partnership with them as mentors and role models. This process will vary according to region, race, culture, sexual orientation and other factors.

2. Recognize and appreciate adolescence as a positive developmental stage and promote self discovery. Celebrate the contributions of young women to society.

3. Give young women an active voice and role in decision-making, implementation and evaluation.

4. Address and work to eradicate poverty, violence and all the other "isms" in young women's lives.

Young Adults (20–35)

In terms of treatment, the young adult stage is seen as a turning point. Early intervention at this stage is very cost-effective over the long term, so should be a primary focus for government programs. This part of the life cycle is also a turning point in that there is a great deal happening in women's lives at this stage, including:

- role shift: women suddenly exposed to everything they weren't supposed to know about as teenagers
- decisions made that will affect the rest of their lives
- harsh reality that women are not considered "equal"
- children, poverty, financial stress—too much responsibility!
- many drugs easy to get
- surfacing of childhood traumas
- binging and eating disorders
- possible discovery of HIV infection
- anxiety disorders develop at the highest rate
- moving from young offender to adult offender issues.

Must Do's:

1. Undertake more research on this group and how to reach them, and link research to service providers. Make as many links as possible between substance use and violence, sexual abuse, HIV and AIDS, and mental health.

2. Reduce barriers (to employment, treatment, education, etc.) by providing childcare. Include necessary elements, such as food and transportation, in costs of all prevention, intervention and treatment programs.

3. Ensure that research, prevention, education and treatment are gender and context specific.

4. Coordinate community efforts. Appoint regional coordinators to keep track of "who does what" in their regions and to help make links.

Mid-Adults (30–65)

Although there is some illicit drug use among members of this age group, the classic picture is one of poly-addiction to prescription drugs and alcohol. Solvent abuse and the substitution of other addictions (sex, gambling, diet, etc.) also occurs, so there is a need to pay attention to context as well as to the particular substance being used. Dealing with violence is not always part of treatment and prevention programs, and it should be. There is a need to influence women's experience when they enter the treatment system. At present, they often seek help from doctors who treat their problems with drugs that may lead to further addictions. Elitism may also be a problem in women's groups—the views of all sub-populations of women need to be considered, and a range of self-help and support groups and empowerment strategies offered. Those involved in women's health must move away from protecting their own turfs to taking risks and developing broader alliances.

Must Do's:

1. Ensure consumer involvement in the development of policies and programs.

2. Create a unified women's health policy (e.g., through a provincial women's committee). Be sure to consider violence, poverty and other issues in this policy.

3. Capitalize on funding and exposure during the International Year of the Family.

Senior Adults (65+)

Senior women are not considered to be a priority in prevention and treatment programs and those working in research often tend to ignore the area of substance abuse at this stage of life. People tend to believe that the use of drugs and alcohol are an acceptable part of older life and ignore signs of misuse. Yet substance abuse problems do exist among seniors—mostly with alcohol, sleeping pills, tranquilizers, and benzodiazepines, although some young seniors may be longer-term recreational drug users. To address this problem, we need to take a holistic approach and consider mental and physical health, poverty, abuse issues (some problems start during childhood or young adulthood), differences between young and old seniors, and underlying feelings of loneliness, isolation, boredom and worthlessness. We must also increase our knowledge about the effects of aging on alcohol and drug use.

Must Do's:

1. Conduct research on mental health issues for senior women. Examine the difference between the use and misuse of drugs and alcohol, determine which groups are at highest risk, and what their service needs are for today and the future. Study the impact of long-term benzodiazepine use and withdrawal on older women.

2. Empower senior women to play a more active role in policy and program development.

3. Use new data to educate doctors, seniors, communities and caregivers about problems related to substance use and abuse and about the impact of aging on people's reactions to alcohol and other drugs. Change the belief that substance misuse is normal for this population.

4. Create opportunities for older women to share experiences with younger women. Collaborate with the medical community to raise awareness of non-medical approaches (e.g., advocacy and social support) to increase the likelihood of appropriate referrals.

5. Use a holistic approach to service by recognizing links between substance use, poverty, mental health and other issues. Increase the level of priority given to the needs of senior women by treatment and prevention professionals and those working with seniors, and recognize senior women as a group with unique service needs.

Strategies: Tackling Substance Abuse in Specific Groups

Francophone Women

The usefulness of a women-only approach must be demonstrated with francophone women, who experience a unique cultural context. Treatment for francophone women is usually offered in a co-ed setting. There is a strong desire to develop information networks and to ensure that action is coordinated across the country.

Must Do's:

1. Increase knowledge of the specific needs of francophone women through research and devise special strategies for intervention.

2. Improve the distribution of information concerning women's needs and substance abuse issues to the general public.

Aboriginal Women

Loss underlies much of Aboriginal women's use and abuse of alcohol and other drugs: a loss of matriarchy, traditional teachings and values, traditional governing systems, land, language and culture, family solidarity and ceremonies. Strategies for addressing the issue of Aboriginal women and substance abuse were discussed under six sub-headings:

i) Policies and Legislation:

- Replace the *Indian Act* with a system of Aboriginal self-government
- Implement health policies that reflect Aboriginal women's traditional approach and values
- Create health programs for Aboriginal people that are community-based and culturally appropriate
- Ensure that Aboriginal people are full participants at all levels of government
- Re-allocate three per cent of Health Canada's budget for dealing with Aboriginal alcohol and drug use to off-reserve populations.

ii) Information and Education:

- Increase immersion language teaching
- Establish comprehensive community education workshops by local people
- Connect proposal reviewers of Health Canada with Aboriginal peer reviewers (Health Canada should hire First Nations people)
- Reintroduce cultural activities, such as pow wows, feasts and healing circles
- Increase funding for National Addictions Awareness Week
- Develop an Aboriginal student assistance program.

iii) Research:

- Include an Aboriginal focus in Canada's Health Promotion Survey (with input from First Nations people)
- Monitor the relationships among sexual activity, AIDS and HIV and alcohol use among members of "at risk" youth communities
- Research and document traditional grieving ceremonies from different First Nations
- Consult with Aboriginal groups on AIDS prevention and national groups on grieving research.

iv) Community Development:

- Encourage community gatherings to promote networking and training in culture, language and traditions
- Lobby for Aboriginal rights
- Improve awareness and education on grieving issues, sexual abuse, family violence, residential school syndrome and dysfunctional families
- Cost-share in the training of Aboriginal community workers in family violence, mental health and substance abuse.

v) Collaboration and Networking:

- Develop provincial resource directories listing Aboriginal designed, directed and delivered programs and services
- Implement a National Native Clearinghouse on Health Issues
- Develop a national newsletter or computer bulletin board of health programs with contemporary and traditional approaches.

vi) Programs and Services:

- Provide long-term, stable funding for programs that prove their worth
- Canada's Drug Strategy must target Aboriginal youth as a priority
- Study existing curricula on solvent abuse to develop one for use in the regular school curriculum
- Ensure that Aboriginal designed, directed and delivered child care services are available at all women's shelters, transition centres, schools and treatment centres
- Give elders an active role in all above-noted areas for transmittal of language, values, and life experiences to both parents and children, particularly single-parent families and those on income support.

Must Do's:

1. Provide Aboriginal people with their own treatment facilities and programs (e.g., for treatment of sniffing and solvent abuse)—especially off-reserve.

2. Negotiate new, collaborative health policies.

3. Involve the justice system, child welfare, women's shelters, transition centres and schools as partners with treatment centres. Return jurisdiction to native communities—both on- and off-reserve.

4. Provide government funding and social resources to meet the needs of Aboriginal communities (i.e., care for the caregivers, time for personal healing).

5. Use education and awareness campaigns to stress zero tolerance for domestic violence, alcohol and other drug abuse.

6. Focus government attention on prevention, housing conditions, lifestyle choices, recreational activities, economic status, education and public health (i.e., Aboriginal elders and disability care).

7. Provide non-Aboriginal frontline workers with cross-cultural training.

8. The Solicitor General must educate doctors working in federal jails on their prescribing patterns for Aboriginal women (young offenders facilities, jails and psychiatric units).

9. Undertake research to examine the effect of gambling addictions and substance abuse recovery on native women and their families.

After the presentation, participants discussed the usefulness of applying the traditional role of elders in Aboriginal communities to that of senior women in society at large. It is time to move away from our "disposable" approach and to take advantage of the experience and contributions of elder parents and grandparents.

Immigrant Women and Women of Colour

"Women hold up half the sky."

- Liu Shao-qi

"But the women who hold up half the sky are not all the same." That was the observation of a symposium participant who addressed the substance abuse problems faced by immigrants, refugee women, women of colour, and women in settlement.

Although immigrant women have various experiences, the majority share experiences of isolation, and linguistic and cultural barriers. Refugee women have similar experiences which may be heightened by post-traumatic stress disorder as an effect of the violence and torture they may have suffered. In Canada, their experiences may be misunderstood and denied as being real. Although little research has been done on substance abuse among these women, prescription drugs and mental health issues are real. A major barrier to treatment for this group is that immigrant and refugee women feel very dependent and do not want to make waves.

Women in settlement are immigrants who came to Canada 20 to 30 years ago and worked in skilled labour and technical jobs. This aging population is facing a whole new set of problems—job ghettos, bereavement and grief issues, and unemployment. Women of colour—faced with extreme body image issues and racism—are showing increases in tobacco use.

Must Do's:

1. Put into place more equitable immigration and refugee policies.

2. Undertake research on the specific needs of immigrant and refugee women and women of colour.

3. Undertake research on the specific needs of women with physical disabilities.

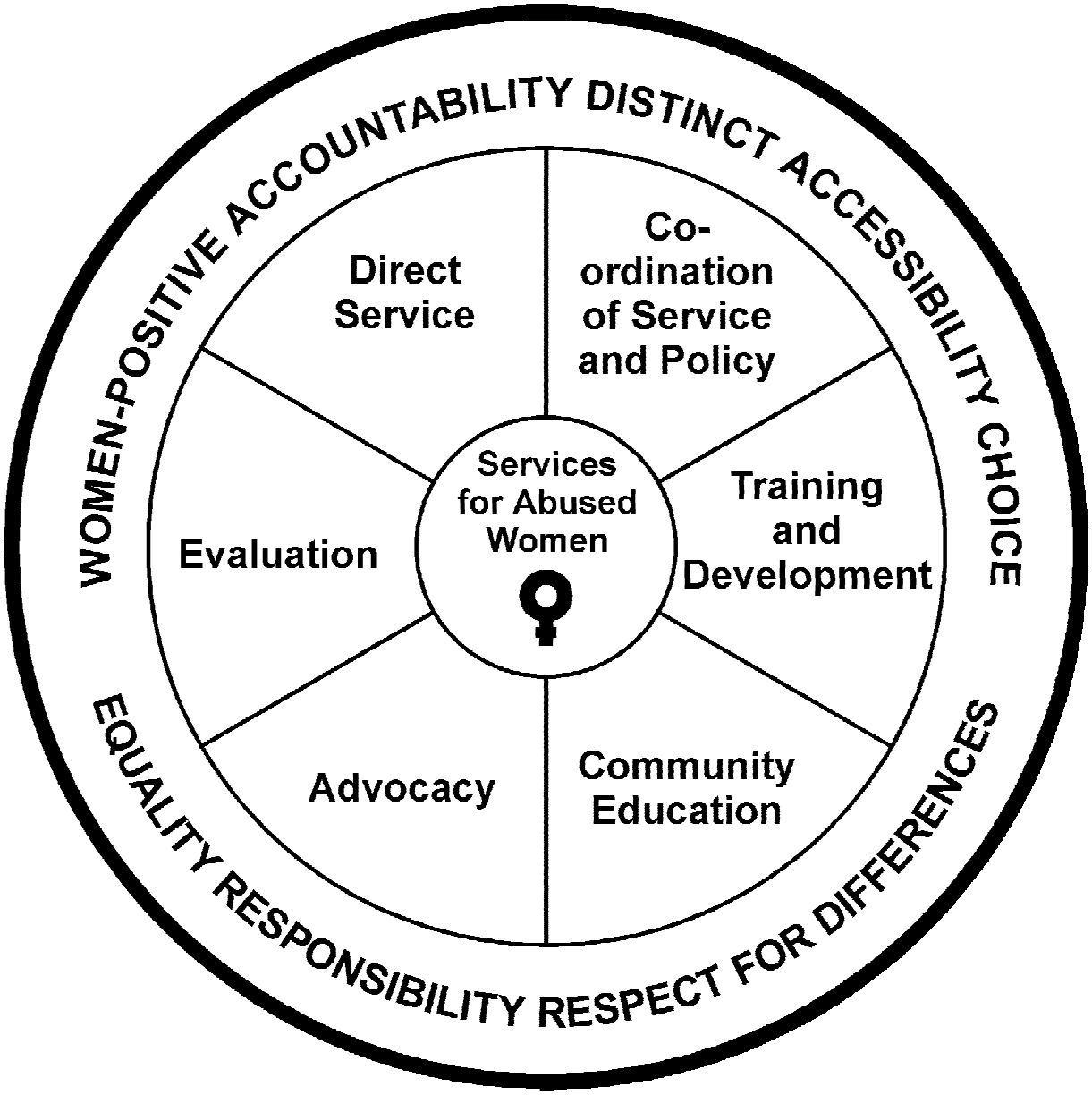
Making the Links

Violence

Joan Gillespie is a Policy Associate for the Family Violence Program at the Canadian Council on Social Development.

The Framework Project involves 14 different agencies that collaborate to deliver services and programs to abused women. The model is based on a Framework Wheel, made up of an outer ring of values—accessibility, choice, equality, responsibility, respect for differences, women-positive—that influence the process of delivery (similar, in theory, to the "We Believe" statements). The process—that is, getting people to think about these beliefs—is more important than content. The inner wheel is the "what" of service delivery—community education, advocacy, evaluation and research, direct service, coordination of service and policy, and training and development. Historically, services in the area of violence have been very fractured; the irony is that they are all very integrated in women's lives. Addressing one area without the others is not a whole solution; client involvement in all of this is also essential. It is not always common for people working in violence to make links with substance abuse and vice versa. We need to work harder at this.

The Framework Wheel



Framework for Services for Abused Women, Ottawa-Carleton

HIV/AIDS

Louise Nadeau is an Associate Professor in the Department of Psychology at the University of Montreal.

Young women (15-25) are more susceptible to contracting HIV infection than older women because the walls of the vagina are less resistant at this stage of life. When there is a lack of lubrication—as is often the case with young women who have sexual relations without desire—there is greater likelihood of a rupture occurring. Young women are also more vulnerable to intoxication and therefore more likely to lose their way in the face of a sexual situation. Another, less physiological reason for this susceptibility to HIV is that young women may have misconceptions about men—for example, some see jealousy and possessiveness as a sign of love and monogamy. The desire to love and be loved, coupled with fears of rejection, leads women to believe in other myths—for example, that a clean, virile man cannot have AIDS. The willingness of a woman in love to give of herself without protection is another factor that affects the level of risk (most prostitutes questioned in one study said that they only used condoms when they were working). A belief that a risk-taking man—possibly an intravenous drug user—is masculine and attractive puts women at an even higher risk.

Mental Health

Sherry Stewart is currently an Assistant Professor in the Psychology Department at Dalhousie University, Nova Scotia.

Studies suggest a link between anxiety and depression and alcohol and benzodiazepine abuse. Panic disorder is a serious concern characterized by frequent, intense panic attacks—uncomfortable physical sensations, such as a pounding heart, sweating, dizziness, and numbness coupled with a fear of dying or losing control and a feeling of unreality. The condition can lead to severe lifestyle restrictions (agoraphobia) and is often treated through the use of benzodiazepines, such as valium. However, long-term use of these drugs causes memory and motor difficulties. In addition, people who are on benzos experience greater, more frequent panic attacks when they are taken off them.

Early theories (Hallam, 1978) suggested that men and women coped differently with panic attacks. Men turned to alcohol abuse while women avoided the stimulus that provoked the panic attack in the first place. This theory was not well supported, however, as women in the general population also represented a smaller percentage of alcohol abusers than men. When women with panic disorder and women without panic disorder were compared, those with panic disorder were found to be four times as likely to be alcohol abusers, while panic disorder men were only twice as likely as their non-panic disorder counterparts. When you consider that panic disorder is more common among women than men, a serious potential for substance abuse exists.

A later study showed that approximately 90 per cent of women with panic disorder took benzos, while only about 20 per cent of men with panic disorder did. More research is required into the reasons behind the difference in usage between genders. Another question researchers have attempted to answer is "which came first?—the mental health problem or the substance abuse?" Studies show a vicious cycle—women get panic attacks, drink or self-medicate to cope, become substance abusers, suffer withdrawal or guilt, which in turn brings on increased panic attacks. Although it appears that the mental health problem usually comes first in women, the opposite is true for men. However, the problems quickly become so inter-twined that they are almost inseparable—a vital consideration for treatment approaches, in which communication between the mental health field and substance abuse field are essential. The implications of these studies for prevention are that some women at high risk for substance abuse (i.e., who are anxious or depressed) can be identified early on.

Areas for Action

Participants came up with the following list of areas on which to concentrate future efforts:

1. Research
2. Networking and collaboration
3. Linking and addressing violence, HIV/AIDS, mental health, poverty and broad social conditions
4. Advocacy—media, pharmaceutical industries, tobacco industry, alcohol industry
5. Program and service needs
6. Policy (e.g., national day care strategy)
7. Education and training—public, doctors, ourselves
8. Changing public image—view of women and substance use.

Next Steps

The following activities were suggested by participants as a follow-up to the workshop:

1. Form a national working group with NGO, provincial, territorial, and federal representatives and link using available technology and hardware. Representation from this working group should be an advisor to the Women's Health Bureau (perhaps the Centre of Excellence for Women's Health). It should include Aboriginal women, as well as those from a diverse range of strata (i.e. social, cultural, lifestyles, etc.).

2. Provide funding for networking. Explore the use of technology to keep the network going.

3. Consider developing a national newsletter or use existing vehicles (such as Vis-a-Vis) more effectively.

4. Follow-up on local networking which began at the National Roundtable in October, 1993, by selecting a central point of contact in each community (position could be funded from small percentage of funds from each agency).

5. Get involved in the political process. Talk to the media. Invite MPs to visit programs and explain what we do, rather than just approach them for money. Promote activism: write letters, encourage clients to write letters, etc. Employ "target tropism"—raise issues from the unconscious to the conscious by naming and talking about them.

6. Frame needs within the context of health advancement for women.

7. Create a separate Aboriginal strategy.

Appendix A

Workshop Agenda, Participants and Showcase Exhibitors

Workshop Agenda

Tuesday February 22, 1994

15:00 Registration and set-up Showcase

16:30 Working Together: An Introduction

18:00 Dinner - Opening remarks on behalf of the Minister of Health Canada, the Honourable Diane Marleau

19:30 **Working Together: "We Believe"**

21:30 Adjourn

Wednesday February 23, 1994

08:30 **Exploring Issues and Trends**

10:30 Break (Showcase)

11:00 Issues and Trends Panel

12:15 Lunch

13:30 **Working Together: Strategies for Action**

15:45 **Showcase (open to guests)**

17:30 Adjourn

Thursday February 24, 1994

08:30 Strategies for Action (continued)

10:00 Break (Showcase)

10:30 **Working Together to Make the Links (with violence, mental health, HIV and AIDS)**

12:00 Lunch

13:30 **Working Together: "We Will"**

16:00 Adjourn

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Appendix B

Speech: Dawn Walker on behalf of the Honourable Diane Marleau

Speaking Notes for Ms. Dawn Walker
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Working Together, A National Workshop
for Action on Women and Substance Use
Ottawa, February 22, 1994

Check Against Delivery

Thank you for your kind introduction and words of welcome. On behalf of the Minister of Health, the Honourable Diane Marleau, I am delighted to be here this evening to talk about ways we can work together to develop an agenda for action on women and substance use.

I welcome the opportunity to discuss this issue of great personal interest and national concern. Like every one of you in this room, I have seen the face of substance misuse and abuse within my own community. I am well aware of the pain, the indignities and the unfulfilled potential of far too many women.

I am inspired by your statement of purpose at this workshop – the "We Believe" principles – which will guide your discussions over the next few days.

I am a firm "believer" in the power of people. People can bring about meaningful change. There are many who subscribe to the philosophy that seeing is believing. But I prefer to approach taken by the late great Canadian, Marshal McLuhan, who once said:

"I wouldn't have seen it if I hadn't believed it"

It is precisely because we believe so strongly these issues can and must be addressed that we **will** see real progress. Through workshops such as this, and the agenda for action which will result, long-term solutions will be found to the problems of substance misuse and abuse among women.

What will it take to realize that goal? Admittedly, the answers are not easy. The solutions will require patience, perseverance and partnerships.

Yet, the work of the two roundtables which preceded this workshop have proven that where there is a willingness, there is a way.

I want to congratulate those of you who contributed to the success of those roundtables. Through exchanges of information and the sharing of experiences, you have identified and priorized the challenges we face. Most important, you have provided insights into achievable solutions.

Your life-cycle approach to women's substance use has underscored that there are critical transition points in women's lives, from birth through to old age. This knowledge is key to our understanding of substance abuse.

This approach helps to clarify under what circumstances, and when, misuse or abuse may begin; who is likely to be at highest risk; and when intervention or treatment – or ideally, prevention – are most effective.

You have made it abundantly clear that women's needs are very different from men's. It is only recently we have recognized women's substance-use problems must be approached from women's perspective, taking into account their age and life-cycle stage. We know that the traditional, gender-neutral methods do not work.

In recognizing the differences between the sexes, I do not suggest we should segregate women and their substance use problems. These are not just women's issues. They are society's concerns – with widespread ramifications for our families, our communities and our country.

It does mean we need to focus our research, policy and programming efforts specifically on the experiences of women. We must become more sensitive to women's needs within the broader social and economic context of their everyday lives.

It is no longer possible to isolate substance misuse as just a physical or personal problem. We now know we must address the larger issues of mental health, poverty, violence, racism, HIV/AIDS and a host of other ills that are inextricably linked to women's substance abuse. We also realize that women need help with child-care, job training, and other important supports if they are to break the cycle of despair and achieve dignity and independence.

Your roundtable discussions last year underlined another essential theme: we must recognize and respond to the diverse needs of women – which may be unique to an age group, a region of the country or a particular minority. We cannot expect to find "one size fits all" answers to the many and varied substance use problems facing Canadian women.

Just as there is a variety of needs, there is a multiplicity of possible solutions. In fact, sometimes the communities facing the greatest challenges can also offer the greatest hope. I am thinking of the substance abuse problems of Aboriginal women, as just one example.

Increasingly, health and social services professionals recognize that culturally-sensitive approaches are often more effective than mainstream methods of addressing substance abuse.

I was particularly interested to learn of a project called **Rediscovering the Traditional Mother in the Yukon**. The program is aimed at preventing Fetal Alcohol Syndrome and Fetal Alcohol Effects. It targets women at risk and helps them to rediscover the natural way of becoming a mother, from traditional teachings.

Through the use of traditional ways and guidance, the program enhances the emotional, spiritual, mental and physical health of women – and their families – within the community.

In many ways, the Aboriginal approach mirrors the objectives outlined in the "We Believe" principles that form the foundation of this meeting. It acknowledges that, while we are more than the sum of our parts, we must help heal all the parts in order to be whole.

Perhaps of all the lessons learned, the earlier roundtable has also proven one invaluable point. The solutions will be found within this caring community of researchers, policy makers and people on the font-lines – the social workers, nurses psychologists and volunteers – who help women with substance problems.

We in government are proud to take the lead – through initiatives such as **Canada's Drug Strategy**, which targets special-needs groups; the **Women's Health Bureau**; and the creation of a **Centre of Excellence for Women's Health**.

Canada's Drug Strategy, now in Phase II, is specifically focused on helping high-risk groups, including women and youth.

The **Women's Health Bureau** is equally dedicated to promoting a better understanding of how programs, policies and practices in the health system affect women. The Bureau, too, can offer insights and support to those of you working in the field.

The **Centre of Excellence for Women's Health** will address the differential treatment Canadian women have received in our health system by developing the data and research necessary to change policies and practices which have been disadvantageous to women.

Through such efforts, the federal government is working to ensure that women's substance use concerns receive the appropriate attention and responses they deserve.

But government is only one part of the equation. Only when we all work together does it add up to success.

The government is committed to working closely and collaboratively with you as you strive to help women with substance use problems. This workshop, developed and sponsored by Health Canada, is a recognition of the importance the department places on your contribution.

Whether you are involved in innovative research, creating women-appropriate policies or offering a friendly face at a detox centre, you are our best hope for meaningful and lasting solutions to these very serious problems.

Yes, the challenges are great. But so too is our determination. At the end of this forum we will move forward, from **"We Believe"** principles, to **"We Will"** agenda for action.

As a woman and a mother, I have never been more hopeful or encourages that I am today. This year – the **International Year of the Family** – provides hope that the world will focus on the central figure in families, the woman, and work to improve support for her.

I believe 1994 has opened a challenge and offers a chance to draw attention to the urgent problems of women and substance abuse. That is why it is critical that we move from words to action. We must seize this exceptional opportunity.

Which is not to suggest there are instant solutions. It would be irresponsible to pretend that we can solve all of these problems, quickly or painlessly. Progress comes at a slow pace.

Neither is it for the federal government to determine what precise actions to take. We must work collectively to build policies and programs based on the reality of women's lives. Workshops such as this one are invaluable to achieving that goal.

Just as the roundtables were a very open process, I encourage you to be frank and fearless as you debate the best ways to bring the **"We Believe"** principles to life.

I want to assure you of the Minister's support and confidence. Because nothing is impossible. Because as individuals and as caring professionals, we **believe** we can learn to conquer the problems of women and substance abuse, eventually we will see that day.

Thank you.

Appendix C

Herstories

Herstory #1: Donna Harris (Kingston, Ontario)

A counsellor at a shelter for the partners and children of incarcerated men, Donna Harris shared a poem she wrote about her life, simply entitled "Her" (attached). The poem tells of how her failure to meet her own expectations about life and love led to an alcohol addiction problem.

Pregnant at a young age, Donna quit school and married, only to find herself unable to cope with the stress of raising three children at the age of 20. Alcohol was soon joined by prescription drugs; the problem was worsened by her husband's problem drinking.

Pushed to the limit, Donna entered recovery and turned her life around at the age of 41. Now involved in a caring relationship with a new man, she is helping her fourth son grow up without booze, drugs or fear. Her message to others was that "YOU are WORTHWHILE"—that life can be good again.

Herstory #2: Barbara Hatfield (Pictou, Nova Scotia)

Barbara Hatfield was addicted to drugs and living in an abusive relationship when she became a member of a self-help group for chemically-addicted women called "Women in Active Recovery."

Part of the Pictou County Women's Centre (PCWC) in Nova Scotia, the group was created because AA and NA programs alone were not working as the sole solution to the problem of substance abuse among women in the region. The group felt imporant to encompass both addictions in the group because the women were challenged with AA and NA philosophies of separatism. Core members of the group gradually drew closer, and a level of honesty progressed—people began to share more than they had ever felt safe to reveal.

The self-help group—which determined its own structure, format and purpose—has undertaken several major initiatives over the past years, in addition to regular weekly meetings. In 1990, the group helped the PCWC plan and run a special conference about women and recovery; in 1991-92, the group made presentations to the professional community about barriers facing recovering women; in 1993, the group undertook to document its experiences as a handbook for other recovering women interested in forming a self-help group.

The growth of this group has been astonishing—women are learning to like, trust and respect one another; a quantum leap for most members, who grew up and fostered the notion that women were the competition. Issues of women's rights, sexism and poverty, are only a few topics that have been addressed in this group. In the words of several group members "It is with awe and gratitude that we continue in the growing experience of this self-help group, and it is our hope this group will provide a model for more women to realize we truly are not alone."

Herstory #3: Arlene Harper (Prince Albert, Saskatchewan)

Arlene Harper shared her story to illustrate the point that substance abuse can be a vicious, fatal cycle that devastates generation after generation of a family.

Originally from a poor community in rural Saskatchewan, Arlene’s family lacked a feeling of empowerment and control, and were not prepared to deal with difficult issues. When she and other children at her school were molested by a teacher, her parents denied the experience rather than make waves (her mother’s marriage had been an escape from a punitive father).

Although addictions were unheard of in the family, Arlene and her siblings would all become victims of addictions—either directly or indirectly—as adults. Their struggle to cope and to break the chain of addiction that eventually followed their children is a lesson to anyone who thinks "it could never happen to us." We must look at the long-term effects of addictions and abuses that do not get effective intervention, because they have a spin-off effect on family members. There is a lot of work to be done in trying to pick up the pieces in both families and communities.

Her

By Donna Harris

Long ago there was a girl,
Fifteen, tall and slender.
She spent her time
Looking for a prince,
Who was charming, warm and tender.

These unrealistic expectations
Led to internal hurt and pain.
Inside she questioned,
"Life hurts so much,
Am I even sane?"

To deal with this self-inflicted pain,
She turned towards "the drink".
Getting drunk was a part of her life,
Before she could even think.

Life goes on! Quit school! Get a job!
Go out with some guy named Bob.
Then Dave,
Ted,
Joe,
and Harry.
Who will love her enough to marry?

She's pregnant with two.
Gary steps in.
The Church disowns her
And says "It's a sin."

Married with three babes at twenty.
Looking for stress? You got plenty!
Weekend parties and lots of booze,
To cope with this life, it's her right to choose.

Three babies grow up. Another comes along.
Abortion! No way! Her life is a song.

Dr! Dr! I Hurt! Give me "SOMETHING".
He does, he gives her a bottle of Valium.
Alcohol, Valium or sanity "please".
The merry-go-round brings her to her knees.

The three oldest sons learn to cope,
Using alcohol and other drugs.
The husband as well is boozing too.
"Oh my how this can BUG."

She is so LONELY, so SCARED,
If ONLY someone out there cared?

Freedom is near!
Death may appear.
Pills! Over-dose! Cars crash!
Fear!
Pain!
Help!.....Help!
It hurts so much.
Give her life back.
Give her touch!

Death claimed her Dad ...
Oh....so sad.

She fell off the merry-go-round.
Insanity! How her heart did pound.
Valium,
Wine,
a burning cigarette!

Sleep,
relief,
and burning flesh!

Sorry kids...There is no more her.
Her life was nothing but a blur.

Then help came along in the form of caring.
All at once she was out there sharing.
Back with her kids, husband and life,
Being a person, mother and wife.

The marriage was not to last.
Her mother's death came to pass
But she was learning fast.
"No Alcohol" in no glass.
"Coping" without "Doping".
Living life and hoping.

Fighting to survive and
Feeling good to be alive.
Living on her own with her youngest son.
Great incentive for her to get things done.

Life carries on...
Quit her job and back to school.
She finally stops living
Her life as a fool!

At forty-one life just begun.
At thirteen, say the same for her son.
"Let's get out there and live dear
Without booze, drugs or fear!"

Good things start happening.
LOVE
swoops in...
...on wings!
Gratitude for the birds that sing!

She and her son both getting "A's"
Positive reinforcement and with praise!
Three sons doing "SO-SO".
Everyone coping with the "OH-NO's".

Hope they learn to shed some tears
And live their life without those fears.

There's a new man in her life now.
(Prince Charming, he is not!)
He supports, cares and shares
Pain and also joy "and How!!"
Love is always a matter of dares!

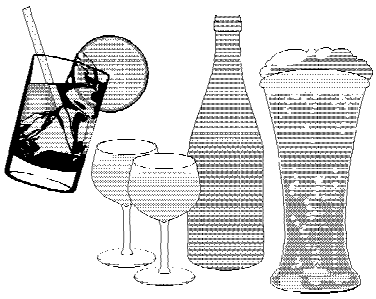
This is the story of her life, so far.
She's writing it for herself,
And the girl in the Bar.

Get by the pain.
Get by the fear.
"HELP" is NEAR
YOU are WORTHWHILE!
Let's bring back your smile.
It's possible to get by the shame.
Life CAN be good again.

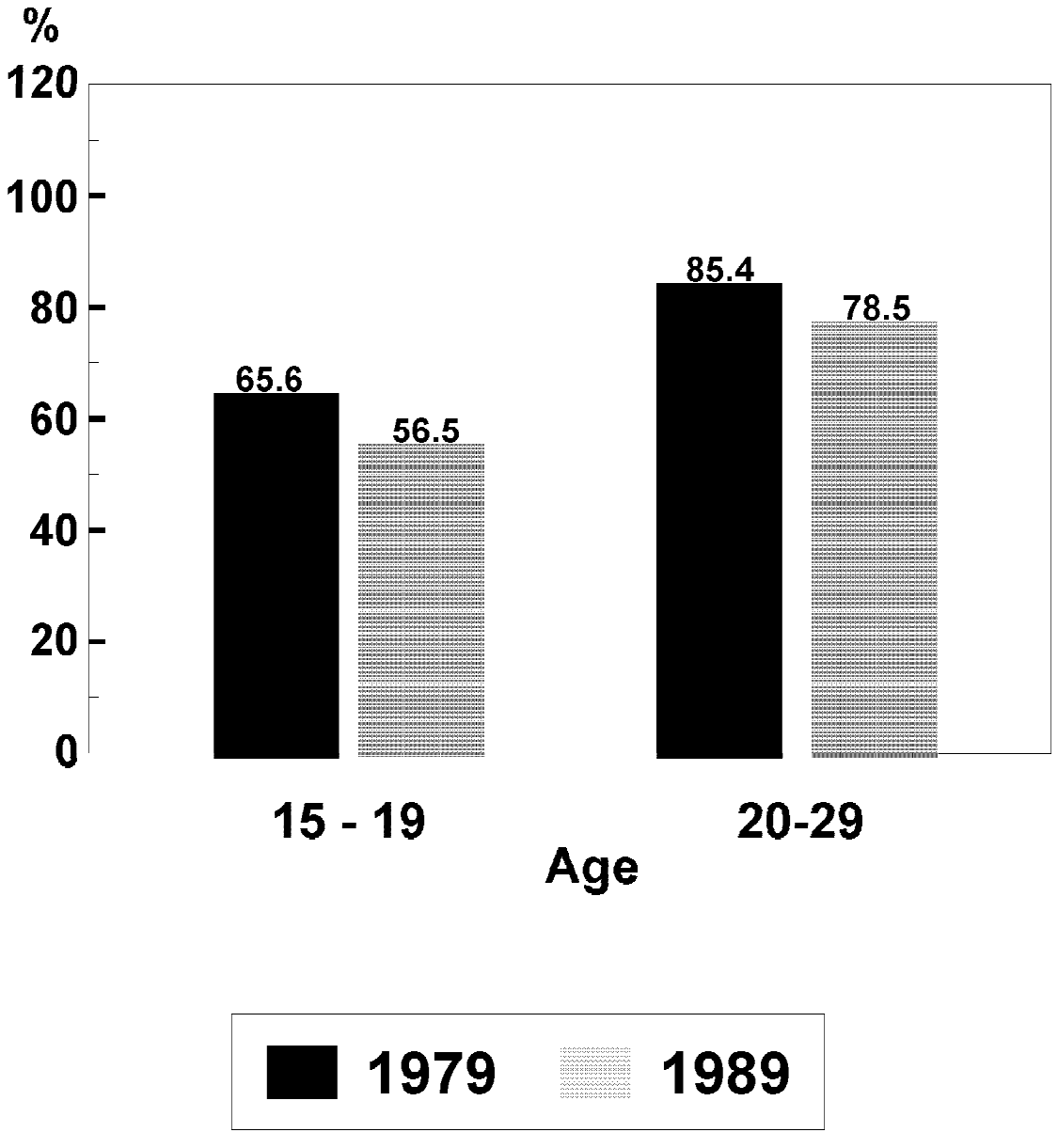
Tears,
Laughter,
and Love
Wow! Feels like a dove.
Freedom is near.
Death needn't appear
Reach out your hand
"SHE'll" understand.

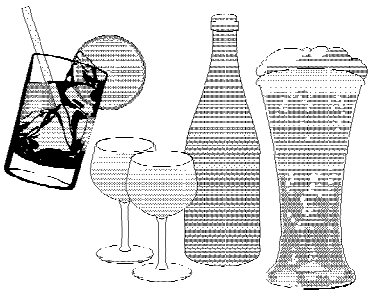
Appendix D-1

Trends in Substance Use

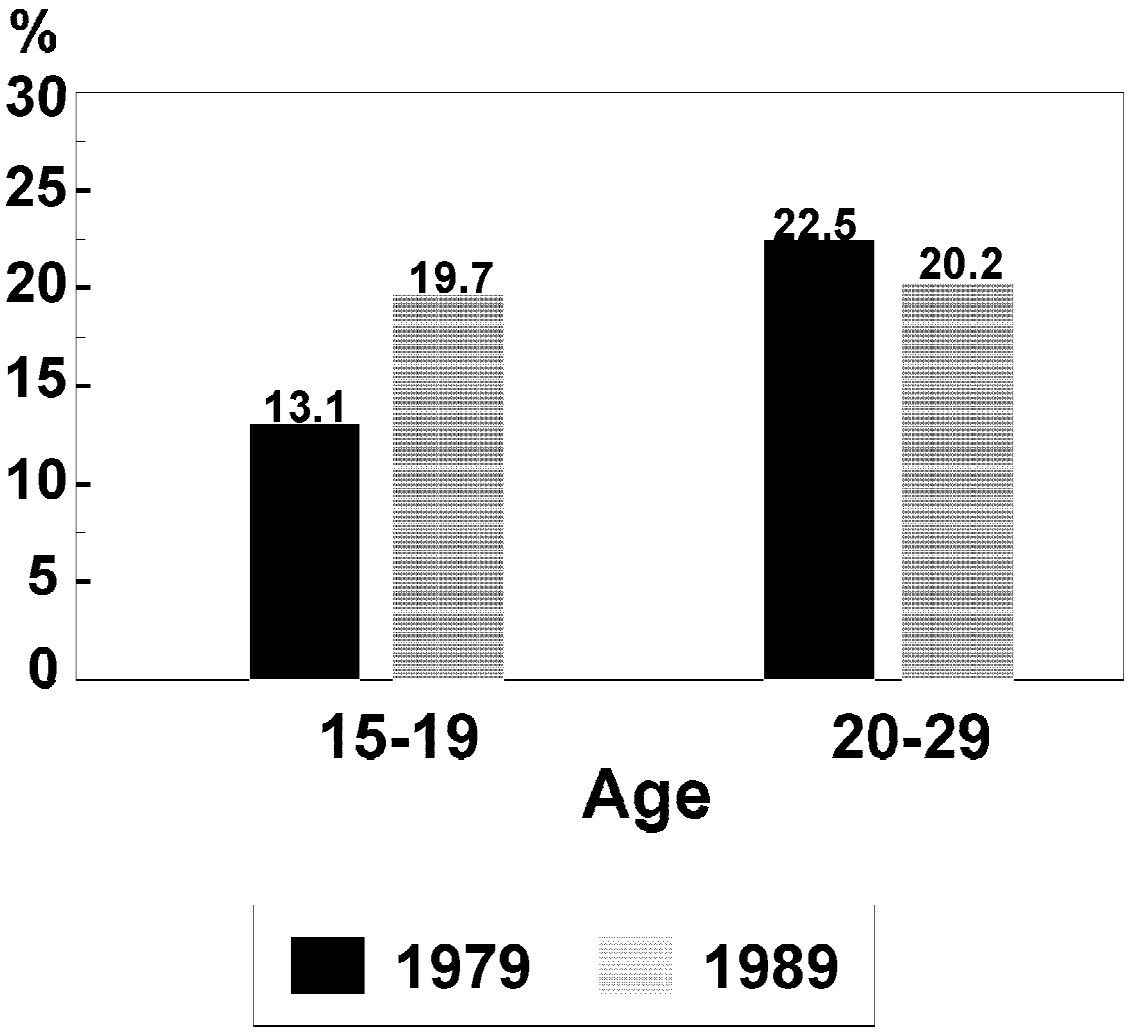


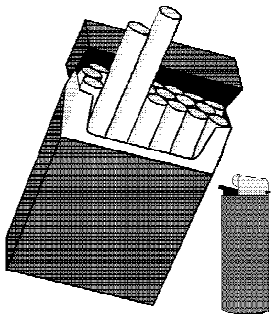
Current Users, Alcohol Young Women (15-29)



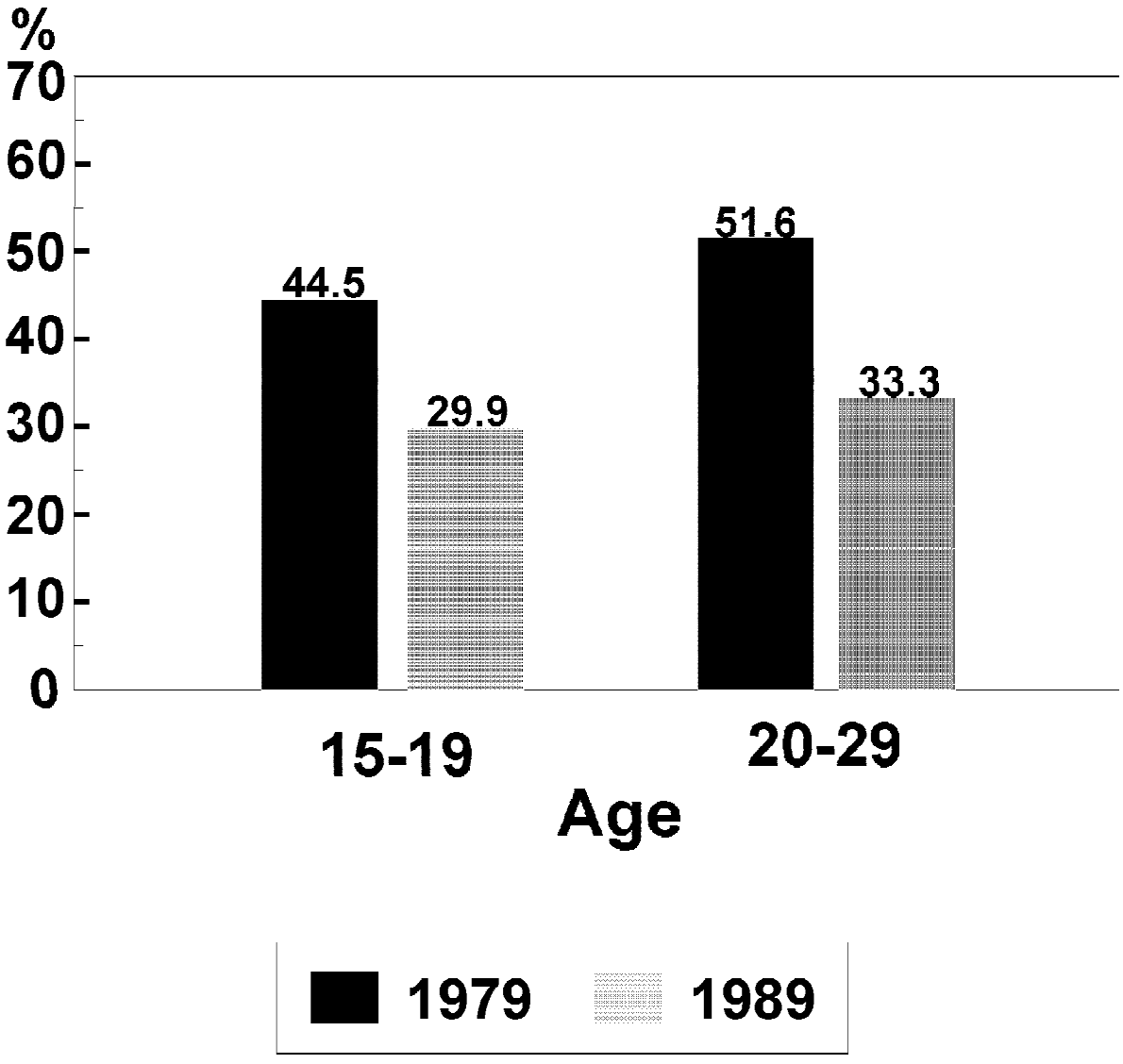


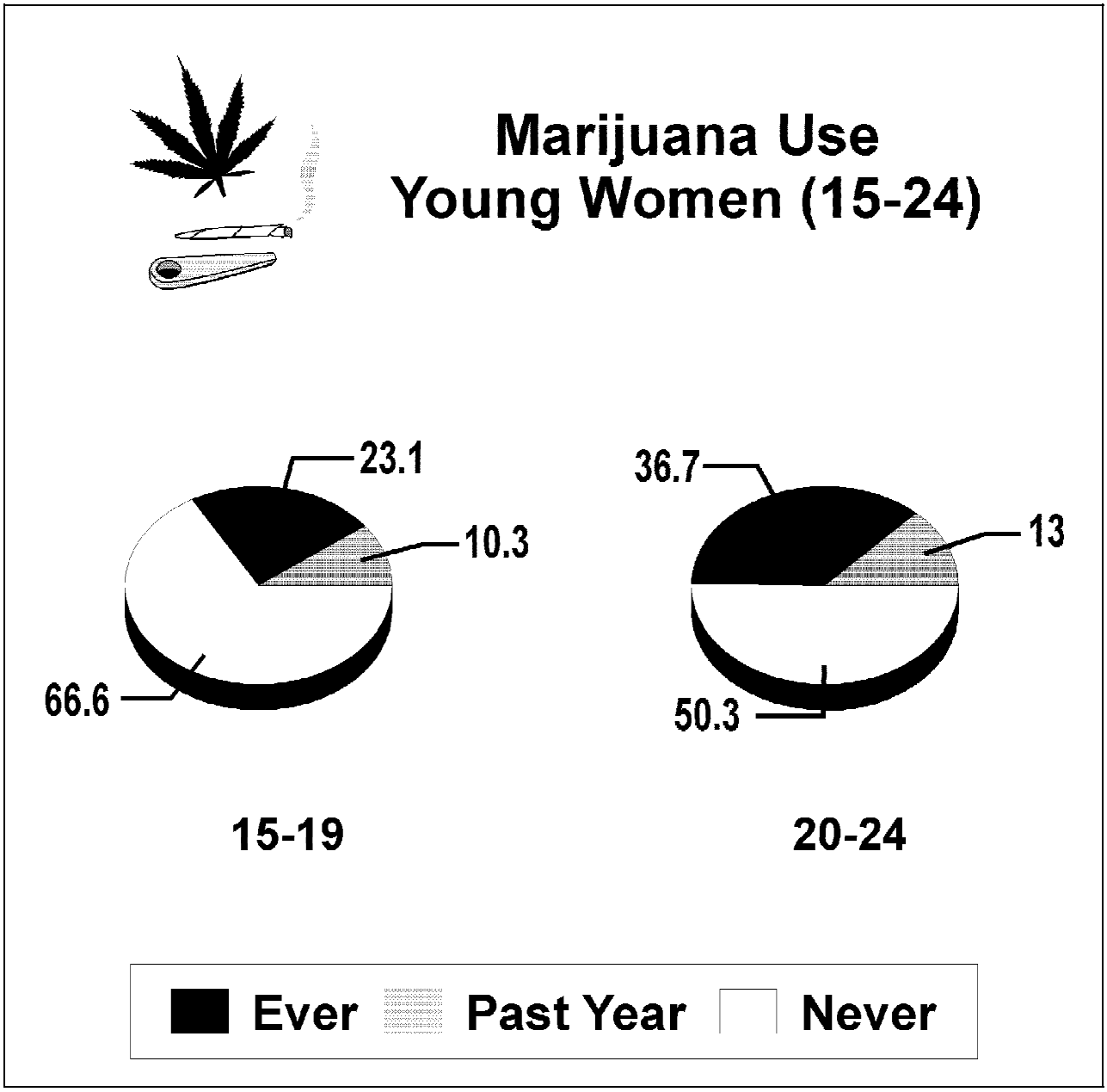
Heavy Drinking Young Women (15-29)

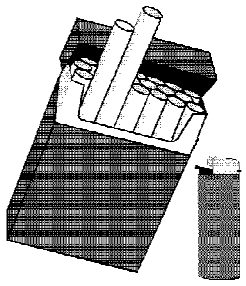




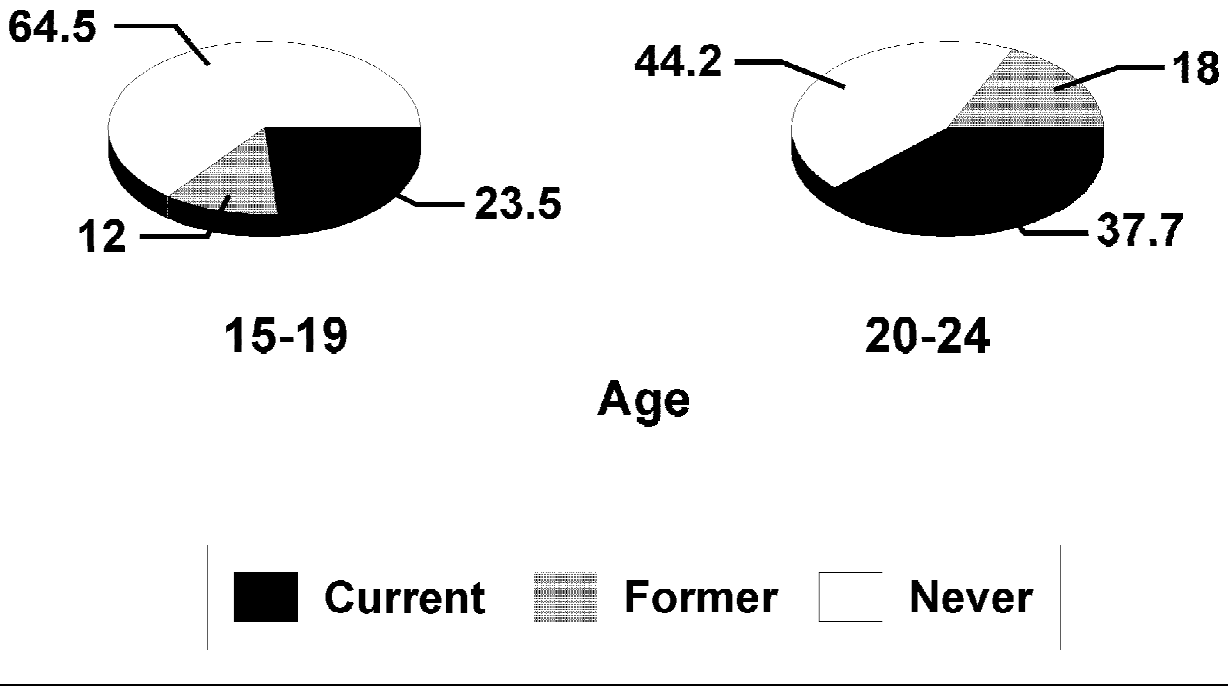
Current Users, Tobacco Young Women (15-29)

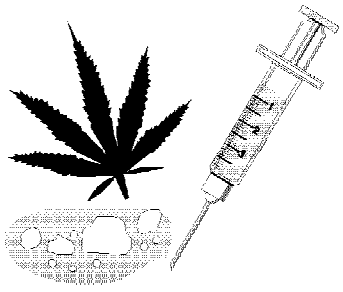



Marijuana Use
Young Women (15-24)
23.1
10.3
66.6
36.7
13
50.3
15-19
20-24
Ever
Past Year
Never



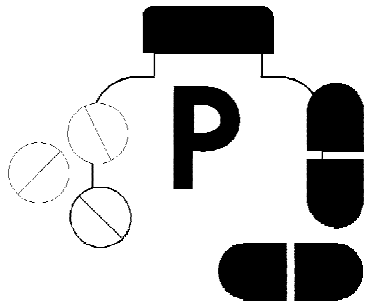
Smoking Status
Young Women (15-24)





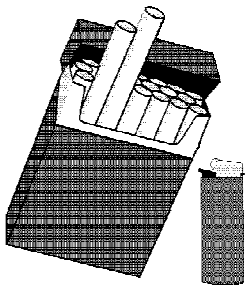
Illegal Drugs
Mid-life Women (25-64)

		Cannabis	*Cocaine*
National Alcohol & Drug Survey 1989	25-44	6.0	1.8
	35-44	2.9	
	45-54		
	55-64		
Health Promotion Survey 1990	25-34	5.0	
	35-44	2.0	
	45-54		
	55-64		

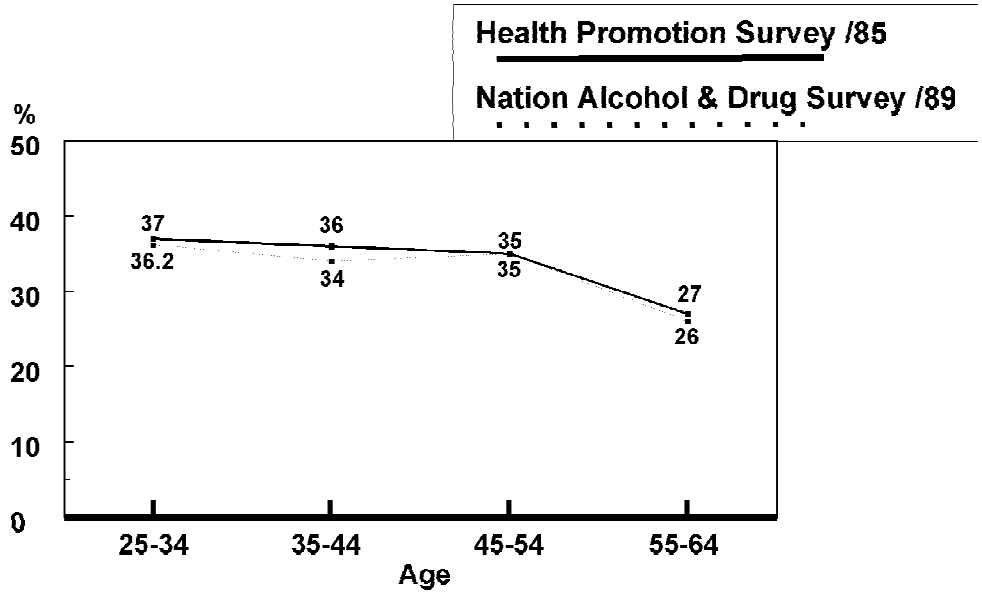


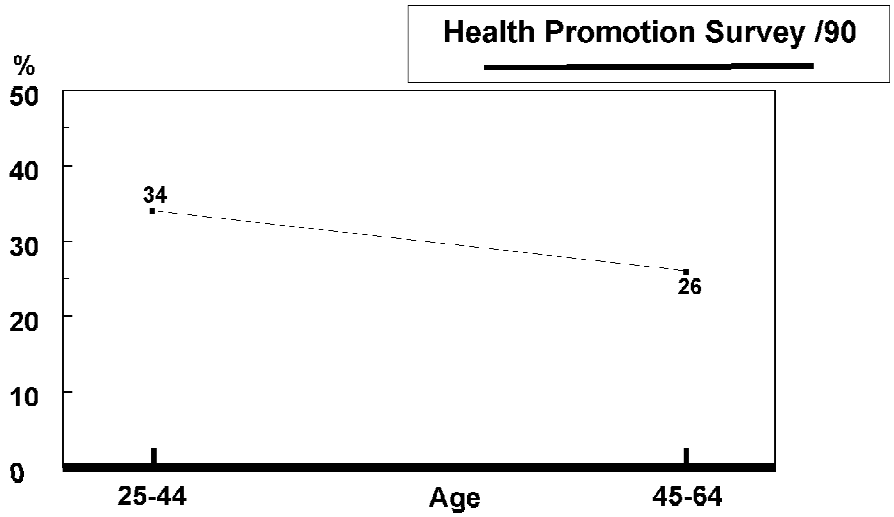
Prescription Drugs
Mid-life Women (25-64)

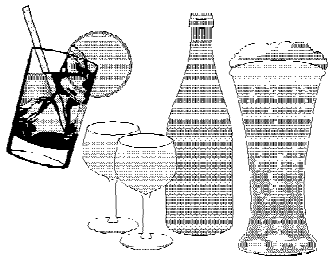
		Tranquilizers	*Sleeping Pills*
Canada Health Survey 1979	25-44	5.2	
	45-64	13.7	
Health Promotion Survey 1985	25-34	4.7	5.4
	35-44	8.2	8.8
	45-54	10.0	11.7
	55-64	11.7	13.5
National Alcohol & Drug Survey 1989	25-34	1.8	1.6
	35-44	3.5	2.9
	45-54	7.1	7.1
	55-64	9.6	6.2
Health Promotion Survey 1990	25-34	4.0	5.0
	35-44	6.0	5.0
	45-54	7.0	8.0
	55-64	7.0	11.0



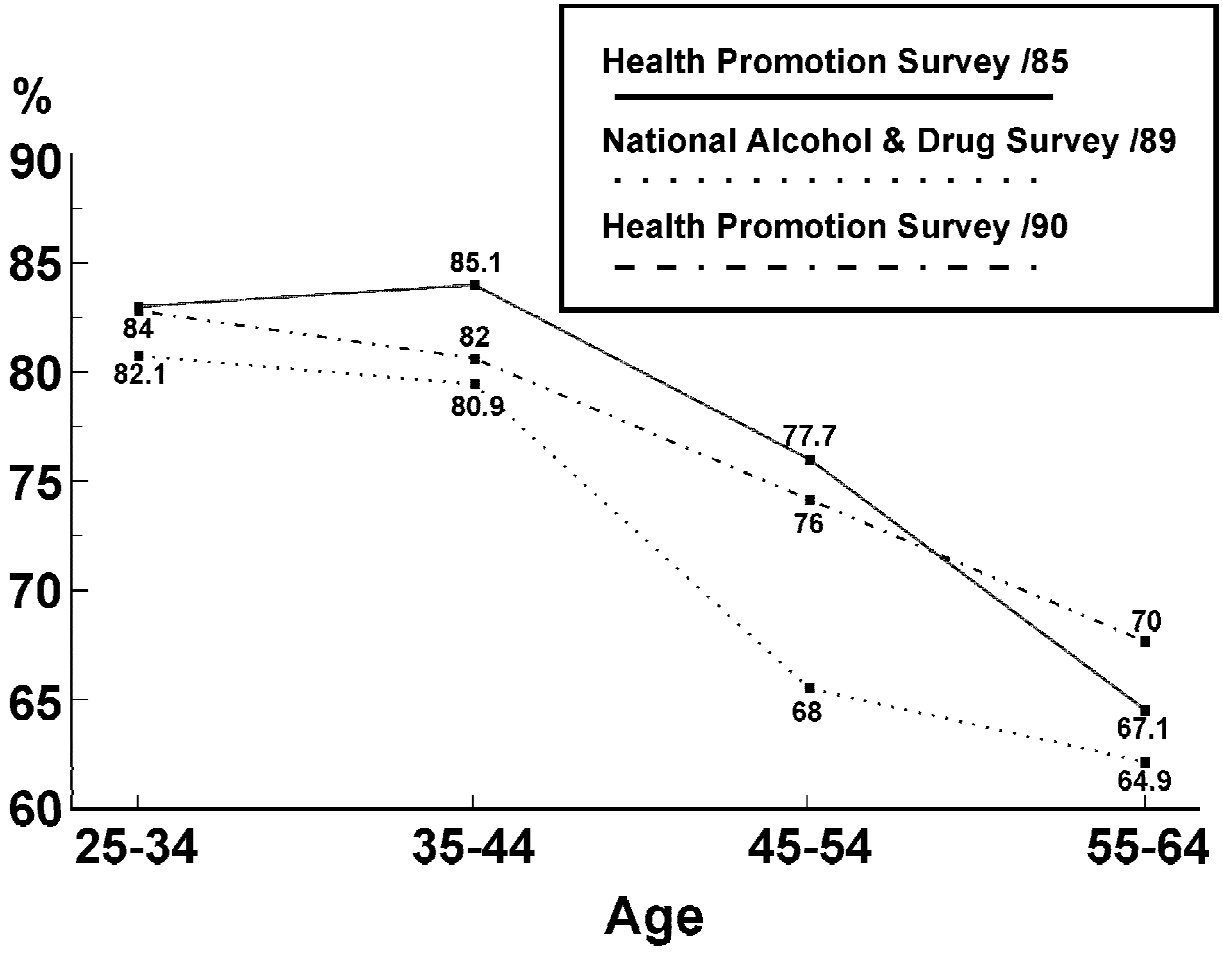
Smoking Patterns
Mid-life Women (25-64)

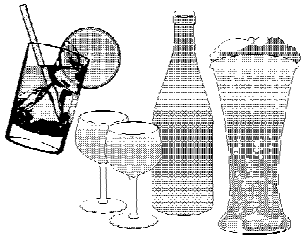




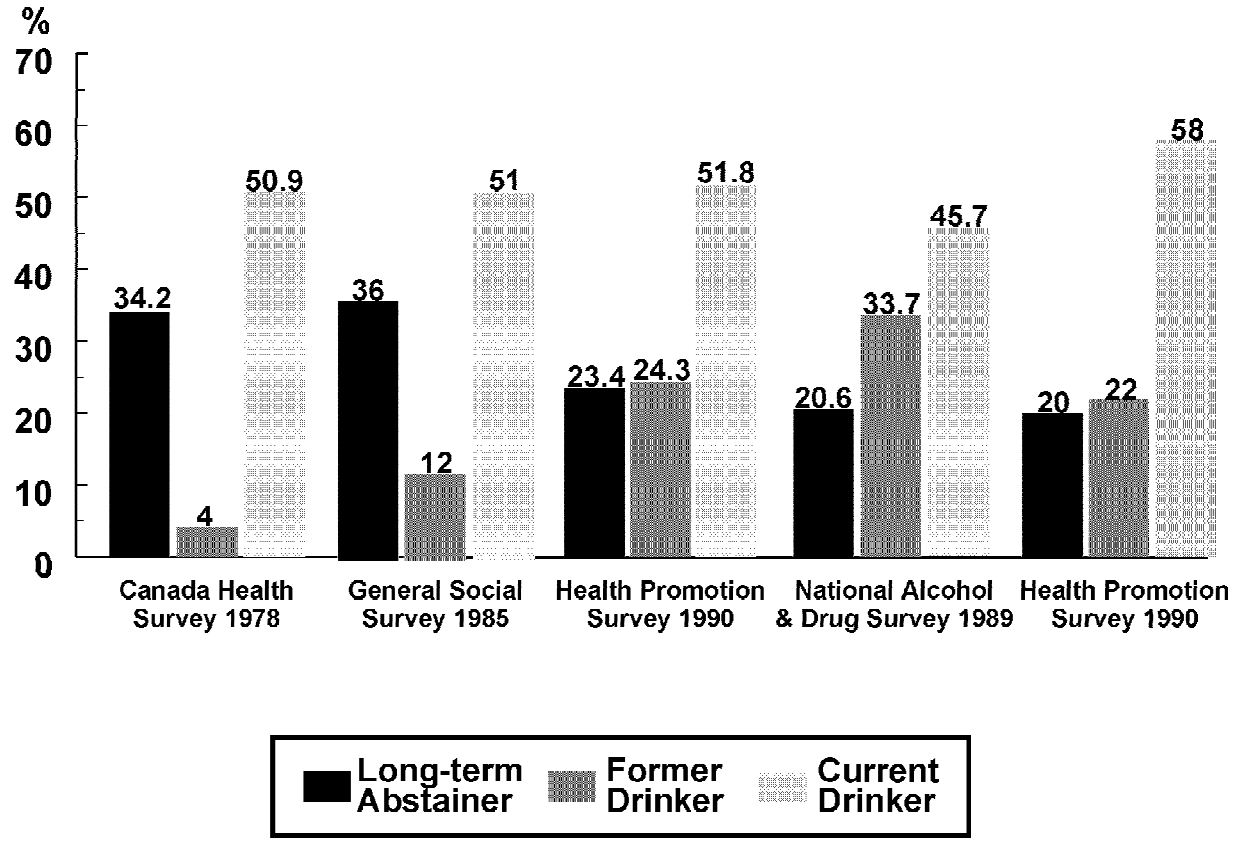


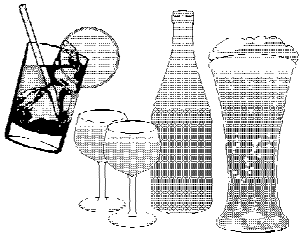
Drinking Patterns Mid-life Women (25-64)



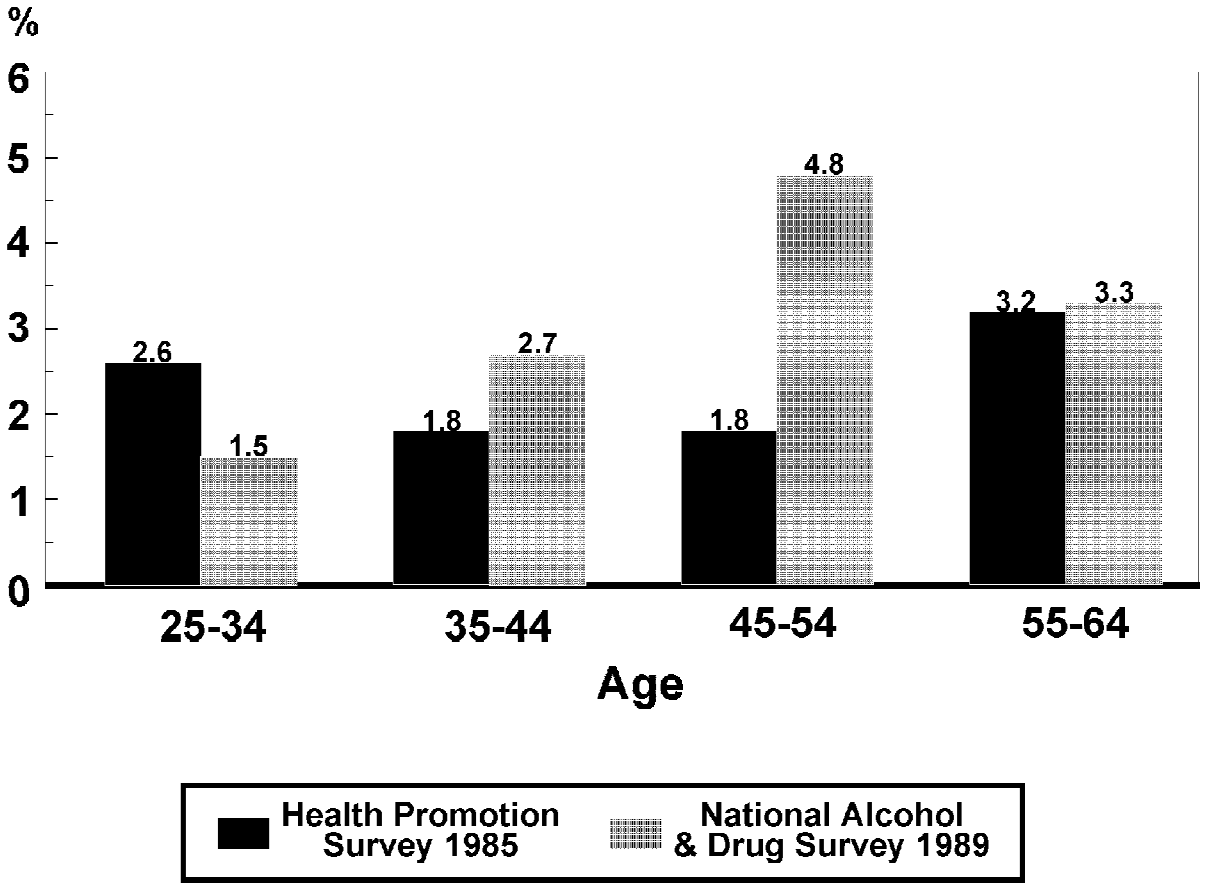


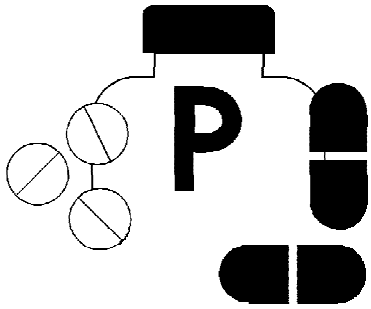
Drinking Status Older Women (65+)





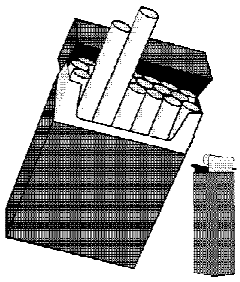
14 or 15+ Drinks Per Week Mid-life Women (25-64)





Psychotherapeutic Drugs Older Women (65+)

	Tranquilizers	Sleeping Pills	Narcotic Analgesics	Pain Killers	Anti-depressants
Canada Health Survey 1978 (2 days)	19.7			24.6	
Health Promotion Survey 1985 (12 months)	14.1	22.8			
National Alcohol & Drug Survey 1989 (1 month)	6.8	11.6	4.5		3.2
Health Promotion Survey 1990 (12 months)	11.0	20.0	7.0	70.0	6.0



Smoking Patterns Older Women (65+)

	Non-smoker	*Former Smoker*	*Current Smoker*
Canada Health Survey	58.8	11.2	15.0
General Social Survey	67.0	16.0	17.0
Health Promotion Survey /85			
National Alcohol & Drug Survey	62.6	20.8	16.6
Health Promotion Survey /90	51.0	35.0	13.0

Appendix D-2

Dimensions of Inequality

Dimensions of Inequality

The following statistics illustrate the objective realities of gender inequality Canadian women face every day.

→ The average annual wage of women full-time workers in 1991 was $26,842. For men it was $38,567.

→ The average wage of women increased by 14% in the decade of the 1980s, while that of men remained constant. However by 1990, despite a decade of employment equity and increased educational attainment and work experience among women, women's earnings were still just 60.3% those of men.

→ Three out of four earners in the 10 lowest paying occupations are women. Eight out of ten earners in the highest paying occupations are men.

→ The lowest average employment income in 1990 was for child care occupations at $13,518.

→ The average income for female lone parent families in 1990 was $26,500. For male lone parent families it was $40,792. There were 165,245 male lone parent families and 788,400 female lone parent families in 1990.

→ In 1989, only 7% of all full professors at Canadian universities were women. In engineering and applied sciences women accounted for only 15% of lecturers and instructors and just 1% of full professors. Even in education faculties, only 15% of full professors were women.

→ 11% of women in 2 parent families with pre-school children missed work in 1991 for family reasons. Only 2% of men in these families had absences from work for family reasons.

→ On average, women who work outside the home for pay spend almost an hour and a half more per day on unpaid household work, including domestic work, primary child care and shopping, than do men – 3.2 hours per day on average over a 7-day week compared with 1.8 hours per day for men.

→ Four times as many women as men reported that 4 out of 5 domestic responsibilities were mostly theirs. Women said they had the main responsibility for household shopping, cleaning inside the home, looking after ill children and taking children to activities. Men said they had primary responsibility only for "cleaning outside the home".

→ 42% of women household maintainers (i.e. the person responsible for mortgage, rent, taxes and upkeep) own their dwelling, compared with 70% of male household maintainers.

→ Elderly unattached women are among the poorest Canadians. But, while the percentage of these women living in poverty has gone down since 1980, an increasing proportion of all low income elderly people are women.

→ In 1991-92, all levels of government expended $1.876 billion on adult correctional services. On an average day, there were 25,712 prisoners serving a custodial sentence. Women accounted for just 1,254 or 9% of all provincial prisoners, and only 354 or 3% of all federal inmates.

→ Women account for 10% of all persons charged with violent crimes and 20% of those charged with property crimes.

→ Breast cancer is the leading cause of death for Canadian women aged 35-54 and the leading cause of death from cancer for women aged 30-74. Less than 1% of health care research funds are spent on breast cancer.

Source: ***Changing the Landscape: Ending Violence - Achieving Equality. Final Report on the Canadian Panel on Violence Against Women. Minister of Supply and Services Canada. 1993. Ottawa. P.15.***