

Illicit Alcohol in British Columbia

Results from a Qualitative Research Study

July 19, 2013

This report presents the findings of a qualitative research study on illicit alcohol done in British Columbia in July and August, 2012. The views expressed in this report are those of the authors and do not necessarily reflect the views of the participating sites or the position of the BC Centre for Disease Control or Vancouver Area Network of Drug Users.

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Abbreviations

BCCDC - BC Centre for Disease Control

BCYADWS - BC-Yukon Association of Drug War Survivors

Detox - Detoxification Programs

EIDGE - Eastside Illicit Drinkers Group for Education

MAP - Managed Alcohol Program

VANDU - Vancouver Area Network of Drug Users

Summary

Little is currently known about illicit alcohol consumption in BC but this has been identified as an issue during previous research done by the BC Centre for Disease Control (BCCDC) and the BC-Yukon Association of Drug War Survivors (BCYADWS). Illicit alcohol is defined as: alcohol that is not intended for human consumption; illegally produced homemade alcohol; and store bought alcohol that is consumed in a highly criminalized way (i.e. drinking in public spaces).

Preliminary research has been conducted on illicit alcohol consumption in the Vancouver area with the Eastside Illicit Drinkers Group for Education (EIDGE), a peer advocacy group that is part of the Vancouver Area Network of Drug Users (VANDU). This new research on illicit alcohol was undertaken to determine the differences and similarities between Vancouver and other communities in BC to shed light on what public health and community services would be appropriate in these different settings.

To conduct this research, focus groups were held in the Fraser, Interior, Vancouver Island, and Northern Health Authorities. Ten focus groups were held and a total of 114 people participated; each focus group had an average of 12 participants. The participants were adults who currently consume illicit alcohol, who have consumed it in the past, and people who do not consume it but support the issues of those who do. Focus groups were facilitated by EIDGE members. Each focus group explored participant's experiences with illicit alcohol, including: what, where and how people are consuming alcohol, the harm reduction methods of consumers, current health services in their community, and ideas for new services.

This research is an important step in learning about illicit alcohol use, harms and harm reduction methods. Our findings show immediate steps can be taken to improve the health and well-being of people who consume illicit alcohol in BC communities by increasing the availability of shelter beds and affordable housing units, and creating indoor spaces for people using illicit alcohol so they are able to look after one another.

The BCCDC and EIDGE are working together to share the results from this research and to do advocacy work to promote health and community services to aid those who consume illicit alcohol.

The results of this research are being presented at many conferences and the full report is being shared with community groups and policy makers to help increase awareness of illicit alcohol in BC. A user-friendly short report has also been developed. See [here](http://www.bccdc.ca/prevention/HarmReduction/Research+Articles.htm) (<http://www.bccdc.ca/prevention/HarmReduction/Research+Articles.htm>).

A poster presentation on the results of this research was given at the Public Health Association of BC's annual meeting in November, 2012, at the Alcohol Policy Conference in Washington, D.C., in April, 2013, at the Alberta Harm Reduction Conference in Calgary, May 2013, and at the Canadian Public Health Association's Annual Conference in Ottawa in June, 2013, and potentially other forums in the future.

Background

This study was undertaken to learn about illicit alcohol consumers’ practices and perceptions about its use in order to help develop appropriate public health and community services. Illicit alcohol is defined as: alcohol that is not intended for human consumption; illegally produced homemade alcohol; and store bought alcohol that is consumed in a highly criminalized way (i.e. drinking in public spaces).

Little is currently known about illicit alcohol consumption in British Columbia (BC) but it has been identified as an issue during previous research done by the BC Centre for Disease Control (BCCDC) and the BC-Yukon Association of Drug War Survivors (BCYADWS). This previous research, done from 2009 to 2010, was undertaken to determine the needs of drug users in BC. However, people who consume alcohol and illicit alcohol came to the meetings held as part of this research and voiced unique concerns.

Preliminary research has been conducted on illicit alcohol consumption in the Vancouver area with the Eastside Illicit Drinkers Group for Education (EIDGE), a peer advocacy group that is part of the Vancouver Area Network of Drug Users. This new research was done in the summer of 2012 to find out more about illicit alcohol, including what people are consuming, the harms faced from consuming illicit alcohol and what can be done to reduce these harms, and to determine if there are major differences in illicit alcohol use between Vancouver and other BC communities. This information will help us to identify what public health and community services would be appropriate in these different settings and the province as a whole.

Methods

To conduct this research, focus groups were held in BC’s Fraser, Interior, Vancouver Island, and Northern Health Authorities. Meetings were held in Abbotsford, Fort St. James, Hope, Kamloops, Lytton, Nanaimo, Prince George, Smithers, Victoria and Williams Lake (as shown on the map below). Ten focus groups were held and 114 people participated in total. The participants were adults who currently consume illicit alcohol, who have consumed it in the past, and people who do not consume it but support the concerns of those who do. The EIDGE Coordinator (see explanation below) planned the meetings by contacting harm reduction and health service sites in BC that were interested in the project and felt that they had clients who would be interested in participating.

Focus groups were facilitated by EIDGE members. At the focus groups facilitators presented information on illicit alcohol consumption in Vancouver and led a discussion of similarities and differences between Vancouver and the other



community. The discussions at these meetings focused on these questions:

- What are people drinking and how?
- What actions are people who drink illicit alcohol already taking to protect their health and how they could they be helped in their efforts?
- What additional harm reduction services would people who drink illicit alcohol value and could realistically be put in place in their community?

During each focus group a student researcher took typed notes on the discussions and a thematic analysis was undertaken on these notes using the NVivo software program (version 8). The student researcher worked with EIDGE to finalize the report and to

EIDGE

The Eastside Illicit Drinkers Group for Education (EIDGE) is a peer advocacy group that is part of the Vancouver Area Network of Drug Users (VANDU). EIDGE is run by a Steering Committee and a paid Coordinator who is not a consumer of illicit alcohol.

EIDGE was formed in October, 2011, and holds weekly meetings at the VANDU building in Vancouver. At the weekly meetings discussion topics include: issues for illicit drinkers; community events and activism; housing; and services available to members. Approximately 30 people attend the meeting each week, plus two facilitators and a note taker. Approximately 90% of the participants are Aboriginal.

The Steering Committee was heavily involved in the development and implementation of this research project. Steering Committee and general EIDGE members facilitated the focus group meetings and have helped to present and refine the study results.

discuss the notes from the meetings to ensure accuracy. Low barrier consent was obtained and a small honorarium, which was not contingent on consent, was given to participants (\$5) and facilitators (\$20) for their time. Ethics approval for this study was obtained from the University of British Columbia’s Behavioral Research Ethics Board.

Research Findings

What people consume

In each meeting participants were asked to identify what alcohol they consume. Answers included: high alcohol content beer and wine, sherry, coolers, hair spray, hand sanitizer, hard liquor, homebrew/moonshine, Listerine (also called ‘List’), Lysol, massage oils, pure vanilla, rubbing alcohol (also called ‘rubby’), and salt wine (also known as cooking wine or rice wine). The most common drink was different in each community, however, high alcohol content beer and wine, sherry and coolers were said to be popular in a number of communities.

There were many reasons identified for why participants chose their drink of choice. For example, one participant said,

“different groups, different drinks. Some people will drink anything with alcohol in it”.

Another person said,

“[h]and sanitizer is popular because it’s the easiest to steal”.

Regarding why people consume illicit alcohol one person said *“it’s a buzz problem”*; it is something to drink until you can get something from the liquor store. We heard at a number of meetings that if participants

cannot afford alcohol from the liquor store they¹ will drink illicit alcohol.

What people drink is also influenced by liquor store and grocery store policies. We heard that many stores have policies regarding who they will sell to and how many times a day they will sell to someone. To get around these policies people said that they will drink with a group of friends who pool their money together and each go in to buy something from the store at a different time to stay within the store’s policy; one person said,

“they only let us in the liquor store twice a day so we switch off who goes in. Some people are already banned for the day”.

How people consume alcohol

Participants told us that they drink to become intoxicated, to be social, for something to do, and due to issues in their lives. Some participants said that they mix drinks to make them taste better or to increase the potency. Some people drink in public because they are homeless and have nowhere else to go and others because they are part of a group who drink outside.

How people pay for alcohol

The different methods of paying for illicit and market alcohol that we heard were: collecting bottles, panhandling, pooling money, stealing, selling drugs, and using their social assistance to buy alcohol. Many participants said that they collect bottles to pay for alcohol. In several of the communities some participants said that they panhandle at least some of the time to pay for alcohol. Of their success when panhandling one participant said,

“People are poor out here. No money. So it doesn’t always work”.

Most people at the meetings said that they

pooled their money together with a group at least some of the time to afford alcohol.

Where people buy illicit alcohol

Participants who drink illicit alcohol said they have bought it at major groceries and drug store chains as well as smaller independent stores. They will buy it anywhere that it is available and where they will face the least issues when purchasing it. In one community it was mentioned that there is a supplier of moonshine where people buy relatively cheap alcohol.

Barriers to accessing alcohol

Participants told us that there are barriers to their accessing market and illicit alcohol. This included cost, bans on some substances (e.g. salt wine), and removing products (e.g. hand sanitizer and rubbing alcohol) from stores and hospitals. In some communities participants said that stores were starting to put illicit alcohol behind the counter so patrons would need to ask for it to buy it, however these barriers were not apparent in all communities; some participants said illicit alcohol is very easy to obtain.

We heard from some participants that they did not appreciate the changes to product availability or the bans on certain alcohol products. A participant said that if you ban certain alcohol products in certain areas people will move to locations where it is available rather than stop using that product. The person added that,

“everything should just be kept where it is; people have the right to buy what they want and use it for what they want”.

Store policies were also identified as a major barrier to people buying alcohol. A few people said that at some stores you can buy illicit alcohol, but at the bigger stores they

¹ They is used in this paper as a gender neutral pronoun to protect the identity of study participants.

said that it depends what you look like and how they profile you on whether they will sell it to you or not. A participant said that the liquor stores list who comes in and out. They look at the surveillance tapes and they try to stop people from coming in if they see from the surveillance that they have been in too many times. We heard that drinkers prefer to go into the liquor store multiple times per day where they buy smaller quantities of alcohol, so if they are caught drinking outside by the police they will not have too much of their alcohol poured out. Barriers to purchasing alcohol were not apparent at all stores, however. At one meeting a participant said,

“[there are] no questions asked when we buy alcohol”.

Where people live and drink

Housing and shelters was a topic that came up at every focus group meeting. Many people we spoke to did not have a place to live and there were not adequate shelters in the community for them to have a place to stay. We heard many people speak of how they sleep outside all year long, putting people at risk of hypothermia in the winter. We heard that there are many obstacles to obtaining and maintaining affordable housing that was supportive or non-judgmental of participants’ consumption of alcohol. The issues participants spoke of included that there is very little subsidized housing, long waitlists, restrictive conditions required for staying in certain residences (e.g. not allowed to have visitors), being evicted for their behavior or substance use, and a lack of overnight shelters in the smaller communities. One participant told us that there are thirty homeless people in need of a shelter bed in his community of approximately 5,000 people.

Harms faced from drinking

At every meeting we held participants expressed some form of harm from drinking

alcohol. These harms ranged in severity from minor cuts and scrapes to liver failure. Many participants also spoke of grief from losing loved ones to alcoholism and at some meetings participants spoke of memorial services they were attending later that day or within a week of our meeting. At one meeting a participant said,

“There’s lots of grieving in this town. Grief is constant”.

The harms faced from drinking can be roughly categorized into these areas: physical injuries and mortality; personal safety; emotional harm and stigma; and, addictions. Each of these categories will be discussed further below. Some of these health effects stem from the substances and volumes of alcohol people are drinking or using, where they are drinking (e.g. outside where they are exposed to the weather), and accessibility of health services.

Physical injuries and mortality

In many communities participants spoke of recent mortalities due to drinking. A participant said,

“Us people we’re dropping like flies”.

Another participant said that they used to drink salt wine but they stopped because someone close to them died from liver disease from drinking it. Of alcohol a participant said

“[t]hat’s the only legal thing that you can buy and it kills people”.

The health effects participants have experienced from drinking include: liver disease, withdrawal, seizures, delirium tremens (DTs), shakes, blackouts, migraines, kidney failure, cuts and bruises, comas, falls, eyesight, memory, hearing and stomach issues, being hit by cars and hypothermia. Two participants said,

“I see people in the morning who are just vibrating [from withdrawal] and I feel so sorry for them”.

“My kidneys are failing and I’m starting to bruise all over the place because of that”.

Personal safety

People face harms to their personal safety both due to having impaired judgment when intoxicated and due to being marginalized within the community so people are unaware of their issues. This marginalization can even lead to harassment. One person said sometimes it can be dangerous collecting bottles; at 5am there can be “weirdos” out. Another participant said,

“I drank more when I was housed...I could get drunk and passed out and I don’t have to worry about cops or someone trying stuff on me”.

Other people have had their personal safety threatened when they become intoxicated because their coordination and balance are less reliable which makes it easier for them to fall or be hit by cars.

Emotional harm and stigma

Many people spoke about personal issues in their lives and why they started drinking. A community service provider said that the drinking then increases problems in people’s lives. For example, they had heard of someone who could not see their children because of their drinking which led the person to drink more. Participants also were dealing with the emotional harm of being stigmatized for drinking in public and drinking illicit alcohol. In many meetings people spoke of keeping the details of their drinking from their families because they felt shame.

Addictions

Addiction harms people’s lives in that they spend most of their time focused on drinking.

It was clear at a number of meetings that people were suffering from lifelong struggles with addictions. One person spoke of their typical day and said that they start collecting bottles at 4 am and they “stop when we get drunk or go to jail. Either or.” At another meeting someone said, “people putting their mind toward alcohol all the time” was a harm that they faced.

In some communities intergenerational drinking was identified as common, meaning older family members drink with their younger family members. This was identified as an issue by service providers because it means that there is a cycle of drinking in the community and it is thus harder to prevent young people from drinking and developing addictions.

At one meeting, the facilitator asked if young people drink in the community and a few participants responded:

“[That’s a] hard subject. They graduate high school and there’s no work for them so they start selling crack”.

“Nobody gives them a chance so they’re selling crack to make a living and at night they run around like wolves. I can hear them”.

Police Interactions

Interactions with police were brought up at all of our meetings. For most participants the police were a major presence in their day-to-day lives; people spoke of being arrested often and spending a lot of time trying to stay away from the police to avoid having their alcohol poured out, being given a fine or put in the police sobering unit. For some people police involvement in their daily life seemed to be accepted. One person said,

“we prefer to get it [buy alcohol] little by little because it’s not worth losing it all to the cops. Unless we have a home to go to we won’t buy a lot at once”.

For this person, meeting the police and having them pour out their alcohol was a near certainty so they changed their buying practices. Other participants were upset by this interaction and said,

“a lot of us get bullied by the cops really hard. When we do get the money together it’s to cure the shakes and we lose people that way”,

meaning people have died from withdrawal.

Of their interactions with the police, people were frequently asked to move and said that they were running out of places to go to drink. The area that they feel safe and comfortable is restricted. For example, one person said

“I spend most of the time running away from the cops”.

Harm reduction methods of drinkers

The harm reduction methods of drinkers varied depending on the community we visited and the services provided there, but in each location the majority of drinkers were part of a group that consumes alcohol together. Many people who drink with a group look out for one another by pooling money for alcohol and sharing food. We also heard in one community that the group has a “designated walker” who gets less drunk than the others and looks out for the group and walks people home when they are intoxicated.

Mixing and diluting

At most of the meetings participants were very knowledgeable about how to mix drinks to make them safer and to make them taste better. For example, one person said,

“[w]e mix rice wine. Mix it with orange juice to take the salt away”.

At another meeting someone mentioned that illicit alcohol and moonshine need to be

diluted before you drink them. At many of the meetings there was a discussion of the different kinds of hand sanitizer, rubbing alcohol and rice wine (this typically has 18-25% alcohol content compared to other wine which has 9-16% alcohol content). Participants discussed the kinds to drink that cause the least harm, such as those with the least salt.

Eating before drinking

Most participants said that they did not eat before drinking. One participant said,

“once in a while before we leave home we eat but we try to drink on an empty stomach so we can get drunk faster”.

At a few of the meetings we discussed the availability of free food and in most communities there was very little provided that participants were aware of. This is different from Vancouver where there are numerous providers of free and low-cost food that are well known to residents. One participant said,

“I went to [a service provider] to get a sandwich and they made me feel like I was begging for a peanut butter sandwich”,

so the person left without receiving anything to eat.

Services and treatment options currently available

We discussed the participants’ use and access to services. This included the harm reduction services, detoxification (detox) programs and health care services offered in their community.

Harm reduction services

There was a range of responses from participants about what harm reduction services are provided in their community, if any. In one community people at the meeting

could not think of any place that they would go to if they needed help. At another meeting when asked if there were outreach services in their community, and examples of outreach services were described, a participant said,

“no, never heard of that”.

In other locations the service providers were much more visible. Of a specific service provider one participant said,

“he’s found me by myself in the middle of nowhere. Next thing you know we have blankets, water, [granola] bars. And I know it was him”.

In another community participants said that people from the outreach centre will bring people water, especially on a hot day.

In some communities participants felt that their community wasn’t doing enough to provide support to those who consume illicit alcohol. For example, a participant said of when they lived in Vancouver,

“I drank two bottles of vodka a day in Vancouver. There was always someone there to help. People are dying because this city turned their back on us”.

This person wanted their community to have the same supports that they had experienced in Vancouver. However, in other communities trust of government was very low based on historical experiences, such as being forced to attend residential schools, and negative experiences with health care providers. As a result, even if there were more community services offered people would not necessarily use them.

Detoxification programs

In a few communities people mentioned that it is hard to access detox and did not know about all the detox services provided. For example, in one location a participant said that there are no detox programs there. A service provider at the meeting clarified that there are options available but nothing like what is offered in a large city like Vancouver.

Options in that community included a mobile detox unit, for people who can detox at home, and a few detox beds at different health facilities.

At another meeting participants were more aware of facilities available to them but there was a waitlist to get in and conditions they needed to meet to attend detox, such as quitting smoking and going to Alcoholics Anonymous. A person said,

“Some places you need to be clean before you go in there”

and that this is not possible for everyone. Of the waitlist for detox a participant said,

“[i]f you wanna stop you wanna stop now, you don’t wanna stop three weeks from now”.

One person said,

“I quit drinking myself. I learned to detox myself because I couldn’t depend on getting in there [to the detox centre]. I went to the doctor to get some Ativans but it’s working today”.

In another community, there were more detox services available. Here, a participant said,

“[Y]ou can go in for a week to detox and you can go in there drunk; you do not have to be sober before entering.”

Another participant at that meeting said “most people have beverage right up to the door”, meaning they are drinking right up to when they enter the detox facility. Other participants said that they had never had to wait long to get into detox. This variation in services was in part due to the size of the community and due to the number of people who consume alcohol in public spaces in the community. One community that had more accessible detox services had more public attention toward this population than in other locations.

Health care services in general

Services at hospitals and from family doctors also varied from community to community. At one meeting there was discussion regarding some people's experience of going to the hospital and not being treated because the doctors did not want to treat them when they had been drinking. One participant said that he had an accident at work and needed medical attention. He was driven somewhere to have a drink before going to the hospital and was then asked to leave the hospital because the staff smelled alcohol on him. As a result, he didn't receive medical care for his injury. A service provider in another community said some people who do not have doctors go to the hospital when they need medical attention and have to wait for hours to be seen by a doctor. Many people in this situation leave the hospital without being treated. This lack of attention and care given to these individuals can lead them to be distrusting of health care services, making it less likely that they will use these services when they are in need of them.

Accessibility of services

At some meetings participants spoke of services being too far away for them to be of use. Most people did not have access to cars and bus service was limited or not available so they depended on rides, hitchhiking or walking to get where they needed to go. In one community people spoke of the court house being over an hour walk each way and there was no bus service there.

Views on a managed alcohol program in their community

At the meetings, participants were asked about whether they thought a managed alcohol program (MAP) would be a good thing in their community. A managed alcohol program was described as a place where market alcohol is provided to the people in the program at regular intervals throughout the day to help

people stabilize their drinking. Participants had varying opinions on the usefulness and potential success of a MAP. It seemed that prior to our meeting most participants had never heard of a MAP, although this varied by community. Given that the idea was new to many participants, the opinions we heard on a MAP tended to focus on what people felt the goals of the program were, whether that was managing alcohol intake, staying out of jail or quitting drinking.

Overall, most participants thought it would help, if not them personally then someone they know, but were unsure it would be accepted or allowed by the public in their community. Having an increase in the types and availability of alcohol-related health services was seen as a good thing even if the participant didn't see themselves using it.

On the usefulness of a MAP program we heard a variety of opinions. One person said,

“it would just be a free ride. [We] would drink there and just come downtown and drink more”.

There was some agreement from the participants at that meeting that a maintenance program would not work in their community because they would never stop drinking. At another meeting a person said,

“for the hardcore drinkers, for the ones trying to wean themselves off, it would be good”.

Another participant said,

“I think it would work really well. It would keep people from going to the jail”.

Some participants were not sure the volume of alcohol given to people as part of the MAP would be enough. A participant said,

“[O]ne drink an hour isn't going to be enough. If I have one drink it isn't going to be enough”.

Another person said,

“It works for some people. There’s times where I need at least one drink a day just to keep me from going in to seizures. I can handle one an hour or even less, it depends on how I am. I’m on pills now but I still drink”.

On whether a MAP would be accepted in their community some people thought it would be and others did not. In one meeting a participant said that the police are the worst in the city and they will not allow a prescribed alcohol program. Other participants disagreed and said they might allow it. It would be a safe place for people to drink instead of people being in the street and might get support from the public because of this.

Kamloops is already working on getting a MAP there and Nanaimo is working on incorporating a wet component to their new supportive housing project. This would mean that people using that housing would not be expected to abstain from drinking while living there.

New ideas for services

At some meetings, participants suggested new ideas for services and/or the expansion of current health and social services. These included: building more shelters, having an indoor drinkers’ lounge and bringing illicit drinkers from Vancouver to their community to tell people what it is like in Vancouver’s Downtown Eastside. At another meeting a participant said,

“lots of us have relatives in the street [in Vancouver and other cities] and it would be interesting for them to come up to our community and to let us know about their lives. People have to be made aware of this. It would be a good activity to be aware of their lives”.

At one meeting, a participant asked the facilitators if they had heard of the Scared

Straight program. The person explained that the program brings fifteen people from their community to Vancouver to see what it is like there. A participant said,

“if you don’t have a criminal record [and get arrested] it’s an ‘alternative methods program’. I have to attend these functions, go to counseling two times a week. If I go through this for three months then I don’t have a criminal record”.

Similarities and differences across BC communities

Differences

Major differences between Vancouver and the other communities are the availability of illicit alcohol, the opportunity to talk about illicit alcohol consumption and the availability of health services, housing and shelter beds (as discussed above).

In Vancouver there are more stores that sell illicit alcohol than in smaller communities. This makes it easier for people to buy it because if one store refuses to sell to them they can go somewhere else. In smaller communities if a store will not sell to someone they do not have as many options for other places to go.

Another major difference between many communities and Vancouver was that there are fewer opportunities to talk about alcohol consumption and participate in support groups. At the time of this study, there were no peer support groups that focused on illicit drinking in BC other than EIDGE. Many participants said they would like to see one in their community, especially in Victoria where meeting participants said they are currently working on getting a peer group started.

Due to the relatively small number of programs and services in smaller communities it was evident that people have

a different relationship with service providers than in Vancouver. In smaller communities we heard that some participants do not have a doctor or a good relationship with their doctor. In Vancouver if a person does not have a good relationship with their doctor there are many others that they can go to.

The availability of more health services in larger communities was apparent as well. In Vancouver there are many clinics, hospitals and outreach centres and people living there are exposed to healthcare workers on a more regular basis. In smaller communities, where fewer services are available, there is less awareness of health services and people use services less often as a result.

Similarities

In Vancouver and the other communities, people told us that they often drink in groups of friends and look out for one another when drinking. In addition, in both Vancouver and other communities, people spoke of waiting to get into detox programs. This was seen as a major issue because when people want to go to detox they want to go immediately, not weeks or months from the time that they make that commitment.

Conclusion

This research is an important step in learning about illicit alcohol use, harms and harm reduction methods. Our findings show immediate steps can be taken to improve the health and well-being of people who consume illicit alcohol in BC communities by increasing shelter beds and affordable housing units and creating indoor spaces for people using illicit alcohol so they are able to look after one another.

We heard at many of the meetings that drinkers' issues were not supported by the general public or by some service providers.

This discrimination leads to stigma within the drinking population that keeps people from receiving the care that they need and from seeking out services. New and existing services should be made with their input rather than trying to have people conform to services and delivery methods that do not meet their needs.

The stigma surrounding illicit alcohol and illicit drinking keeps people from living healthier, safer lives. The public, health-care decision makers and the police all need to know more about the drinking community so that they can support it where needed and wanted by the drinking community.

Next Steps

The BCCDC and EIDGE are working together to share the results from this research and to do advocacy work to promote health and community services to aid those who consume illicit alcohol.

The results of this research are being presented at many conferences and the report is being shared with community groups and policy makers to help increase awareness of illicit alcohol in BC. Poster presentations on the results of this research were given at the Public Health Association of BC's annual meeting in November, 2012, at the Alcohol Policy Conference in Washington, D.C., in April, 2013, and at the Canadian Public Health Association's Annual Conference in Ottawa in June, 2013. A PowerPoint presentation on this study was given at the Alberta Harm Reduction Conference in Calgary in May, 2013. In the future this research may also be presented at other forums.