To All Who Are Excellent:

This is my paper that you contributed to. I cannot thank you enough for your patience, generosity and kindness in guiding me through the rice wine issue in the Downtown Eastside. I would not have received such a high mark or wonderful comments without your help. A photocopy of my mark and comments is on the next page.

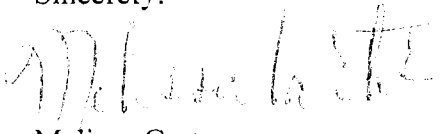
To understand my paper in its entirety, the following is the exact assignment parameters as written in our university course package:

> "Select a community health issue of interest or concern to you. This may be an issue that you have explored before or an issue that is totally new to you. If you have explored this issue before, be sure the reader knows how you examined it before and why you are examining it again. It must be clear to the reader that you are exploring an entirely different aspect of the issue in order to expand your knowledge.
>
> Briefly describe the nature and magnitude of the community health issue. Discuss how you would approach the issue from a program planning and from a community development perspective. Compare and contrast these two approaches, identifying the strengths and challenges in each approach. Finally, describe a pattern of practice that you believe would best attend to the community health issue. Critique the dilemmas encountered in mixing different approaches to community health promotion practice."

I realize that my paper has one major flaw. There is not one Chinese voice featured in it. Disappointingly, I have not had the time to seek out someone in the Chinese community for a comment. While distributing the paper to you, I will give one to a representative of their community.

I encourage you to give me feedback on any aspect of my paper so that I can expand my knowledge base, be a better person and most importantly, become a stronger facilitator of care to those in the Downtown Eastside. I would enthusiastically welcome more opportunities to talk to you because I have so enjoyed our previous communication. My e-mail address is hatl@home.com and my telephone number is 731-3428.

Sincerely:



Melissa Carter
University of Victoria Student Nurse

Melissa

A. National/International Issue

Definition of the issue

very thorough 2/2

Evidence of health promotion perspective

Critical ~~examination using principles of Ottawa Charter~~ contrast, struggle + challenges. 5/5

~~Impact of nursing/nurses~~ Critique dilemma 5.5/5.

~~Contrasted:~~

Pattern of practice to address issue. 5/5

Use of literature and resources 4/5

Formatting: spelling, grammar, APA, punctuation, presentation 4/5

(+2 extra points for being good?)

OVERALL: Melissa — excellent exemplary paper. demonstrative of your interest, passion and innovative vision. Based on sound patterns which are emerging in the DTES and power infrastructure.

Grade: 27.5/30 = 91.6 = 92%.

Lauralee Richardson RN MSN

N350 Jan.-Apr. 2000 Major paper Instructor: Debbie Dunn RN, MSN

3/15/00 4:21 PM

Personal Comments:

Anne,

Thank you so much for your
patience and your fireball
attitude. While I was writing
this, I tried to insert
that into this paper.
I will take it with me
while I work too ♥
The video study stuff
is marked by the
yellow post it Note.

-Melissa

The Rice Wine Issue: More Than Just Confetti.

Melissa Carter
00-28861

Health IV:Health Promotion and Community Development Practice
Nursing 350
Heather Richardson
University of Victoria
August 7th , 2000

Table of Contents:

Sheilds and Lindsey's (1998) article "Community Health Promotion Nursing Practice" outlines a step by step process to assess health promotion within families and communities, derived from the work of among others, Freire and Wallerstein. This process begins with the step entitled "listening and critical reflection" (p.30), and continues with "participatory dialogue and critical questioning" (p.31), "codification" (p.31), "pattern emergence and recognition" (p.33) and finally "movement into action: praxis" (p.33). This framework will provide the basis for detailing the importance of the rice wine issue, looking the dilemmas created by the current and other "solutions" to this problem, and proposing my own through the examination of the community development and the program planning perspectives.

"Listening and Critical Reflection"

My desire to understand the rice wine issue in the Downtown Eastside (DTES) can be detailed through Sheilds and Lindsey's (1998) first step. They say that it is about listening attentively to gain ideas about the issues leading to further examination. Two conversations which piqued my interest at my current practicum placement, WATARI, a multipurpose organization in DTES for persons with drug and alcohol problems. In the first, a question was posed about the connection between rice wine/non-beverage alcohol and diabetes when developing a resource manual for WATARI. I did not find the connection at the time but this raised my awareness. At another time, I overheard a conversation about having detoxification centers where overdoses of non-beverage alcohol and other substances occur. I was drawn to this issue and began my quest to find out more.

"Participatory Dialogue and Critical Questioning"

The central precept of this second step outlined the way in which I found key information. Sheilds and Lindsey (1998) featured an opinion which suggests complex familial or communal issues can be accessed through problem based inquiries. Using this mode I found from a variety of sources what rice wine was and the large impact it has on the community, statistically and medically.

Rice wine or rice alcohol is one of a myriad of low cost substances with a wide range of alcohol content and added salt. Rice wine is a distilled liquor whose alcohol percentage can range from zero to 54%, according to Rice Alcohol Options Paper (Craig & Matthews, 1999) prepared for the Liquor Control and Licensing Branch (See Appendix A) and the Ministry of the Attorney General news release "Regulation Of Rice Alcohol Will Save Lives" (See Appendix B). Community sources stated that the rice wine in the DTES had an

alcohol content between 38% and 40% (G. Kliewer, P. Taylor & J. Sommers, personal communications, June 28-30, 2000). One source commented that the percentage could go as low as 18% (G. Kliewer, personal communication, August 2, 2000). The Options paper and a community source agreed that the rice wine available in the DTES has a 2% salt content. (P. Taylor, personal communication, June 28, 2000). In the Options paper, rice wine falls under one of the three types of non-beverage alcohol. These include medicinal, cleaning preparations and lastly culinary preparations including rice wine. My community sources gave a number of non-beverage alcohol examples that are consumed besides rice wine such as Lysol, rubbing alcohol, shoe polish and Spiced Aqua Velva (G. Kliewer, T. Lehman, P. Taylor & J. Sommers, personal communications, June 28-30, 2000). According the Options paper, Vancouver Injection Drug Users Study (VIDUS, Kain, Tyndall, Currie, Johnston, Li, O'Shaughnessy & Schechter, 1999, See Appendix C for the report), and the first of two Rice Wine Meetings held for consumers on Dec 3rd, 1998 (See Appendix D for both meetings), the price of rice wine ranges from $1.50 to $7.00 depending on the amount, place of purchase and the date of purchase. The price is usually highest on "Welfare Wednesday". Because it is so inexpensive, three to twelve bottles are consumed per day.

To begin to detail how the rice wine issue has impacted the community, I will delve into the statistics about who and how many rice wine drinkers there are. According to VIDUS (Kain et al., 1999), which has done longitudinal research examining the habits of over 1400 drug users since May of 1996, 56 people of the 906 interviewed between June and December 1999 had used rice wine. These tend to be older, Aboriginal or Latin American persons who used cocaine, did not live in stable conditions and had higher HIV prevalence and risk. A community source added that these Aboriginals were often gay in the group which she had contact with (A. Livingston, personal communication, June 28, 2000). According to Saferide, an organization which drives people home or to detoxification centers, in Rice Alcohol Options Paper (Craig & Matthews, 1999) of the 2000 customers serviced in the last two years, 90% have been rice wine drinkers, most of whom are male and a high percentage were Native Americans.

The statistics of how many rice wine related deaths are varied. Of the 114 deaths reported within VIDUS (Kain et al., 1999), 21% were known rice wine drinkers. The B.C. Coroner's Office (2000, April) states that there were at least 39 deaths related to rice

wine consumption in 1999. In the Rice Alcohol Options Paper (Craig & Matthews, 1999) there were a reported 39 deaths in 1998 and 21 deaths in 1997 which were indirectly caused by rice wine. According the Walk - In Medical Clinic 1998 Annual Report from the Vancouver Native Health Society which was compiled by Adilman and Kliewer, there were six alcohol related deaths in 1998 of the 59 total reported and an equal number in 1999 of the total 38 reported deaths (See Appendix E for both reports). I was told by the nurse who compiled both reports that generally all of these alcohol related deaths could be attributed to rice wine (G. Kliewer, personal communication, June 30, 2000). Anecdotally, one community source said that he knew six people who were rice wine drinkers and five had died (J. Sommers, personal communication, June 29, 2000). Another source said that there had been 125 deaths related to rice wine in the DTES as a general figure (A. Livingston, personal communication, June 28, 2000). One source said that these deaths had taken over the DTES and one said that he knew of one person who had lost several family members due to rice wine consumption (P. Taylor, personal communication, June 28, 2000). A quote from a rice wine drinker at the second Rice Wine meeting on March 4th, 1999 (See Appendix D for both meetings) stated that "this rice is killing our people. I see a lot of them. They are dropping like flies...There's so much death" (p.2).

To understand how the alcohol in rice wine effects on the body of the long term drinker, I consulted our nursing text book. According to Medical Surgical Nursing: Assessment and Management of Clinical Problems (1996), chronic use of alcohol has multisystemic effects. Most of these effects manifest themselves in the central nervous system creating conditions like dementia, mood swings and impairment of psychomotor skills and cognitive function. In the peripheral nervous and musculoskeletal systems, it can cause for example pain, muscle wasting and osteoporosis. Chronic alcoholism can create immunodeficiencies resulting in an increased risk of a variety of cancers and infections. A wide range of blood deficiencies, hypertension, cardiomyopathy and increased risk of stroke and myocardial infarction can occur in the cardiovascular system. In the liver, chronic use has been linked to steatosis, which can lead to alcoholic hepatitis and alcoholic cirrhosis. In the kidneys, there is an increased diuresis due to antidiuretic hormone suppression. Any part of the gastrointestinal system can become inflamed, causing for example gastritis as well as ulcers and esophageal varices. Chronic abuse causes alterations in libido and impotence, and causes a various skin discolorations. Long term use leads to a variety of nutritional issues.

I consulted three medical professionals, people who work in the DTES and the Rice Alcohol Options Paper (Craig & Matthews, 1999) to learn about the real human impact of rice wine. The nurse, I spoke to said that both the high salt content and the low cost make rice wine extremely poisonous and deadly. He stated that the salt contributes electrolyte imbalances because of the increased diuretic effect which then leads to swollen extremities, increased dehydration, exacerbated kidney problems, hypertension and most devastating, decreased thiamin (G. Kliewer, personal communication, June 30, 2000). The Options paper added that the salt content leads to skin problems and increases the progression of natural disease processes. Both the Options paper and a doctor who is a medical advisor on addictions for the Ministry of Children and Families, mentioned compounded heart problems caused by the added salt (D. Rothon, personal communication, July 5, 2000, **statement not reconfirmed at the time of distribution**). The paramedic I spoke to said that this population is likely to take recreational drugs while consuming the product which magnifies their effect, making the drinker difficult to stabilize at the scene of an emergency. Also, he said that rice wine drinkers tend to die from head injuries due to falls because of the intoxicant effects and that consumers can be passed out drunk in 20 minutes post-consumption. (T. Lehman, personal communication, June 29, 2000). In a later conversation, he added that rice wine drinkers, while intoxicated, can die from jay walking inappropriately and from bicycle accidents (T. Lehman, personal communication, August 6, 2000). The doctor told me that because people who drink rice wine also drink other non-beverage alcohol, it can be difficult to "disentangle symptoms" and that they can drink enough to cause severe respiratory depression leading to an alcoholic coma (D. Rothon, personal communication, July 5, 2000, **statement not reconfirmed at the time of distribution**). A non-health professional commented that the general appearance of a person who drinks rice wine decreases dramatically due to being too perpetually drunk to care. He added that their bodies are "thrashed" due to accidents, trauma, noticeable weight loss and violence that commonly follows excessive rice wine drinking (J. Sommers, personal communication, June 29, 2000).

"Codification" and "Pattern Emergence and Recognition"

Using codification and pattern emergence and recognition, I will lay out the suggested solutions to the rice wine issue. Sheilds and Lindsey (1998) say that coding is a way of defining and detailing key parameters of issues into concrete meaningful frameworks.

They establish that pattern emergence and recognition stems from recurring events or parts of events which can be identified. The identification of reoccurring situations comes from critical questioning and thinking critically about the answers received. Through identifying the patterns which arose in the suggested solutions, I will also detail some of their benefits and problems or dilemmas for the nurse.

Earlier in the Sheilds and Lindsey (1998) article, they comment about the power relations or the politics of a community. In my experiences in the DTES, a strong pattern became apparent. They point out that it is part of my job as community nurse to acknowledge, understand and work within the patterns created by the residing power structures. In my conversations and readings leading up to this codification process, I experienced two reoccurring polarized ideologies, which if attributed could potentially cause friction within the present power dynamics. As a way of respecting this political infrastructure and the people who have so generously given me their precious time, and truly representing the ideologies, I will not give the name any community sources from whom I received information. This protection of my personal communications with people will begin from this point and continue for the rest of the paper unless they have given quotes in a format printed for the general public.

There were seven possible solutions from my questioning which I will codify. The first three are a part of an established pattern of an abstinence based ideology.

(A) The removal from store shelves: On October 21st, 1999, the Order of the Lieutenant Governor in Counsel (Province of British Columbia, See Appendix F), changed the Liquor Control and Licensing Act. The new law allowed rice alcohol equaling 10% or lower to be sold in general stores and that any stronger could only be sold in liquor stores or shipped directly to commercial businesses in bulk amounts starting December 1st, 1999. This has had few beneficial results and only addresses half of the issues related to rice wine abuse according to some sources. The apparent health benefit is that there are fewer people passed out and dying from rice wine for example there are significantly fewer people with heatstrokes that are complicated by the effects of rice wine this summer (2000) over last summer according to a source . The medical and social problems that the DTES are seeing now are that rice wine drinkers are going back to drinking other forms of non-beverage alcohol and rice wine is now a black market item. The most disturbing thing about this solution is a quote from a VIDUS

(Kain et al, 1999) participant: "do they think that they have stopped the sale of rice wine. I mean there it is at the Liquor Board Store, sitting right out there – and it is even cheaper than when I bought it at the stores in Chinatown" (Wayne, Dec 4th, 1999).

(B) Sobering center: A detoxification center which provides service on demand. A source has told me that this is radically different than the current system where people have to wait for a period of time, and according to Vancouver's Coalition's "Action Update" for October 1999 (See Appendix G), they see it as an important initiative to combat alcohol problems in the DTES. The major problem with this solution for nurses is that it is three years or more away from inception because of funding and location issues. A secondary problem, according to one source, is that this center must be associated with other programs such as counseling and treatment to prevent a nursing practice dilemma within the center of establishing a revolving pattern of getting drunk and drying out.

(C) More Treatment and Detoxification Beds: This was posed by many of my sources in the community. According to the Rice Alcohol Options Paper (Craig & Matthews, 1999) this solution reaches the underlying issues of alcohol abuse, which can include domestic violence, genetic predisposition and sexual abuse. There are 50 detoxification beds and a limited number of other treatment services. People feel that "there is not enough of anything, there are waiting lists for everything and we are chronically under-serving many" (Vancouver's Coalition, Discussion Paper, 1999, p.2, See Appendix H). The potential problem or dilemma with this solution is that if its sole intent is to provide abstinence based treatment, then according to one source, it is severely unrealistic and the nurse would fail to address all needs of rice wine/non-beverage alcohol consumers. The current problem is government funding, infrastructure and building location issues.

These last four are a part of the pattern of the harm reduction ideology

(D) An alcohol exchange: This center would provide a service to rice wine drinkers where rice wine or any other non-beverage alcohol could be exchanged for something with a reduced alcohol content like a 12% sherry. According to a source, this would ensure that the rice wine drinkers that drink anything who used the service would have a safer beverage therefore reducing harm. Harm reduction is defined in Vancouver's Coalition's "Discussion Paper" for October 1999 from the Canadian Center on

Substance Abuse as a "policy or program directed towards decreasing adverse health, social and economic consequences of drug use without requiring abstinence" (p.3) According to the Rice Alcohol Options Paper (Craig & Matthews, 1999), there could be vitamins added to the exchanged alcohol increasing its benefit but this center would have to follow all liquor regulations and laws. According to a source, this exchange could be a part of a "wet" center which could provide shelter where rice wine drinkers could be allowed to drink some of the time like a program set up in Toronto called Seaton House. The chief nursing problem and practice dilemma associated with this solution, according to sources, is the maintenance of the alcoholic disease state and the provision of poisonous materials.

(E) A government run liquor store in the area: This store could provide low cost safer alcohol to all rice wine drinkers at a convenient location. The first benefit is clearly the convenient location because chronic users do not have the stamina to hike out of the DTES to the nearest store which is likely the one in Harbour Center on Cordova and Richards. Secondly, as discussed above, the provision of safer alcohol is considered a good harm reduction measure. This solution could be combined with an alcohol exchange. The problems and dilemmas that a nurse would face would be similar to the above.

(F) A U-Brew: This service would allow rice wine drinkers to make their own cheap alcohol. This also would be considered a good harm reduction measure and, according to a source, could be connected to an alcohol exchange and/or a liquor store but with the same associated dilemmas. A series of problems mentioned by a source about this solution are that people who are rice wine drinkers are often too old and ravaged by alcohol to have the stamina or the wherewithal to do this and they would not have the patience required to wait for the alcohol to age

(G) The Manitoban Solution: In Manitoba they have implemented a unique solution. According to the Options paper (Craig & Matthews, 1999), they have opened one downtown liquor store in Winnipeg earlier in the morning and decreased the prices of beverages with high alcohol content. Apparently this harm reduction strategy in conjunction with changing liquor laws is having some beneficial effects by reducing the use of non-beverage alcohol but it still allows greater access to a lethal product.

"Movement To Action: Praxis"

From a community development and program planning perspective, I will move into action. Sheilds and Lindsey (1998) feel that this movement or praxis is the establishment of an effective plan which details how things are done and by whom via a strong knowledge base. Historically, the people of the DTES have taken actions which reflect a community development perspective which can easily be slotted into Labonte's (1992) principles referenced in "Community Development" by John English (1995). His five principle are: "empowering services" e.g. care which includes dignity and sensitivity; "connective processes" or the bringing of people together with a common issue; "organizational actions" or groups taking action to make the necessary changes within the community; "collaborative strategies" or many groups working together, and "advocacy that challenges control" (p.518). Healthy conflict is included as a part of these principles. In light of the issues surrounding the current solution, the community development perspective has had mostly negative effects. Using Labonte's model, I will detail other mostly negative aspects of this perspective when dealing with rice wine drinkers. In contrast, I feel that from a program planning perspective, positive results can be gained in helping those who drink rice wine. I will propose a solution using the Comprehensive Health Education Model (CHEM) developed by Sullivan (1973) as referenced in a chapter called "Models for Health Education and Health Promoting Programming" by McKenzie and Smelter (1997). The CHEM model (Sullivan, 1973) involves six sequential steps which are to: "involve people"; "set goals"; "define problems"; "design plans"; "conduct activities"; and "evaluate results" (p. 18)

The historical aspects of the rice wine issue fit nicely into the Labonte (1992) model. According to two community sources, death from rice wine was the impetus for the connective processes, organizational action and collaborative strategies which were a part of a five year struggle. A number of DTES groups banded together to stop these deaths that were devastating the community which demonstrated organizational action. The goals of collaborative strategies used by this band were to reduce the harm done by rice wine, gain political awareness, embarrass the store owners who lied about selling it and who were flagrant abusers of the laws against not selling non-beverage alcohol to people who were obviously drunk. The first strategy to embarrass store owners was a "wine tasting" where the group went around to store owners/clerks and encouraged them to try what they sold.

Another strategy was to pour the wine, which they said they did not sell, all over the store floors. A harm reduction strategy, instigated by one faction, was exchanging sherry, which had 12% alcohol and no salt content, for rice wine. One of the group members involved herself in political meetings in order to make allies, influence change on this issue and combat the non-acknowledgement of the powerful work done in the DTES. In addition, the Vancouver Police Board sent a letter detailing their resolutions to Vancouver City Counsel (1999, July 20, See Appendix I for applicable minutes) on the rice wine issue which were to reclassify the product so it could be removed from the general store and moved to a liquor store and asked for more detoxification beds for the DTES. The collective actions of the both the band and the police provided advocacy for the rice wine drinker and challenged control by actively pursuing the option of rice wine removal by instigating the political process leading to the current solution.

This action, entrenched in the principles of the Labonte (1992) model of community development, has facilitated a only a small amount of empowering services but mostly cultivated a great deal of conflict and negativity. Empowerment finally came to the rice wine drinker because there clearly had been a sensitivity shown to the issue after five years of fighting but the situation for the rice wine drinker was only arguably better. The deaths, these strategies and advocacy, obviously spurred conflict, which was and remains unhealthy, between the community action group and the store owners who were largely Chinese and part of the local merchants association. The store owners and the association said that rice wine was important in food preparation, was part of their cultural tradition and that the removal was racist. The band of community groups felt that these merchants did not want to give up their "cash cow" because of the well known fact in the DTES that rice wine sales were very lucrative. Community development in action mostly did not work for rice wine drinkers or their advocates in the DTES.

Using the CHEM model (Sullivan, 1973) from a program planning perspective will be based on a solid foundation by involving people and clearly defining the problems associated with rice wine drinking. I will identify five major problems first. The large problem is gaining the greatest amount of consensus on one solution so the plan would have to marry the ideologies of abstinence and harm reduction. Secondly the plan or program would have to address the underlying social and familial issues of alcoholism by providing an environment where a person could develop stable relationships within family-

like structures. Next, the program would have to generate interest in or matter to the people who have the dollars, primarily the government and large corporations. Another problem is the lack of beds and long term services so a program would have to include increasing these long term services. Lastly, the program would have to have a large teaching component because rice wine drinkers have poor life skills and coping mechanisms which prevent them from being fully actualized. I would involve as many people as I could in developing a plan for the community. I would include representatives from the civic, provincial and federal government. From the community I would want to involve and talk to all the community organizations and representatives who had contributed to the Rice Alcohol Options Paper (Craig & Matthews, 1999). Lastly, and most importantly, I would include the rice wine drinking community for their expert knowledge.

After listening intently to this collective I would establish my program design with associated goals. I have already generated a prospective program design with some program objectives after the many conversations and readings I have done. It would be adjusted to incorporate the additional expertise. I would have a two year program in a new forty bed treatment center which would cater to rice wine/non-beverage alcohol drinkers. There would be a variety of service providers, with the majority being nurses. My center would be located somewhere around the 1200 or the 1500 block of East Hastings/Pender Street so that it would be away from the epicenter of the DTES but not too far to be extremely difficult for a rice wine drinker to arrive at or be escorted via Saferide. This would address lack of services problem and achieve my program goal of the provision of alcohol services where they are needed within the DTES.

To be a successful applicant, the rice wine drinker must have a community/hospital referral which would include a full explanation of the program objectives. Successful applicants would check into the center on their own volition after the referral process with my center accepting five applicants at each intake every three months. This would (hopefully) ensure that the center would stay open for a long period of time and this low and slow intake would allow for increased patient-centered care. These would accomplish my next two program goals of the provision of long term client care which would become consistent and contiguous and establishing strong and effective patient care in environments whose staff are not overloaded.

In the first two to three months, clients would have restricted access to the community so as to have some control over their own lives, help with their move into the center and curb the amount of non-beverage alcohol purchased. Also, this approach would be the impetus for the rice wine drinker to view and cultivate trusting respectful relationships modeled by the center's staff and practice with their peers. During this relationship building time a harm reduction strategy of exchanging non-beverage alcohol to sherry or red wine would be performed so that this relationship building experience can occur in safer situations. This would be a start to deal with the problem of consensus by marrying the two ideologies, abstinence and harm reduction and the establishment of a family-like unit for the rice wine drinker. The program goals would be the provision of realistic alcohol treatment which addresses all needs of the rice wine drinker and providing conducive environments for rice wine drinkers to learn and develop relationships from staff and each other.

Once some form of healthy relationship is built, contracts between rice wine drinkers and staff can be developed outlining strategies and commitments on how the rice wine drinker intends curb alcohol ingestion done every two to three months with the end result being to be sober by the end of the year. This contract would include statements such as "As a rice wine drinker, I intend to go from four bottles to three bottles of non-beverage alcohol per day in one week time" and "As a staff member, I will reward our work by sharing a whole cheesecake with you when we fulfill our contract". These contracts would also specify what chores around the center will be performed and life skills will be learned. In later contracts peer mentoring statements to help the newer successful applicants would be actively encouraged in order to continue the healthy relationship building. Throughout these contracts the use of the harm reduction strategy of the alcohol exchange would take place. The contracts would address the problem of dysfunctional relationship skills and encourage family development or group cohesiveness. The goal of realistic service provision would be upheld and adding a new dimension of accountability to the relationship building goal. Another program goal would be to achieve at least one week of sobriety by the end of the first program year.

The focus of the contracts, throughout the last year and six month follow up period would be on learning, developing and integrating skills for everyday living. Each teaching opportunity would be directed at helping the recovered rice wine drinker bridge back into

the community for example finding new housing or providing budgeting and banking skills. Also coping strategies would be taught and role-played. There would be no rice wine exchange at this time. All of these skill building opportunities address the lack of life skills in recovering rice wine drinkers and facilitate the final goal which is the development and sustainability of the independence in the rice wine drinker by creating situations of empowerment.

The final steps in the CHEM model (Sullivan, 1973) are conduct activities and evaluation which coupled with the other steps will point to my limitations within the program planning perspective on the rice wine issue. The main focus of conducting activities is looking for funding for my program which I have very little idea how to do. I know that it would involve all of the people I would speak to in developing my program and developing a proposal. Since I have never seen or been a part of a proposal process, I would have no concept of what pertinent information one would need to attract the people with the dollars to the project. In terms of evaluating my programs performance, I have only rough ideas. I know that there would have to be multilevel evaluations of the patient/clinician relationships, peer relationships, professional performance and the use of alcoholism statistics, post-program. Also I have had no experience with rice wine drinkers so I do not know if in actuality a system of contracts, which is my programs basis, would work in the target population. My last limitation would be the people I would speak to. Since I have never designed a program before, I would not know who the best contacts are and who would have the most money to give. Despite my limitations on this perspective, I believe that this program shows a better potential than the community development model because it identifies and attempts to address the major problems with the rice wine issue.

Conclusion

I have learned a great deal from researching the rice wine issue. I know that I have gained a better insight into the political substructures which make up DTES. I feel that I have had the wonderful opportunity to appreciate some of the more complex issues in the area such as harm reduction and the scarcity of resources from both a community development and program planning perspective. In the past, I was impressed with the work done in the DTES from the newspapers. Now, I am empowered to become the nurse who has strong ideas, the knowledge of the proper time to initiate those ideas and the stamina to make them a reality by having conversations with such a passionate tapestry of people.

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Appendix C: Vancouver Injection Drug User Study.

Rice Wine Use Among Injection Drug Users in Vancouver

Steve Kain, Mark Tyndall, Sue Currie, C Johnston, Kathy Li,

Michael V. O'Shaughnessy, Martin T. Schechter

British Columbia Centre for Excellence in HIV/AIDS, St. Paul's Hospital, Vancouver, Canada

Funded by the National Institutes of Health

Study Objectives

- To study the demographic characteristics, risk behaviors and patterns of injection drug use among rice wine drinkers.
- To collect ethnographic data to enhance our understanding of rice wine use within the community.

Background

- Rice alcohol, commonly known as rice wine, is actually distilled spirits with an alcohol content as high as 54% and a salt content of over 2%.
- Rice wine is an accessible and inexpensive source of alcohol in the downtown area of Vancouver.
- Staff observed that there appeared to be rice wine drinkers who were low frequency injectors who were seroconverting.
- Public and community sentiment have been against rice wine use because of its "terrible toll in human life" and how it "has greatly increased the perception of crime and disorder in the downtown eastside". (Vancouver Police Sergeant, Ken Frail, Oct.24, 1999).
- Public policy changed regarding rice wine distribution on December 1st, 1999. The new policy now disallows any rice wine sales outside of a Provincially controlled Liquor Distribution facility.

VIDUS - Vancouver injection drug users study

- VIDUS is an open cohort of over 1400 injection drug users
- Enrollment began in May 1996 – mean follow-up 28.2 months
- Participants are referred for recruitment through community advertisements, service organizations, and word-of-mouth
- Inclusion criteria is the injection of drugs within the previous month
- Following written informed consent, baseline HIV and Hepatitis C testing is performed and a semi-structured questionnaire is administered
- Return visits are arranged every 6 months when repeat blood testing is done and a follow-up questionnaire is administered
- Referral to social services, medical care, and addiction treatment are arranged if requested
- HIV prevalence 28.5% and global HIV incidence 5.2% per 100 person year
- Hepatitis C prevalence 86.5% and global HCV incidence 29.1% per 100 person year

Methods

- At the 6th biannual follow-up visit (June to December 1999) participants were asked about their rice wine use.
- Drug use and risk activities were compared for rice wine drinkers and those who were not rice wine drinkers in the cohort.
- Ethnographic, community and staff observations were collected regarding rice wine use.

Results

- 906 VIDUS participants were interviewed during follow-up visit #6
- Rice wine use was reported 56 of 906 (6%) participants. Users were older, more likely to be aboriginal or latin american, to live in unstable housing and to use cocaine.
- HIV Prevalence was 46% among rice wine drinkers
- Rice wine drinkers were much more likely to serocnvert. 14% of the cohort's seroconverters were rice wine drinkers.
- Despite comprising only a small percentage of the cohort, 24 of the 114 (21%) persons who died from the cohort were known rice wine users.
- Rice wine drinkers may be at higher risk of HIV infection and/or death as a result of the binge behavior associated with this product.
- Rice wine is a highly social activity. Drinkers have strong social networks and sharing of rice wine bottles amongst peers is commonplace.
- **Table 1** shows the demographic characteristics and drug use patterns of the VIDUS cohort stratified by rice wine use or non-use.
- **Table 2** highlights public, government and community data regarding rice wine use.

Table 1 – Demographic Characteristics of the VIDUS cohort at Follow-up #6 stratified by rice wine use

Characteristics	Rice Wine (n=56)	No rice Wine (n=850)	p-value
Age (years)	36.5	34.3	.086
Male	42 (75%)	525 (62%)	.047
Ethnicity			
White	18 (32%)	519 (61%)	.001
Aboriginal	26 (46%)	231 (27%)	
Latin American	7 (13%)	18 (2%)	
Other	5 (9%)	82 (10%)	
Unstable housing	39 (70%)	448 (53%)	.001
IV Heroin use	25 (45%)	485 (57%)	.070
IV Cocaine use	38 (68%)	434 (51%)	015
Speedballs	15 (27%)	232 (27%)	.934
Crack cocaine	44 (79%)	419 (49%)	.001
HIV positive	26 (46%)	262 (31%)	.015
Hepatitis C positive	49 (88%)	775 (92%)	.245

Table 2 –Public, government and community data regarding rice wine

Individuals purchase rice wine for use as beverage alcohol. The relatively low price ($1.50 for 60 fluid ounces) and widespread availability of the product make it popular among persons with alcohol abuse problems and individuals who wish to avoid paying the higher price for beverage alcohol through "usual" outlets. The consumption of rice wine as beverage alcohol may result in serious health problems due to its high salt content.
(Exemption Policy Report, Attorney General's Office, March 1999).

In 1999, there were at least 39 deaths directly linked to rice alcohol abuse, almost double the number recorded in 1997.
(BC Coroner's Office, April 13th, 2000)

"Drinking rice alcohol kills people," Dosanjh said. "Abuse of this product in Vancouver's Downtown Eastside is devastating the community. "
(Media Release, Attorney General's Office, July 29th, 1999).

The product (rice wine) is a potent alcohol-salt substance that destroys the kidneys and heart and leads to pneumonia and other serious illness.
(Media Release, Attorney General's Office, July 29th, 1999).

Rice wine, which is used in for cooking in some Chinese dishes will be available in liquor stores after Dec, 1st (1999). Police and community leaders hope that will make it harder for abusers to obtain the wine, which has a high salt content.
(Vancouver Province, October 24th, 1999)

"Do they think that they have stopped the sale of rice wine. I mean there it is at the Liquor Board Store, sitting right out there – and it is even cheaper than when I bought it at the stores in Chinatown!"
(Wayne, VIDUS participant, Dec.4th, 1999)

Conclusions

Rice wine users are a unique sub-group of the VIDUS cohort and appear to be more vulnerable to HIV infection through high-risk behaviors.

Rice wine use is more prevalent amongst aboriginal and latin-american men. There are clearly defined social networks established among rice wine users due to the shared consumption of rice wine bottles.

Rice wine drinkers were over-represented by 350% in the deaths in the VIDUS cohort indicating that rice wine use is a factor in the mortality rate of drug users in the community.

Implications

Harm reduction strategies need to be developed to address this group of drug users who are at greater risk of HIV infection and death. This may include stabilized housing, enhanced detox facilities and even education amongst rice wine users.

Special initiatives may be needed to address the social networking aspect of rice wine consumption. This may include strategies such as peer support development and education within the social network during rice wine binges. (Similar to the government initiative that: "Friends don't let friends drink and drive.")

The new policy controlling the distribution of rice wine through the liquor store needs to be evaluated to ensure that it is meeting its objectives.