ALBERTA NNADAP REGIONAL NEEDS ASSESSMENT

Final Report

July 13, 2009

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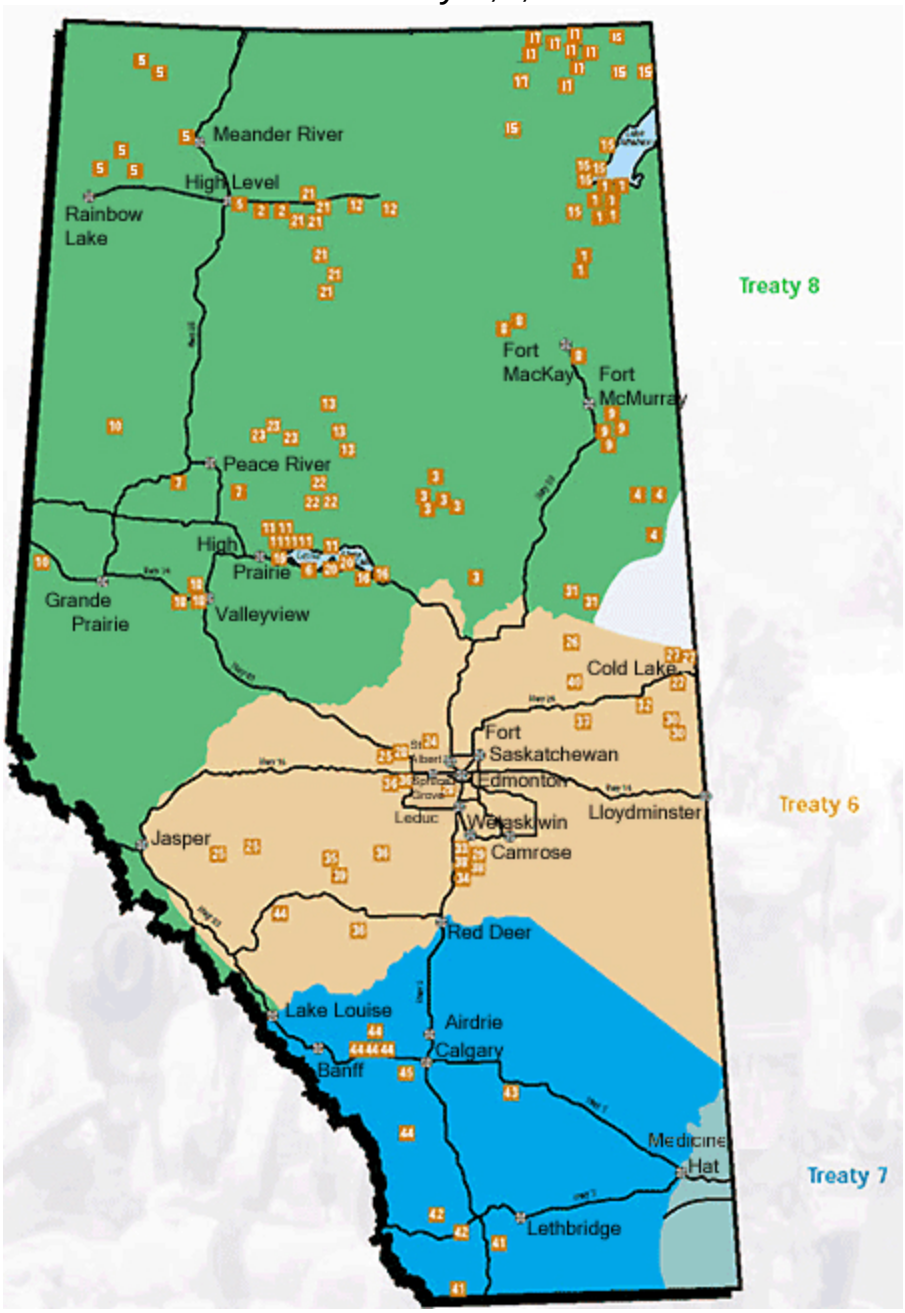
Map of Alberta[1]
Treaty 6,7,8



[1] Permission Granted INAC – Alberta Treaty

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Thank you, *Leem Lumpt*

In Wellness, Tina-Marie Christian

Table of Contents

EXECUTIVE SUMMARY

The National Native Alcohol and Drug Addictions Program (NNADAP) will be developing an Addictions Evidence-Base for on-reserve First Nations addictions services. The goal in developing the evidence base is to highlight the potential for modernized and improved addictions programs, policies and services. The assessment identifies the addiction services needs of specific target audiences such as youth and pregnant women. The aggregate data from each of the Regional needs assessment will form the basis for a renewed addictions system that ensures First Nations are receiving the best possible care.

The National Native Alcohol and Drug Abuse Program (NNADAP) is an example of a Health Canada program that is now largely controlled by First Nations communities and organizations. From its inception, the goal of the National Native Alcohol and Drug Program (NNADAP) has been to provide culturally-based addiction prevention and treatment services to First Nations and Inuit peoples. In light of recent trends occurring both in mainstream and Aboriginal delivery systems, the Addictions Evidence-Base process has been proposed to provide NNADAP with strategic direction, at community, Regional, and national levels. This report presents the findings from the Alberta Regional NNADAP Needs Assessment conducted from January to May 2009.

The project was overseen by a ten member advisory committee with representatives from each of the three treaty areas and from the First Nation Inuit Health Branch. The process for gathering data included a literature review, personal interviews with key stakeholders in the provincial health and addictions service providers, aboriginal community stake holders, 44 community focus groups in fourteen First Nations representing different demographic groups and through a survey administered to 127 community services providers and interested community members. In total over four hundred people participated in the data collection process.

The results of the report are presented in sections specific to the goals of the project. Section 3 presents a detailed discussion on the process and methods used in the research which included a community survey completed by 127 service providers, (54 of the respondents were NNADAP Workers, 29 were other health care professional working in the community and 44 were other interested community members). Thirty-seven focus groups were conducted in 14 First Nation communities and in eight treatment centres; seven were held in the Treaty 8, 4 in the Treaty 7, and 4 in the Treaty 6 for a total of 250 community members. Of the 250 community participants 44 were youth and 49 were seniors; the remaining were an equal amount of men and women. Additional research was drawn from other studies that were specific to the demographic groups on alcohol and drug use.

Section 4 discusses the findings from the literature review of a large number of documents provided to each Regional needs assessment by the national advisory board.

Section 5 presents information on integrated NNADAP programs which includes the 8 NNADAP funded treatment centre (2 of which are designated for youth treatment) and the NNADAP program which includes the NNADAP Wellness Consultants role and recommendations, and the NNADAP Workers role and recommendation. Wellness Consultants agreed that it was the communities' responsibility to address substance abuse issues and the communities need a lot of support. *"There are so many things that need to be addressed by leadership – social problems are not seen as a priority."* Another Consultant responded that, *"Communities must be accountable and have ownership, to come up with their own solutions to fit their needs.* "

Section 6 begins the discussion on each of the demographic groups covered in the report. Each of the demographic groups, youth (Section 6.1), men (Section 6.2), women (and pregnant women) (Section 6.3) and seniors (Section 6.4) each section presents background data on the needs and issues as identified by the survey respondents, community members focus groups and key stakeholders. Each section reports on resources and services available for the specific demographic group and on recommendations that arise from the research findings from the above mentioned key informants. Each demographic section concludes with a sample of promising practices.

In summary, the data reveals that alcohol and marijuana were viewed as the most prevalent problem in the youth followed by use of illegally acquired prescription drugs, crystal meth and ecstasy. For men, the areas of greatest concern was the use of alcohol and marijuana. Two-thirds of the survey respondents perceive that crack/cocaine and heroin to be a serious problem among young men. Over 80% of survey respondents said that alcohol use among women was a concern, followed by marijuana (75%) and use of prescription drugs (60%)

Survey respondents perceive that prescription drug misuse and gambling were the biggest problems for seniors. In focus groups the seniors expressed the same concerns.

Each of the demographic groups expressed a concern for co-occurring disorders. Among the youth, 80% said that aggressive behaviour, suicidal thoughts, vandalism and conflict with the police were a concern. More than 80% identified depression, anxiety and aggressive behaviours as co-occurring disorders among men. Over eighty percent of survey respondents said that sexual promiscuity and depression/anxiety and over seventy percent believed that suicidal thoughts and aggression to others were a problem among female alcohol and drug uses. Almost one hundred percent (96%) of respondents reported that seniors exhibited signs of depression and anxiety, followed by 57% who reported concerns about senior's aggression toward others.

Research as well as the findings from community respondents indicates that the needs of youth, men, women and seniors are very distinct, and age and gender appropriate services were required to address these needs. Life span development is a well understood factor in developmental and life stage issues. Community respondents overall felt that the service providers, community, family members and leadership do not understand their needs which adds further to the sense of isolation many people expressed.

Overall, survey respondents and community expressed a general satisfaction with the access to services and to the quality of services available. Most noticeably lacking were the need for more detoxification centres and after care support. A few communities have reported they have re-allocated staff time and programs funds to provide after care support services in the form of life-skill building programs. Other communities report that only about 40% of clients returning home after completing treatment actually participate in the after-care services offered by NNADAP workers. The concern for greater collaboration, better communication among service providers and more integration of services is needed. The general consensus from NNADAP workers was that motivation to get treatment was very low among the individuals exhibiting substance abuse problems or related mental health issues, especially for youth and young adults.

Section 7 discusses mental health and other related issues. Studies have shown that First Nations in Alberta had three times more episodes in psychiatric treatment services and have

higher rates for seeking mental health support through physician visits, emergency rooms and hospital admissions rather than going through mental health outpatient clinics.

Not all addictions are to substances. Gambling addiction is a growing concern among many First Nations. In each of the community focus groups, gambling was identified as a problem that affects personal, family and community wellness.

First Nations living on reserve have limited access to mental health professionals, transportation difficulties and misdiagnosis and limited knowledge about mental health services were cited as barriers and puts further limitations on those needing mental health services.

Section 8 discusses community support to support substance abuse issues. The survey respondents were asked to identify some of the constraints within the community to addressing substance abuse and addiction issues. Poverty, residential school trauma and family violence/abuse were cited by three-quarters of the respondents. Between 70 and 80 percent of survey respondents and community members felt that leaders do not pay enough attention to substance abuse issues. The remaining 20-30 percent said they have strong leaders that send strong anti-drug messages and ensure that resources actively focus on addressing the issues. Over thirty percent reported they have restrictions about alcohol and drug use at community events and promote cultural and social norms prohibiting substance abuse.

Section 9 discusses the Addictions and Mental Health Care system. Section 10 discusses community wide issues from the perspective of the Regional NNADAP Wellness Consultants.

Section 11 presents five models of emerging integrative strategies. Each of the models has a strength that meets specific needs identified in the study. The communities that cares model is the one that provides a community empowerment and capacity building approach that most matches First Nations philosophy of self-determination. The Wellbriety Model will appeal to those who believe the culture and tradition are the heart of wellness and recovery.

Section 12 provides concluding comments and Section 13 presents recommendations and discussion on NNADAP governance and coordination, NNADAP capacity issues and recommendations for change in these areas as well as recommendation for priority services for targeted demographic groups.

Key findings remind us that Aboriginal people already make positive efforts to make changes to protect their health and we are challenged to find ways to enhance this trend. Other findings remind us to pay attention to some important hidden groups such as social support needs of the seniors, pregnant women, gender specific treatment, youth needs for support, and recognition and thirst for cultural knowledge and identity.

In Aboriginal tradition, the health and well-being of an individual flows, in large part, from the health and social make-up of the community. This infers that not only must substance abuse be understood in terms of social behaviour, but that its solutions lie in collective action of the communities.

SECTION 1 INTRODUCTION and BACKGROUND

1.1 Study Purpose and Audience

The National Native Alcohol and Drug Addictions Program (NNADAP) will be developing an Addictions Evidence-Base for on-reserve First Nations addictions services. The goal in developing the evidence base is to highlight the potential for modernized and improved addictions programs, policies and services. To do this, each Treaty has undertaken a needs assessment which examines the challenges, issues and assets. The assessment identifies the addiction services needs of specific target audiences such as gender, youth, pregnant women and mental health (co-occurring disorders). The scope of the assessment is limited to in-patient and out-patient non-medical treatment services and community-based prevention, promotion and aftercare programming[2]. The aggregate data from each of the Regional needs assessment will form the basis for a renewed addictions system that ensures First Nations are receiving the best possible care.

A need can be defined as the gap between what a situation is and what it should be. A need can be felt by an individual, a group, or an entire community. Examining needs helps to discover what is lacking, and points to the direction of future improvement. The NNADAP needs assessment will report on how the community feels about addictions and addiction services and what community members think should be done about it. The assessment examines the opinions of community members, while at the same time maps the resources and limitations. It provides a holistic view of the issues, and the system of response while also looking at the needs of the intervention sectors – health promotion, secondary prevention and tertiary treatment.

The outcomes from the assessment include:

- understanding of incidence and prevalence of addictions problems by geographical area as well as special demographic groups
- identified specific addictions service needs
- understanding of best practices in Aboriginal addictions interventions
- improved communication and collaboration with other agencies and the public
- guidelines for influencing professional development
- recommendations for more effective use of resources
- creation of a medium by which community members, service providers, and service users can become involved in Regional decision making

1.2 The NNADAP Program in Canada and Alberta

The National Native Alcohol and Drug Abuse Program (NNADAP) is an example of a Health Canada program that is now largely controlled by First Nations communities and organizations. From its inception, the goal of the National Native Alcohol and Drug Program (NNADAP) has been to provide culturally-based addiction prevention and treatment services to First Nations and Inuit peoples. Since it was established as a pilot project in the 1970s, hundreds of community-based alcohol prevention and community treatment projects have been created across Canada. The program was made permanent in 1982 because of the "urgent and visible nature of alcohol and drug abuse among First Nations people and Inuit[3]". This stability enabled NNADAP to better coordinate with other programs in the promotion of community health and sober

[2] Gambling addictions services, private treatment and enforcement issues are outside the scope of the assessment
[3] http://www.hc-sc.gc.ca/fniah-spnia/substan/ads/nnadap-pnlaada-eng.php

lifestyles. In 1989, NNADAP underwent its first program review, but was of limited scope. While it has been acknowledged that First Nations and Inuit people are, in general, satisfied with NNADAP's services, alcohol and other substance use problems persist as a priority concern to the health and well-being of First Nations and Inuit communities. Today, NNADAP supports a national network of 52 residential treatment centres, with some 700 treatment beds, and provides over 550 prevention programs with over 700 workers - almost all employed by First Nations and Inuit communities. Program activities vary, based on the size and needs of each community and the availability of skilled workers. The program activities generally fall into three key areas: 1) prevention activities, that are aimed at preventing serious alcohol and other drug abuse problems and include activities such as public awareness campaigns, public meetings, public speaking, developing content for schools on alcohol and drug abuse, school programs and cultural and spiritual events. 2) intervention activities, that are aimed at dealing with existing abuse problems at the earliest possible stage, and include recreation activities for youth, discussion groups and social programs, and native spiritual and cultural programs 3) aftercare activities, that are aimed at preventing alcohol and drug abuse problems from reoccurring, and include: counselling, sharing circles, outreach visits, social service referrals, medical referrals, and Band services referrals.

In the 1998 NNADAP Review, it was acknowledged that a principle challenge for NNADAP remains its ability to coordinate and integrate services. While this challenge is not unique to the NNADAP system, many municipal, provincial, and Aboriginal services have, over time, introduced measures to integrate, renew, and coordinate their addiction treatment and prevention services based upon population needs and best practices. It follows that First Nations communities and FNIH Treatys stand to benefit from a comprehensive review of the NNADAP system to ensure the best allocation of existing and potential resources, and the optimal configuration of services at community, Regional, and national levels.

Over the years there has been increased recognition of the interrelationship between substance use and mental health problems, particularly when considering the prevalence of concurrent disorders. While mental health and addiction services have historically operated in separate spheres, more recently, there have been calls to further integrate and coordinate these services. Within the NNADAP system, service providers have worked to increase their awareness of mental health issues; provide services for concurrent disorders; and work collaboratively with provincial services to ensure that clients also have access to appropriate mental health services and supports.

In light of recent trends occurring both in mainstream and Aboriginal delivery systems, the Addictions Evidence-Base process has been proposed to provide NNADAP with strategic direction, at community, Regional, and national levels. This process is guided by the collaborative work of the Assembly of First Nations (AFN), the National Native Addictions Partnership Foundation (NNAPF) and the First Nations and Inuit Health Branch (FNIHB) of Health Canada. The purpose of this partnership is to develop a comprehensive national program framework that will enable Health Canada and its community-partners to enhance the coordination and integration of services offered through NNADAP. The Addictions Evidence-Base process will involve a two pronged strategy: 1) FNIH Regions will complete a Regional Needs Assessment on their substance use and addiction-related services, and 2), FNIHB, in collaboration with the AFN and NNAPF, will convene a First Nations Addictions Advisory Panel (FNAAP), consisting of members of the AFN's Public Health Advisory Committee and additional addictions experts. FNAAP will provide guidance on the renewal of addictions services for First Nations communities by: assisting with Regional needs assessment work plans; reviewing the available evidence and promising practices; considering current gaps and

needs; reviewing Regional priorities; and providing a national program framework to guide NNADAP's renewal activities over the coming years. [4]

SECTION 2 DESCRIPTION OF ALBERTA REGION

2.1 Treaty Areas

Within the province of Alberta, there are three treaty areas [5]. They include

1. Treaty 6. Signed at Carlton and Fort Pitt in 1876. Covers central Alberta and Saskatchewan. 16 First Nations
2. Treaty 7 Signed at the Blackfoot Crossing of Bow River and Fort Macleod in 1877. Covers southern Alberta. 5 First Nations
3. Treaty 8 Signed at Lesser Slave Lake in 1899. Covers portions o northern Alberta, BC, Saskatchewan and part of NWT. 23 First Nations[6]

2.2. Regional Demographics

Total - Census Family Status 2001 reported 80,775 registered First Nation in Alberta (male 38,510 and 42,260 female) The average earnings (all persons with earnings($) was $22,363. (Earnings for men were substantially higher (27,187 vs. $17,323 for women). Approximately 32% First Nations reported to be married or living common-law, 12, 575 were reported to be lone parents. [7]

Alberta First Nation Population [8]

Treaty Area	Total Registered Population	Living on-reserve
Treaty 6	36,325	25,798
Treaty 7	24,663	18,368
Treaty 8	32,700	58,778

There are approximately 42,000 Aboriginal people in the greater Edmonton area (2001), comprising about 4.3% of the total Edmonton population (6,657,355). This is the second highest Aboriginal population of urban centers in Canada, after Winnipeg with 55,750 Aboriginal people. In Winnipeg, Regina and Saskatoon Aboriginal people comprise of about 8% of the total urban population. The term Aboriginal includes First Nations, Métis, and Inuit people. First Nations people make up the largest Aboriginal group in Canada and represent one half of the total non-reserve Aboriginal population in the country. However in the City of Edmonton, there are more Métis than First Nations people. In Edmonton, over half of the total Aboriginal population is Métis (52%), followed by First Nations people (44%) and Inuit (1%)[9]. There are 44 First Nations in Alberta; of these 40 are within Treaties 6 and 8, the areas served by Capital Health. Cree is the most commonly spoken, traditional language in the communities however Saulteaux, Beaver, Stony and Chipewyan are also spoken. Alberta is divided into three Treaty areas, according to when the First Nations peoples of that Treaty signed agreements with the federal

[4] Regional Addictions Needs Assessment Guidelines (March 2007)

[5] In some instances, the words treaty and region are used interchangeably.

[6] For a detailed list of First Nation communities. See http://www.ainc-inac.gc.ca/ai/scr/ab/fn/pubs/fna/fna-eng.pdf

[7] Census Canada 2001

[8] INAC 2004-2005 Year in Review

[9] Statistics Canada, 2001 and City of Edmonton Fact Sheet, 2004

government (see Map #1).Capital Health serves mainly the First Nations communities in Treaty 6 (central Alberta) and Treaty 8 (northern Alberta). Treaty 7 covers the area of Calgary and southern Alberta.

Within both rural and urban Aboriginal communities in Alberta, there is a great diversity of cultural perspectives and ways of life. Some Aboriginal people, particularly those in more isolated northern communities, chose to live a more traditional life that is based on the hunting-gathering ways of their ancestors. Their lives and activities often revolve around the changing seasons and the extended family and community. There are also many Aboriginal people who are active in dominant mainstream society, with higher levels of education and professional jobs, and who are comfortable with mainstream values and perspectives. Many of these people continue to value their traditional culture and have found ways to maintain their cultural practices. There are others who no longer live a traditional Aboriginal way of life and cannot effectively participate in mainstream society because of limited alternatives and a lack of contemporary life skills preparation[10].

The past decade has seen a large increase in the Aboriginal population in Canada. Between 1996 and 2006, it grew by 45%, nearly six times faster than the 8% rate of increase for the non-Aboriginal population. In 2006, Aboriginal people, First Nations, Métis and Inuit, accounted for almost 4% of the total population of Canada. Internationally, the share of Aboriginal people in Canada's population is second to New Zealand where the Maori accounted for 15% of the population. [11]

Aboriginal people in Canada are increasingly urban. In 2006, 54% lived in urban areas (including large cities or census metropolitan areas and smaller urban centres), up from 50% in 1996. In 2006, Winnipeg was home to the largest urban Aboriginal population (68,380). Edmonton, with 52,100, had the second largest number of Aboriginal people. Vancouver ranked third, with 40,310. Toronto (26,575), Calgary (26,575), Saskatoon (21,535) and Regina (17,105), were also home to relatively large numbers of urban Aboriginal people. The Aboriginal population is younger than the non-Aboriginal population. Almost half (48%) of the Aboriginal population consists of children and youth aged 24 and under, compared with 31% of the non-Aboriginal population. [12]

A smaller proportion of First Nations people live on reserve than off reserve. In 2006 census data, an estimated 40% lived on reserve, while the remaining 60% lived off reserve. The off-reserve proportion was up slightly from 58% in 1996. Censuses in both 1996 and 2006 found that about three out of every four people in the off-reserve First Nations population lived in urban areas.

SECTION 3 ALBERTA REGIONAL NEEDS ASSESSMENT REVIEW PROCESS

To complete the Alberta Regional NNADAP Needs Assessment, a number of tasks were undertaken which included a review of the existing system of addition services, review of literature on best practices, analysis of statistics on incidence and prevalence of addictions, survey of addictions service providers and system collaterals, in depth

[10] Alberta Aboriginal Peoples and Communities Served by Capital Health

[11] Stats Canada. 2006 Aboriginal Peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census

[12] ibid

interviews with representatives of key stakeholders in the field and a group process consultation with key decision makers and leaders on strategies for future system of addictions care. Following is further delineation of each of these components of the study:

1. **Background and Literature Review** The first task reviewed existing documentation on addiction services being provided in Alberta, available statistics and needs assessment studies. The literature review involved a review of best practices in Canada and United States on dealing with current addiction issues and other related issues.

2. **Compiled Statistics on Incidence and Prevalence of Addiction Issues by Area** Simultaneously with carrying out the literature review, health and medical statistics were examined so as to determine incidence and prevalence of various addiction and addiction related problems. Data was sorted by key addiction problems and, where possible, also delineating by demographic groups – youth, young men, women with an emphasis on pregnant women, seniors.

3. **Survey Addiction Service Providers**
   A survey was distributed to providers of addiction services asking them to describe the kinds of problems they see in their program and the degree to which resources adequately respond to the needs of these clients or participants. Specifically questions addressed

   - The needs of clients/participants in their programs
   - What services/resources are utilized to respond to these needs
   - What additional services/resources are needed?
   - Perception of the degree to which client's addictions are prevented or resolved in the long term
   - Barriers to adequately addressing the needs of their clients
   - Barriers to operating their programs

   Survey participation recruitment proceeded through a snowballing approach and thus resulted in a convenience sample. In most cases the survey was hand distributed to groups of addiction service providers at conferences, meetings and training sessions. In some cases, agencies were enlisted to distribute the survey at their work site or training program. The survey was also available by internet access for those individuals preferring that modality. Attempts were made to make the survey accessible to as broad a representation as possible from the different direct service providers groups. One purpose of the survey was to give everyone the opportunity to express an opinion on these issues and to seek further information on the study, should they wish.

4. **Stakeholder Interviews /Group Discussion**
   A series of in person and telephone interviews were held with key stakeholders in the field to assess their perceptions of addiction services needs. For the most part, these stakeholders include provincial and federal funders, NNADAP program administrators, non-profit organizational board members and senior managers and other planners/consultants in the field. The questions focused on their perceptions about:

- prevalence of different kinds of addictions in various areas of the province and among different target groups
- kind and level of addiction services currently being provided throughout the province
- gaps in services being provided
- what resources in the area of prevention and treatment are needed to address different problem areas and in particular gaps in service areas.
- what specific system supports or delivery mechanisms are needed to enhance quality of service delivery,
- what barriers interfere or restrict the delivery of services and resources to adequately deal with addictions and related problems in Aboriginal communities
- suggestions on system organization and funding to support a comprehensive delivery system

5. Community Engagement

There are 103 NNADAP workers in Alberta, sixty-nine workers (67%) participated in large group discussions during 3 Regional training events held in January and February 2009. The workers were asked 4 questions:

- To identify perceived addictions and mental health needs (for each target group; youth, men, women, seniors)
- Services available in their area
- Services needed in their area
- To identify what works well in their area

Fifty four (53%) of 103 of NNADAP workers participated in the NNADAP community survey. Approximately 29 were other health care professionals working in the community and 44 were other interested community members.

In total, there were thirty-seven community focus groups in which 14 First Nation communities participated. Additionally, focus groups' sessions were held at each of the six treatment centres.[13]

Community engagement also included personal interviews with selected community members. Communities were asked to host at least two focus groups that represented youth, men/women, seniors, and leadership and staff. Two hundred fifty community members from fifteen First Nations (Treaty 6 (4 First Nation communities), Treaty 7 (4 First Nation communities), Treaty 8 (7 First Nation communities) participated to respond to questions about their thoughts about alcohol and drug abuse, the effect it had in their community, which group of people they thought were most affected, what the community's role was in addressing alcohol and drug problems and to identify the positive activities happening in their community. This report includes the results from focus groups of seniors in which 44 seniors were involved and youth in which 44 youth were directly involved in identifying the needs and issues communities throughout the Alberta Treaty. Approximately half of the participants were men representing various ages, with the majority being under thirty years of age approximately half were female,. Seniors were asked similar questions with the additional questions about their perception of alcohol and drug misuse in their age group and to comment on how they saw their role in the community.

6. Synthesis, Sharing and Feedback

[13] Treaty 6 (4), Treaty 7 (4,) Treaty 8 (7)

Responses from the survey, the interviews and the community focus groups were synthesized and integrated into the report on gaps and strategies to address them. This information is compiled into and presented in this final report.

Study Limitations

There are several methodological limitations in this study. For one, much of the data on prevalence and incidence rates for various kinds of addictions and mental health disorders is based on secondary sources that may be outdated (e.g. from 2002) or from other parts of Canada or United States. One would need to triangulate several data sets, with corroborating evidence from expert stakeholders within the Alberta Treaty before arriving at even tentative conclusion about the size and type of problems existing among specific demographic groups, and the aboriginal people of Alberta as a whole. This the investigators attempted to accomplish this but with mixed success for the different demographic groups. Readers must review all data presented and consider both the validity and reliability of the original data set before making any definitive conclusions as to what is the extent of any specific type of substance abuse problem within a specific demographic group. In most cases, further primary research would be warranted.

Secondly, perspectives on problems and the adequacy of existing resources is based on opinion from the people who responded to invitations to participate in surveys and focus groups. While a large number of community members, NNADAP workers and other health care workers contributed to the data and findings presented in this study, one can not conclude that they speak for all nor that they have accurate and full information on the issues at hand. One can therefore only conclude that the perspectives represented in this study are those of key stakeholders and concerned citizens who "have spoken" to the best of their own knowledge and experiences; and may not represent the perspectives of all First Nations in these communities nor accurate fact about substance use and treatment effectiveness in this Treaty.

SECTION 4 LITERATURE REVIEW

The purpose of this section is to provide a brief overview and summary of the literature that was provided by the National Advisory Committee and reviewed on substance abuse in Aboriginal communities. This section will identify the context of the literature review, determine some of the relevant information pertaining to the problems that Aboriginal peoples are facing regarding substance use, discuss the impacts of Aboriginal substance use and provide promising practices for the prevention and treatment of Aboriginal substance use. This section will also examine some of the major limitations that can be identified throughout the studied literature.

The context of this literature review was to identify the needs/problems regarding substance abuse in Aboriginal communities and the intervention/prevention methods that can be utilized in those communities. This literature review not only looked at substance abuse for the general Aboriginal community, but it also looked at substance abuse in different Aboriginal sub-demographics including adolescents, young adult men, young adult women, older adults (30-55), seniors (55+) and the mentally ill. For each demographic the literature was reviewed for material relevant including the needs/problems and the intervention/prevention methods for that sub-demographic.

Aboriginal substance use has been a long standing problem within Canada. There is a multitude of different substances that are misused within Aboriginal communities including alcohol, illicit drugs, prescription drugs, and solvents. All of these substances

are extremely dangerous and are threatening the health of Aboriginal peoples. In a report by the Canadian Centre on Substance Abuse (2007) the morbidity rates between Aboriginals and other Canadians were identified. The rates of death as a result of alcohol abuse for Aboriginals is almost double that of the general Canadian population. In regards to illicit drug users, Aboriginal peoples also have a higher rate of death, which is almost three times the rate of general Canadians.[14]

Throughout the literature there is no consensus as to the cause of substance abuse among Aboriginal people; however, there are many theories that can and have been identified. Some of the theories include the biological theory that suggests that there is a certain predisposition to substance abuse and/or addiction, then there is the disease theory that suggests that an individual's first drink activates their disease, and finally there are the psychosocial theories that suggests that substance abuse is a learned behaviour or that it is a result of some social factor that has occurred.

One of the psychosocial trends that was frequently identified in the literature was the impact of residential schools and how they have affected many generations of Aboriginal people. One of the publications that talk about this was written by the Aboriginal Health Foundation. Residential school experiences were extremely traumatic for those affected and is purported to be associated with other psychological impacts such as attachment disorders or complex post traumatic stress disorder. Subsequently, it has been found that of those who attended residential schools, 82% of them adopted their substance abuse behaviours after their attendance ended. One of the possible explanations for the increased substance use is that those who have been affected by residential school seek out use of alcohol and drug substances as a means of coping with the grief and pain that they feel.[15]

As previously stated, this literature review has also identified different sub-demographics within Aboriginal communities. It is important to look at the problems that substance misuse is causing for these sub-demographics in order to get a more encompassing idea of the true nature of substance misuse problems. Even though, there was not a lot of information on the Aboriginal sub-demographics some of them did provide some significant information. The sub-demographics that generated the most information were Aboriginal youth with substance abuse problems and Aboriginals who suffer from a mental illness and substance use problems.

Substance abuse and youth has been an issue in Canada for many years. It is important to identify the scope of the problem in order to fully understand the extent that needs to be done to prevent, intervene, and treat the problems. In the Alberta Youth Experience Survey it was determined that 35% of Aboriginal youth reported signs of alcohol abuse, whereas only 12% of non-Aboriginal youth indicated similar signs. Aboriginal youth are two to six times more likely to develop substance problems and Aboriginal youth are also likely to start using substances at a younger age than other non-Aboriginal youth.

The other Aboriginal sub-demographic that yielded some information was the co-occurrence of mental health issues and substance use issues. The relationship between substance use and mental health issues are not easily identifiable. As previously discussed, there does seem to be a relationship between post-traumatic stress disorder and substance abuse as a method of coping with previous historical traumas. It was

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[14] Dell, C.A. & Lyons, T. (2007). Harm reduction policies and programs for persons of aboriginal decent. Canadian Centre on Substance Abuse.

[15] Chansonneuve, D. (2007). Addictive behaviours among Aboriginal people in Canada. Aboriginal Health Foundation. *(See matrix-R1)

found that 34% of Aboriginal people with post-traumatic stress disorder also have co-occurring substance use problems.

There are numerous impacts that can result from Aboriginal substance abuse including increased drinking and driving, and fetal alcohol syndrome (FAS). The rates that Aboriginal people drink and drive has been a concern for many years. In 2004 it was found that 73.2% of the Aboriginal motor vehicle fatalities involved alcohol and 61% of the Aboriginals drivers tested positive for consumption alcohol.[16] Some of the literature also identifies an increased prevalence of FAS within Aboriginal communities. It has also been suggested that FAS contributes to the likelihood that an individual will engage in substance use.[17]

There are many promising practices that have been discussed throughout the literature that hope to deal more effectively with the prevention, intervention and treatment of Aboriginal people. One of the practices that had been identified is the use of harm reduction measures. This particular method focuses more on decreasing the adverse affects that substance use can have on an individual such as drinking and driving or the consumption of non-beverage alcohols. The use of controlled drinking strategies is a very promising practice that was identified in a report detailing substance use in Canada..[18] This report discusses the use of certain measures such as avoiding "happy hours", providing safe transportation strategies, and training servers to recognize over-intoxication. A general consensus throughout the literature is that within any program focusing on substance use, the prevention, intervention and treatment programs for Aboriginal people needed to be culturally appropriate.

The literature that was provided to the study investigators was limited in its information on substance abuse specific to aboriginal peoples and there were even fewer documents that focused on the Aboriginal sub-demographics and their substance abuse problems.. There was minimal information obtained that focused on the different Aboriginal age groups including young adult males or females, older adults, and seniors. However, some of the literature did focuses on these sub-demographic groups, but was not specific to Aboriginal communities, could possibly still be utilized in order to understand some of the gaps that could be focused on in future research. It is important to acknowledge the need for future research in order to fill the gaps that are currently present. If this can be done, there is a better chance that policy and decision makers can implement effective policies and programs that will counter the problem with substance abuse in Aboriginal communities that are currently being seen.

SECTION 5 NNADAP PROGRAMS

This section provides a description of NNADAP programs and introduces the concept of an addictions treatment continuum of care. The Mental Health & Addictions Services Continuum is based on best practices for system level delivery, as defined by the

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[16] Rothe, P. (2004). A qualitative inquiry into drinking and driving among Alberta's First Nations post-secondary youth 18-29. Alberta Centre for

Injury Control and Research.

17 http://www.nwac-hq.org/documents/AboriginalWomenandHealthCareinCanada.pdf

[18] Single, E. (2005). Substance abuse in Canada: Current challenges and choices. Canadian Centre on Substance Abuse. *(See matrix-R7)

Accreditation Canada (AC)[19] (formerly known as Canadian Council on Health Services Accreditation (CCHSA). The AC defines a continuum of care as "an integrated and seamless system of settings, services, service providers, and service levels to meet the needs of clients or defined populations".

The Continuum provides a framework to match resources to need, foster continuity of care, and maximize the provision of care through community based services. This framework continues to guide system level service planning and depicts all mental health services.

One example is the Calgary Health Treaty Mental Health & Addictions Services goal to create a seamless network of mental health care across a continuum defined by the following categories:[20]

- Prevention & Promotion Services
- Early Intervention Services
- Crisis Intervention Services *(onsite and mobile in the community)*
- Inpatient Acute Care
- Rehabilitation Services *(facility and community based)*
- Basic Treatment Services *(community based)*
- Specialized Treatment Services *(outpatient and community)*
- Sustain and Support Services *(broad base of community supports for clients who may or may not be currently in active treatment)*

The continuum of care framework is mentioned several times in the report in the form of a reference to services and also as recommendations for improvements. For the purposes of the putting the recommendations into context, the following four levels of the continuum framework is used.[21]

Primary Prevention

Initiatives that provide information on mental health, and harms associated with substance abuse, including education and support through awareness of community resources that facilitate resiliency, positive choices and effective coping skills to enhance problem solving.

- Universal Prevention – Initiatives targeted to the whole population to strengthen protective factors to build resiliency, reduce risks among populations and mitigate potential threats to health, and support healthy lifestyle choices.
- Selective Prevention – Initiatives targeted to individuals or subgroups of population with increased risk of developing a mental or substance use disorder in order to prevent or delay development of disorder by altering the susceptibility or reducing the exposure for susceptible individuals.

Secondary Prevention

Initiatives targeted to early detection and treatment of disorders, targeting to individuals exhibiting early signs or symptoms of a mental disorder or problematic substance use, or experiencing a first episode of an illness. Treatment interventions are intended to reduce

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[19] Accreditation Canada is a not-for-profit, independent organization accredited by the International Society for Quality in Healthcare (ISQua).

[20] Calgary Health Treaty. Continuum of Care. http://www.calgaryhealthTreaty.ca/mh/continuum.htm

[21] B.C. Northern Health See. http://www.northernhealth.ca

severity and shorten course of the illness, limit disability and promote optimal functioning and reduce harms associated with substance use. Secondary prevention includes supports for relapse prevention, or lapses experienced when taking a harm reduction approach.

- Indicated Prevention – Initiatives targeted to high-risk individuals showing minimal signs and symptoms of a mental and/or substance use disorder, or whose biological, social, and/or environmental markers indicate predisposition.

Tertiary Prevention

Initiatives targeted to alleviate or limit disability resulting from illness, reduction of co-morbidity and rehabilitation/restoration of effective function.

Harm Reduction Services

Harm reduction is secondary and tertiary prevention that seeks to lessen the harms associated with high-risk behaviours, impulse control, and substance use (without requiring abstinence). These services and supports reduce the negative impacts of behaviours, alcohol and other drug use, including injury prevention, preventing sexual abuse or exploitation, and reducing the spread of infectious disease. Initiatives include needle-exchange programs and supervised injection sites to reduce the spread of communicable diseases such as HIV, Hep B and C, and drug overdoses. Other services provide practical solutions such as education on impulse control, as well as substance use and helping individuals who use substances to address important health concerns such as nutrition, hygiene, or immediate physical health problems such as wound abscesses, and safe housing options.

Treatment Centers in Alberta

There are 8 NNADAP funded treatment centres in Alberta. One treatment centre (Footprints Healing Lodge) receives minimal funding but is not part of the NNADP funded programs. All treatment centers were co-ed. Referrals were made to an out of province treatment center in Saskatchewan for a female only treatment program or specific female (only) youth treatments. Listed below are the names of the 8 NNADAP funded treatment centres, as well as those centres that have been closed or will be opening soon:

1. Beaver Lake Wah Pow Treatment Centre (Beaver Lake)
2. St. Paul Treatment Centre (Cardston)
3. Kainaiwa Adolescent Treatment Centre (Kainai)
4. Mark Amy Centre for Healing Addiction (Fort McMurray)
5. Morning Sky Treatment Centre (Frog Lake) – closed
6. Tsuu T'ina Nation Spirit Healing Lodge – closed (Tsuu T'ina)
7. White Swan Treatment Centre – closed
8. Young Spirit Winds Youth Treatment Program (Hobbema)
9. Kapown Treatment Centre (Grouard)
10. Footprints Healing (not part of the NNADAP funded programs) (Morinville)
11. Sisika First Nation (opening July 2009)

St. Paul Treatment Centre is the only program that offers a women's only program and is offered at times when there are sufficient numbers that have applied.

There are two treatment centres designated as youth programs; one is a full time residential program (Kainaiwa - Kainai) and one offers a day program (Young Spirit Winds – Hobbema). A third youth treatment center is scheduled to open in July 2009 at Siksika First Nation. The White Swan Treatment Centre and Tsuu T'ina Healing Lodge were closed in 2008 and the funds have been reallocated.

All the treatment centers are located on reserves and operated with a Board of Directors. All of the adult programs are full-time residential programs and a few will accept day clients.

The programs varied in duration from four week programs to six week programs. The programs that were less than six weeks were concerned that four and five weeks were not long enough to cover all the topics that need to be addressed. Counsellors reported that between the times spent on orientation and on preparing to leave activities, the clients' evaluations revealed that some areas were not covered with enough depth. Under special circumstances, two centers had provisions to extend the program an additional week.

- Footprints Treatment Centre and Young Spirit Winds are the only two centres that offer an out patient program.
- Footprints Treatment Centre also offers a spousal support program.
- Kapown, St. Paul and Footprints Treatment Centres offer a refresher (follow-up) program

The majority of treatment centre staff is aboriginal and reported to have 80% of the addictions counsellors certified as either the CAC I or CAC II. [22] Most treatment centres had a continuous intake process and reported to have a one cycle waitlist. The client completion rates were reported to be on average 60-70% and two centres rated their completion rates as 90%.

Most of the treatment centers reported to offer cultural activities as part of the program. Some of these programs were only offered on a seasonal basis.

Treatment Centers reported that the most frequent co-occurring disorders were depression, anxiety, affective schizoid disorder, ADHD, and FASD. Youth treatment centers included anger issues and oppositional defiance disorder as their most frequently co-occurring disorders.

One treatment center said that certain prescriptions were not permitted at the treatment centre and another reported that certain psychotropic medicines are prohibited at the Centre (Kapown). Another center would not accept clients that were diagnosed with affective schizoid disorder (St. Paul). Programs determined admission on a case by case basis and reported that their program may not accept clients with hallucinogen abuse due limited emergency medical services being available.

- A number of centers said they offered HIV education but not testing.
- The Kapown Center (Grouard) offers a family program once a year and the family violence and parenting skills components are offered only within this program.
- The Beaver Lake Wah Pow Treatment Center is the only centre that offers a family program with day care available (for children under the age of 6).

See the following page for a complete description the NNADP funded Treatment Centre in Alberta.

22 Certified Addiction Counsellor (CAC)

NNADAP TREATMENT CENTRES

Alberta Region
April 2009

ADMISSION

- First Nations individuals and their families
- Referral by an Alcohol and Drug Counsellor
- Submission of a fully completed application package, including current medical / TB test
- Each Centre provides referral packages & intake schedules.
- Accessibility and admission criteria vary with each program and Centre

* **Provided as required by individual treatment needs**

Program Types

Treatment Centres	Accredited by Accreditation Canada or CARF (IP = In Process)	Adult / Individual / Coeducation Program	Family Program	Men's Only Program	Women's Only Program	Youth Program	Long-term Rehabilitation Program	Out Patient Program	Residential School Program	Walk-in & Crisis Services (Local	Spousal Support Program	Refresher Program	Referral / Helper Program
Beaver Lake	IP	•	•							•		•	
Frog Lake *Note	IP	•						•			•		
Kainai	IP					•	•						
Kapown	•	•	•							•		•	•
Mark Amy	•	•						•				•	
St. Paul	•	•		•	•				•	•		•	•
Footprints	•	•					•	•		•	•	•	•
Young Spirit Wind	IP					•		•		•			•

Accessibility / Recovery Stage

Treatment Centres	Corrections: Parole / Probation (Criteria varies by program)	Developmental Disability (Minor Severity)	FASD (Minor Severity)	FASD (Moderate Severity)	Mental Illness Stabilized/Managed by Psychotropic Medication	Hearing Impairment (Minor Severity)	Learning Disability (Minor Severity)	Literacy Assistance	Methadone Maintenance Therapy (Carries)	Visual Impairment	Physical Disability (Minor Severity)	Wheelchair Access	Non-Medical Detox	Early Recovery / Stabilization	Middle Recovery	Late Recovery
Beaver Lake		•	•		•		•	•		•	•	•		•	•	•
Frog Lake *Note			•	•		•	•				•	•	•	•		
Kainai	•	•	•		•			•				•	•	•	•	
Kapown	•	•	•	•	•	•	•	•		•	•	•	•	•	•	•
Mark Amy			•		•	•	•	•			•	•			•	•
St. Paul	•		•		•	•	•	•	•	•	•	•		•	•	
Footprints	•	•	•	•			•	•				•	•	•	•	
Young Spirit Wind	•		•	•	•		•					•		•		

Substance or Addiction Type

Treatment Centres	Alcohol	Co Occurring Disorders	Crystal Meth	Hallucinogens	Marijuana	Narcotics / Opiods	Polydrug Use	Process Addictions	Solvent Abuse	Tobacco
Beaver Lake	•		•	•	•	•	•	•	•	•
Frog Lake *Note	•	•	•	•	•	•	•	•	•	
Kainai	•		•	•	•	•	•	•	•	•
Kapown	•	•	•	•	•	•	•	•	•	•
Mark Amy	•	•	•	•	•	•	•	•	•	
St. Paul	•		•		•	•	•		•	•
Footprints	•	•	•	•	•	•	•	•	•	•
Young Spirit Wind	•	•		•	•	•	•	•		

Program Components

Treatment Centres	Sweatlodge Ceremonies	Elder Resources	First Nations Identity and Self-Esteem	Cultural Activities / Resources	Intake Screening	Orientation and Assessment	Mental Health Services (Psychologist Resources)*	Crisis Intervention*	Alcohol / Other Drug Education	Case Management and Individual Treatment Planning	Individual Counselling / One-to-One	Group Counselling	Gender Specific Group Sessions	Youth Counselling / Group Sessions	Couples Counselling Sessions (Behavioural /Coaching)*
Beaver Lake	•	•	•	•	•	•		•	•	•	•	•	•		•
Frog Lake *Note	•	•	•	•	•	•	•	•	•	•	•	•	•		•
Kainai	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Kapown	•	•	•	•	•	•	•	•	•	•	•	•	•		•
Mark Amy	•		•	•	•	•	•		•	•	•	•			
St. Paul	•	•	•	•	•	•	•	•	•	•	•	•	•		
Footprints	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Young Spirit Wind	•	•	•	•	•	•	•	•	•	•	•	•	•	•	

Program Components (continued)

Treatment Centres	Family Violence Counselling*	Parenting Skills	Social Development / Interpersonal Skills / Healthy LifeSkills	Problem Solving Training and Goal Setting	Stress Management Training / Healthier Choices	Anger Management / Conflict Resolution	Coping Skills Training (Urges and Cravings)	Harm Reduction	HIV Education (Testing*)	Recreational Therapy	Trauma Counselling Support*	Residential School Counselling Support*	Suicide Ideation Counselling Support (Stabilized)*	AA / NA / Self-help Groups	12 Step Work
Beaver Lake	•	•	•	•	•	•	•		•		•	•	•	•	•
Frog Lake *Note	•	•	•	•	•	•	•	•	•	•	•		•	•	•
Kainai	•	•	•	•	•	•	•	•	•	•	•		•	•	•
Kapown	•	•	•	•	•	•	•	•	•	•	•			•	•
Mark Amy	•	•	•	•	•	•	•			•	•	•	•	•	•
St. Paul	•	•	•	•	•	•	•	•	•	•		•	•	•	•
Footprints	•	•	•	•	•	•	•	•	•	•		•	•	•	•
Young Spirit Wind	•		•	•	•	•	•	•	•	•					

After-care

Treatment Centres	Case Conferences with Referral	Referral Services	Relapse Prevention Training (Cognitive Behavioural)	Follow-up & Individual Aftercare Planning
Beaver Lake	•	•		•
Frog Lake *Note	•	•	•	•
Kainai	•	•	•	
Kapown	•	•	•	•
Mark Amy	•		•	•
St. Paul	•	•	•	•
Footprints	•	•	•	•
Young Spirit Wind	•	•	•	•

Alberta Region: NNADAP Needs Assessment Final Report 2009
* Frog Lake is closed as of April 1, 2009.

Community NNADA Programs

NNADAP Wellness Consultants

The Addictions and Mental Health program in Alberta has three full-time (NNADAP) Wellness consultants that work with NNADAP Workers in each of the three Treaty areas. These positions report to the Team Leader for Addictions and Wellness Program. Personal interviews were conducted with each Wellness Consultant to discuss their role in the NNADAP program, the needs of the community and of the NNADAP workers, the challenges they experience, community mobilization and recommendations for change.

The Wellness Consultants (WC) play a key role in communication between NNADAP workers and changes to the NNADAP program. There are 103 NNADAP workers working in First Nation communities. Wellness Consultants act as coordinators and facilitators and when needed will also provide direct support to treatment centres and may temporarily backfill a position for a NNADAP worker who is attending training. They are the 'go to' person for the NNADAP workers who need orientation, assistance with information on addictions, assessments and referrals and at times, the support and resource person for crisis management. In some ways, the Wellness consultant has the expertise to perform the duties and offer support that the supervisor would normally provide. The Wellness Consultants participated in personal interviews. See Section 10 for a full discussion and a list of recommendations made.

NNADAP Community Workers

The National Native Alcohol and Drug Abuse Program (NNADAP) is a program funded under the First Nations Inuit Health budget. Since the inception of the program in the early 1970's, alcohol and drug prevention counsellors have been working in First Nation communities and in Alcohol and Drug Treatment Centres providing prevention, intervention and aftercare programs. The role of the NNADAP worker has undergone tremendous change throughout the years. As the community needs changed, these workers took on greater responsibilities. The need for continued training has become more pronounced now more than ever before.

For a number of years, the Alberta Treaty of the First Nations Inuit Health Branch has been working with First Nation communities to ensure the continued professional development of addictions workers. Addictions workers are being encouraged and supported with ongoing training opportunities to achieve certification through the Canadian Addiction Counsellors Certification Federation.[23] One of the major functions of the certification program is the protection of the public from the practitioners who may not have the skills necessary to meet the needs of the people they serve.

The role of the NNADAP Counsellor is to work towards assisting First Nations and Inuit people to achieve physical, mental, social and spiritual well-being. The duties of NNADAP Counsellors includes prevention, intervention, pre-treatment, treatment, relapse prevention, post-treatment counselling as well as administrative office duties such as the preparation of budgets, reports and the collection of statistics. NNADAP Counsellors are expected to keep updated on drug and alcohol trends and new materials, attend courses

23 Formerly the Addiction Intervention Association. Incorporated 1985

and in-service training and attend to personal self-care. The NNADAP workers must be seen to be working toward certification in the field of addiction treatment and knowledge, experience in traditional and contemporary healing practices and experience in working with Elders, healers and clinicians.[24] [25]

There are 103 NNADAP Workers working in forty-four First Nation communities in Alberta. The First Nation communities receive funds through contribution agreements from the NNADAP program. Many of NNADAP workers in Alberta have achieved their CAC I[26] and CAC II certification.

Significant changes have been made over the past five years in the role and expectations of NNADAP workers. Most significant has been the expectation that NNADAP workers become certified addictions counsellors. In October 2004, the FNIHB and the partnership committee developed a recommended pay scale that communities could use as a guide in establishing rates of pay for the NNADAP coordinator and counsellor. It is a guide that is used by First Nations communities to establish job descriptions and a pay scale according to their budget allocation. In this regard pay scales vary from community to community. These changes reflect the changing role of the NNADAP worker and provide a clear career path. This represents a sign of an industry moving toward professionalization. Each level requires greater skills, training, and certification.

The following is an example of the job levels of NNADAP workers and salary scale. The salary grid is based on pay groups (A-H) with each pay-group having six levels of pay (1-6) which are separated with five percent increments between pay levels. The pay groups (A-H) are divided into job positions found in a treatment centre environment which also includes community-based NNADAP Coordinators and Counsellors.

The role of NNADAP Coordinator falls within the Pay group B which has a salary range from Level 1 $29,326 to the Level 6 $45,699. The NNADAP Counsellor role falls within the Pay group C ranging in salary from Level 1 $23,462 - Level 6 $ 36,569.

As with most pay scales the difference between levels of pay is dependent on the degree of education, skills, experience and number of year's employment. See Appendix for a full description of pay scales.

The roles of the NNADAP Addictions Counsellor working in First Nation communities and in Alcohol and Drug Treatment Centres have distinct training needs depending on whether they work in a Treatment Centre or in a community setting. Alcohol Counsellors working in community settings provide prevention services, referrals and aftercare support and most often work with clients on a one-to-one basis. Alcohol Counsellors working in Treatment Centres require additional skills in individual treatment planning, group facilitation and individual and group therapeutic techniques.

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[24] Certification of NNADAP workers in Alberta is provided based upon completion of courses offered through Nechi Training Institute and is not awarded based on "evaluation" by an independent certification process.

[25] Established in 1974 the Nechi Training, Research and Health Promotion Institute, is the longest operating facility of its kind in North America. Located north of Edmonton, Nechi shares the 53,000 square foot building with Poundmakers Lodge, a culturally based addictions treatment centre. It is the only facility in Canada that combines an Aboriginal training centre with an Aboriginal treatment centre.

[26] Certified Addictions Counsellor

NNADAP counsellors receive 7-14 days of training each year, in order to advance their knowledge of addiction issues and to increase skills in areas of prevention, treatment, community development and administrative services, specific to their working location.

SECTION 6 DEMOGRAPHIC PROFILES

Alberta is home to 44 First Nations communities in three Treaty areas. Treaties 6, 7 and 8 consist of a combined 134 reserves spread over 741, 426.7 hectares of land. The total First Nation population in Alberta is 112,792 representing 3.8% of the total provincial population. This compares to a total of 2,855,029 non First Nations people in Alberta. [27] Demographic breakdown among this population is approximately children aged 5-14 years of age 36,805, adolescents aged 15-19 years 5,353, adults aged 20-54 years 74,670 and 12,065 who are over 55 years of age[28]. Each demographic group represents differences in historical experiences, lifestyle choices and cultural values. For that reason, the following sections discuss needs/problems in relation to each demographic group.[29] It should be noted that the demographic profiles are more general categories – not specific age groups. For the purpose of this study, the survey uses the following age categories: youth are between the ages 12-18, young men – young women are between the ages of 19-30, adults are between the ages of 31-55 and seniors are over 55.

SECTION 6.1 Youth[30]

Needs and Issues

On average, taking the first alcoholic drink typically starts at a very young age, around 14 (Kids Center for Health, 2004).[31] A study of drinking and driving among Alberta First Nations youth revealed that many of the respondents had taken their first drink around the age of 12 years.[32] The study uncovered the other distressing facts about Alberta First Nations youth: In 2001, 16% of all traffic related deaths in Alberta were people of Aboriginal descent; impaired driving was involved in 73.2% of all Aboriginal motor vehicle fatalities; 61% of Aboriginal drivers tested for alcohol; and RCMP Traffic Services data indicates that 75% of motor vehicle fatalities involving First Nations people were unbelted fatalities and were 5 times more likely to involve alcohol. [33] Some of the reasons the youth

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[27] Cardinal JC, Schopflocher DP, Svenson LW, Morrison KB, Laing L. (2004) *First Nations in Alberta. Focus on Health Use*. Edmonton: Alberta Health and Wellness.

[28] Stats Canada 2001. www12.statcan.ca/English/profil101/AP01/details/page

[29] The above figures are from two different survey years and are accurate for those respective years

[30] For the purposes of this survey, youth are considered to be between the ages of 12-18, in other referenced studies it may be a general category and exact ages may differ slightly.

[31] Kids Center for Health (2004). "Alcohol."www.kidshealth.com.

[32] Rothe, Peter et al. (2004) Alberta Centre for Injury Control and Research: A Qualitative Inquiry Into Drinking and driving Among Alberta's First Nations Post-Secondary Youth Aged 18-29

[33] Aboriginal Traffic Safety Coalition of Alberta, 2003: 11-13)

gave for drinking was to have fun, to be sociable, to temporarily escape reality, to find extra courage, to relieve stress or take a break from school, to drink because I can and/or because of a difficult community situation.

Alcohol is clearly not the only problem among youth. In a 2005 study by C.A. Dell on youth Volatile Solvent Abuse (VSA) in Canada, it was reported that in Alberta 5-6% of youth from grade 7-12 reported to have used solvents in the past year.[34]
In Treaty 8, 138 youth participated in a study on youths' perceptions of community drug and alcohol access and use, bullying, gangs and suicide.[35] The survey revealed that over 88% of their friends or classmates consumed alcohol and 95% had smoked marijuana. Of the 129 that responded to the question on drug/substance use, it was reported Ecstasy (48%), Cocaine (42%), Crack (40%), Mushrooms (41%), Tylenol (41%) and Crystal Meth (24%) were the most used drugs. Seventy-seven percent (77%) and ninety percent (90.3%) respectably thought that alcohol and drug abuse was a problem in their community.

A number of social problems seem to be connected to substance abuse, perhaps as determinants or as consequences. The youth were asked about the prevalence of bullying in their community and schools. Responses per community were varied but were consistent on one point, that bullying was rated as higher in the community than in school. Seventy-four percent (74%) said that bullying was a problem in their community and fifty-three percent (53%) said that gangs were a problem in their community. Forty-seven percent (47%) thought that suicide was a problem in their community and forty-six percent (46%) reported to have lost a friend or relative to suicide. One quarter of the youth indicated that they had no one to talk to if they were feeling sad, depressed or had thought of hurting themselves.

Thirty eight (38%) percent of the youth in the survey said they do not have a friend or family member to talk to; 75% would not talk to a professional helper (such as a teacher, mental health worker, nurse or principal) if they were thinking about self harm or suicide. More than 46% of the youth do not think leadership in their community understand their needs.[36]

In community focus groups, (approximately sixty-five percent were women) participants were asked if they thought alcohol and drugs were a problem in their community. Every one of the participants responded that alcohol and drugs affected their community, especially amongst youth and that in some communities youth were being used as drug runners for the drug dealers in the community.

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[34] What the Data Tell Us About Youth Volatile Solvent Abuse (VSA) in Canada [Dell, C.A., Inhalant Abuse Among Children

and Adolescents: Consultation on Building an International Research Agenda, November 2005

[35] Lesser Slave Lake Indian Regional Council: Youth Survey Report by Dr. Mary-Beth Biggs (2009)

[36] ibid

A few communities in Treaty 6 commented that gang activity is a problem in the community. Gangs, such as Indian Posse and Red Alert, are coming from the city and recruiting the youth; resulting in drive by shootings and random shootings. Several respondents indicated that there is a lot of peer pressure for youth to participate in alcohol and drug related activities.

Contributing to the vulnerability of the youth is family neglect. The majority of the respondents felt that children and youth are being neglected and that in some communities there are high rates of child apprehensions. Several individuals commented that alcohol and drug misuse by parents contributed to children and youth being removed from their homes and placed in group homes and foster homes; thus contributing to the unstable environments that put youth at risk of substance abuse behaviour themselves.

The perception of the focus group participants that drugs and alcohol are serious problems among youth in First Nation communities was further supported by NNADAP workers and other health professionals who completed the needs assessment survey administered as part of this study. (There were over 124 individuals who completed the survey; 36 from Treaty 6, 37 from Treaty 7 and 34 from Treaty 8.)

Table 1: Percentage of Respondents who Perceive there are Many Problem to Chronic Users among **YOUTH** in Community

USING	Across Province	Treaty 6	Treaty 7	Treaty 8
Alcohol	78.3%	67.5%	87.2%	78.4%
Marijuana	78.9%	73.0%	94.8%	73.0%
Solvent Use	17.2%	2.8%	30.5%	19.5%
Methamphetamines	22.0%	14.7%	35.9%	14.7%
Prescription Drugs	41.2%	30.5%	54.0%	44.2%
Ecstasy/Hallucinogens	22.0%	20.0%	23.5%	23.5%
Crack/cocaine/heroin	45.9%	48.5%	52.7%	38.2%
Cigarettes	91.1%	86.1%	97.4%	88.9%
Junk Food Binging	72.7%	59.4%	86.4%	73.6%

The most serious problems among youth reported by survey respondents was alcohol use, marijuana use, smoking cigarettes, prescription drugs, and crack/cocaine. Table 1 provides a percentage of respondents who felt there were many problem and chronic users in their Treaty. In terms of Regional differences, there were more respondents in Treaty 7 than the other areas perceiving drug problems among many youth – especially alcohol and marijuana, methamphetamines, and solvents. Over 35% of the respondents in Treaty 7 perceived methamphetamines were a problem with many youth.

Many co-occurring disorders were perceived to be common among youth in their community. More than 80% of the respondents identified problems of aggression towards others, suicidal thoughts, vandalism and conflicts with police. Alarming was that 92% of the respondents in Treaty 7 perceived suicidal thoughts to be a co-occurring disorder among youth who are using alcohol and drugs.

Table 2: Percentage of Respondents who Perceive **YOUTH** Who Use Alcohol and Drugs are also exhibiting Other Co-Occurring Problems.

	Across Province	Treaty 6	Treaty 7	Treaty 8
aggression to others	85.7%	84.2%	89.5%	83.3%
suicidal thoughts	73.2%	57.9%	92.1%	69.4%
thought problems	62.5%	60.5%	63.2%	63.9%
harmful to others	68.8%	76.3%	68.4%	61.1%
cruelty to others	26.8%	23.7%	34.2%	22.2%
vandalism plus other actions	90.2%	89.5%	100.0%	80.6%
depression or anxiety	72.3%	60.5%	89.5%	66.7%
conflicts with police	70.5%	57.9%	81.6%	72.2%

In general, not many survey respondents perceived youth in their community who are using alcohol and drugs to be motivated to engage in support or treatment. Only 3% of respondents felt youth were very motivated, 8 % in Treaty 7 and zero percent in Treaty 8. But about half of the respondents felt that youth were "somewhat motivated" to address substance abuse issues.

Community engagement was held in fourteen First Nation communities and at each of the 8 treatment centres. The purpose of the youth community engagement was to understand their needs and the best ways to meet them for this specific age group. This section reports on the issues identified by youth in 6 youth focus groups. A total of 44 youth participated in the discussions and were between the ages of 15 to 29 years. The questions for discussion included general questions about alcohol and drugs and its affect on the community.

When asked if alcohol and drugs negatively affect their community, all youth responded yes. The majority of the youth indicated that the most prominent drugs abused included crack, cocaine, methamphetamine, marijuana and ecstasy, as well as alcohol and prescription drugs. The youth also believe that alcohol is the leading factor in suicide and depression.

The majority of the youth observed there are many negative role models in the community. While adults are always telling them not to drink or do drugs, these adults are using themselves. The youth feel that they are lacking positive role models in their lives. The youth felt that alcohol and drugs have an affect on teen pregnancies, failures in school and high dropout rates.

When asked what group of people in the community are most affected by alcohol and drugs, all youth responded that youth, children and Elders are all affected by alcohol and drug abuse in their communities. The majority of the youth indicated that Elders are financially abused and that youth are affected through peer pressure, and teen pregnancies. The majority of the participants also felt that the whole community is affected, including families and individuals who do not abuse alcohol and drugs and parents.

The AADAC initiated two studies [37] (2005, 2002) to measure alcohol, tobacco and illicit drug use and gambling activity among Alberta students in grades 7 through 12, across all racial groups. The surveys also examined student attitudes, perceptions and social networks in relation to substance use and gambling activity.

The AADAC survey included responses from 3,915 youth respondents. The study reported that 63.4% had consumed alcohol in the last 12 months. Almost 6% of students met the AUDIT criteria [38] for hazardous drinking; these numbers increased by grade with almost forty percent (39.9%) of students in grade 12 demonstrating risky drinking behaviour [39]. Overall, 31.3% of all students report incidents of binge drinking. Additionally 28.8% of all students report using illicit drugs (excluding cannabis) in their lifetime. However it should be noted that most high school students perceive substance use among their peers (with the exception of alcohol) to be higher than actual use. Overall, users did not experience difficulty in obtaining alcohol or drugs through their social networks. Although the study did not specify racial origin; it does provide a baseline for measurement studies included in this report that are specific to First Nations in Alberta.

A Saskatchewan study found that there is a connection between economic and cultural status as risk indicators for alcohol abuse and marijuana use among adolescents in Saskatoon. In 2007 with 4,093 Saskatoon youth in grades 5-8, the study determined that the two main risk factors for marijuana use and alcohol abuse were Aboriginal culture status and living in low income neighbourhoods. After controlling for income alone, the association between Aboriginal culture status and risky behaviour was greatly reduced. The study found that 16.7% of Aboriginal youth had abused alcohol in comparison with 5.4% Caucasian youth. And 21.5% of Aboriginal youth had used marijuana in the past year in comparison to 2.7% of Caucasian youth. Similarly, 30.1% of youth who lived in a low income neighbourhood had abused alcohol compared with 5.8% of youth in the rest of Saskatoon; while 35.7% of youth who lived in low income neighbourhoods had used marijuana in the past year compared with 3.8% of youth in the rest of Saskatoon. After controlling for income alone, the association between Aboriginal culture status and risky behaviour was greatly reduced. For example 30.3% of low income Aboriginal youth have abused alcohol in comparison to 29.6% of low income Caucasian youth. For youth that do not live in low income neighbourhoods, only 13.2% of Aboriginal youth and 5.2% of Caucasian youth abused alcohol.

Among the sixty-nine Alberta NNADAP workers that participated in group discussions to identify the needs of youth, there were a number of commonalities. Among the need for

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37 Alberta Alcohol and Drug Abuse Commission. Now known as Alberta Health Services. The Alberta Youth Experience

Survey (TAYES)

38 Babor, T.R, Higgins-Biddle, J.C. & Monteiro, M.G. (2001) The Alcohol Use Disorders Identification Test. Guidelines for use in primary care (2nd ed) Geneva, Switzerland: World Health Organization

39 The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item questionnaire used to identify high risk for harmful drinking or potential dependence.

specific services for alcohol and drug use, three major themes emerged that included the need for an increase in:
Needed Services for all ages of youth.

- Services such as Alateen meetings, detox services for youth, residential and out patient treatment beds, with the option of involving family members and that these services be equally available to all youth regardless of income.

- Education and awareness of addictions, mental health and the continuum of recovery.

- Skill building in the areas of parenting and basic life skills. Recreational activities such as sports, dance, and cultural activities such as drum making and traditional crafts.

- Increased funding and resources. Each Treaty area agreed that there needs to be an increase in funding to provide youth-specific services. Central to these services is the need to have addictions' counsellors that specialize in youth development and recovery from childhood trauma.

It is interesting to note that many of the needs identified for youth were roles that were traditionally provided by the parents. In the absence of strong and supportive parenting, the youth in the community struggle to navigate the tumultuous adolescent years that child development specialists recognize as a critical time for building identity and self-esteem. The intergenerational affects of the Residential School system has created ineffective parenting skills that hinders the parents' ability to nurture and facilitate healthy emotional and cognitive development

Resources and Services Available

Health Canada's activities around healthy child and adolescent development benefit Aboriginal youth in three important ways: firstly, they promote healthy child development which sets the stage for healthy adolescence; secondly they help to create ongoing health-promoting behaviours among the adolescent population; and thirdly, they support youth who are pregnant or are parents.

Health Canada's approach to solvent-abuse prevention and treatment involves a focus on Aboriginal youth. Approximately 20 per cent of the youth treated in the nine Health Canada-funded youth-solvent-abuse areas are from urban areas.

Nationally, there are nine funded Youth Solvent Abuse treatment centres and two multi-addictions treatment centres[40]. NYSAP is funded at $13 million annually. The program is run through nine Youth Solvent Addictions Centres (YSAC) which provide 120 treatment beds in total and are located throughout the country. Each treatment cycle is approximately 180 days long. Nationally, eight of the centres provide treatment programs for youths aged 12 to 19 years, while one centre specializes in youths aged 16 to 25 years. The centres follow a "continuum of care" approach that begins with pre-treatment, then treatment, and finally post-treatment care in which the families of the youths are

40 The program was first established in 1995 and Youth Solvent Abuse Treatment Centres were operational by 1998

involved. The centres also provide information sessions and training on solvent abuse for community workers to optimize the support for the youths. Since the program began, the treatment centres have been used at maximum capacity. A minimum of 212 clients are treated each year.

The accredited programs are funded through the Health Canada – Brighter Futures – Solvent Abuse Initiative.[41] The Youth Solvent Abuse Committee (YSAC – incorporated 1998) provides support to the ten centres. In recent years the YSAC has developed partnerships with the USA, provincial facilities and drug and alcohol centres for youth. In Alberta, there are two funded Youth Treatment Centres (only 1 is funded through the National Native Alcohol and Drug Program (NNADAP).

In Alberta the YSAC funded two treatment centers specifically for youth; the White Swan and the Young Spirit Winds Treatment Centre in Hobbema. The White Swan was closed in 2008 and the funds have been reallocated to the Siksika First Nation that will be opening in August of 2009 with 10 beds to provide addiction recovery services to youth aged 13-18 years.
Young Spirit Winds is a YSAC funded program that provides a seventeen week outpatient day program for youth 17 years of age and under. The Kainaiawa Youth Treatment Centre (located in Standoff) is NNADAP funded and provides services to youth and pregnant youth aged 12-17 years of age.

Both youth treatment centres provide services for alcohol, narcotics, solvent abuse, and hallucinogens recovery and both programs provide assessments, alcohol and drug education, case management, client orientation, crisis intervention, individual counselling, professional consultation, cultural activities, life skills/personal development, group counselling, individual and aftercare planning, referral, individual treatment planning, intake, and recreation therapy. (See appendix for a list of provincial treatment centres in Alberta)

Nationally, Treatment Centres are required to maintain records on client demographics, addictive behaviour, co-occurring disorders, completion rates and bed utilization. The First Nation Inuit Branch collects these statistics by using the Substance Abuse Information System (SAIS reports) and reports on aggregate data. This section reports on the Alberta Regional SAIS from nine treatment centres in Alberta and one youth treatment centre. The results from the youth centre Young Spirit Winds Treatment Centre for 2007-08 indicate that the average age of participants is 14.5, of which 43% are not attending school. Fourteen percent of youth reported a history of suicide ideation and 50% came from families with addictions. Thirteen percent reported to have been a victim of sexual victimization. Over half of those accepted into the program completed. The Kainaiawa, the other youth centre, does not report to the SAIS program and comparable information was not available at the time of this report.

In large discussion groups, NNADAP workers identified that the physical location of the First Nation and the proximity to urban services greatly impact on the community's ability to offer social and recreation services. Some communities are reported to have access to recreation facilities and hold regular recreation nights that include sports activities such

41 YSAC Annual Report 2006-2007 - Each centre is funded at $103,000 per bed annually

as volleyball, hockey, and pool tables; while the more remote communities report a need for a recreation center in their community.

Approximately half of the communities offer support groups, such as healing circles in schools, school counsellors, access to psychologist services, one-to-one counselling services, homework nights, girls' nights out, and cultural events are available. In a few instances, summer employment programs target youth and summer cultural camps are available.

The degree of services available for youth in First Nation communities depends largely on the physical location of the community and the economic ability of the community to hire qualified staff and to coordinate services with existing programs. Other communities report they are underfunded and staff are over extended and under resourced.

NNADAP Workers report that workshops in anger management, lack of parental/guardian support, spiritual guidance, and after hours support are missing in many community programs.

The perception of available intervention resources for youth was high in terms of assessment and referral, one-to-one counselling, family counselling and alcohol and drug resistance skills education (to some degree). But half or less of these respondents did not think resources such as mental health and substance abuse treatment, alternative and social recreational activities and school support/tutoring was readily available. Concern that resources/treatment were not available was only slightly more pronounced in Treaty 7 than in the other Treatys; with the exception of school support and tutoring resources of which over 61% of respondents from Treaty 7 said they had resources available within two weeks of a referral.

Table 3: Perception on Whether Resources Are Available for **YOUTH** Within Two Weeks

USUALLY OR ALWAYS AVAILABLE	Across Province	Treaty 6	Treaty 7	Treaty 8
assessment and referral	76.5%	77.1%	82.0%	68.6%
one-to-one counselling	84.4%	83.3%	89.0%	79.2%
family counselling	70.4%	72.3%	77.7%	61.8%
residential treatment	51.9%	55.9%	55.5%	43.0%
aftercare counselling	54.1%	56.7%	64.8%	36.4%
mental health and substance abuse treatment	55.5%	47.3%	66.7%	55.9%
alcohol and drug resistance skills education	64.5%	69.5%	70.2%	56.3%
USUALLY OR ALWAYS AVAILABLE	Across Province	Treaty 6	Treaty 7	Treaty 8
alternative and social recreational activities	40.2%	40.5%	50.0%	31.4%
school support/tutoring	51.4%	41.7%	61.1%	52.9%

Only 20% of the survey respondents across the province felt that resources and treatment were very effective. However when "somewhat effective" responses were

added in, almost 80% of respondents were positive about resources/treatment. The greatest concerns were in regards to the effectiveness of aftercare counselling. Over 28% of respondents felt after care counselling did not help, it even had a negative effect. There were some Regional differences. In general, Treaty 6 was more satisfied with the effectiveness of resources/treatment for youth, especially in regards to one-to-one counselling, family counselling and aftercare counselling. Treaty 8 respondents were most negative about the effectiveness of resources/treatment for youth.

Table 4: Perception of Service Effectiveness to **YOUTH** perceived to be Somewhat to Very Effective

	Across Province	Treaty 6	Treaty 7	Treaty 8
one-to-one counselling	89.3%	93.9%	94.6%	78.8%
family counselling	82.8%	90.6%	82.4%	74.2%
residential treatment	78.8%	83.4%	80.5%	71.9%
aftercare counselling	71.9%	86.6%	62.8%	66.7%
mental health and substance abuse treatment	77.6%	79.3%	77.8%	75.0%
alcohol and drug resistance skills education	80.6%	84.4%	82.8%	73.3%
alternative and social recreational activities	77.0%	84.4%	71.4%	75.0%
school support/tutoring	82.6%	84.4%	82.8%	80.0%

It is noted that there are many factors that make it difficult to help youth or that interfere with prevention or treatment efforts. For all respondents across the provinces, over 92% identified “dysfunctional or abusive family” as a serious detriment. Ninety (90%) of respondents also identified “not being in school or poor school engagement as also a serious factor. And 85% of respondents identified negative peer culture (such as gangs) as a problem factor. Other factors such as unstable living situation, co-existing mental health condition, fetal alcohol syndrome and learning disabilities were all identified by at least 70% of the respondents. Regional differences are interesting, with Treaty 7 having the highest percentage of respondents (90% or higher) identifying all these factors as interfering with helping youth engaged in substance abuse problems.

When asked what the community’s role is in addressing the issues of alcohol and drugs, all youth responded that the community should have more recreational activities for youth and people of all ages. There are not enough programs in the community reflecting healthier lifestyles or changes. The majority of the youth felt that community gatherings and celebrations are important and that this is something that benefits the whole community and allows the community to come together as one. The youth also felt that recreational centers and youth centers provide safe places where the youth can go to play sports, do fun activities, interact with peers and reach out for support, and to just go there when there is nowhere else to go or nothing else to do.

The youth also felt that more interaction and communication with Elders and adults would provide opportunities for spending time together, and just showing youth that “you care”. The youth felt that the community should be less judgmental and that people needed to stop blaming youth for everything that happens in the community. The majority of the

youth also stated that alcohol and drug awareness, addictions awareness and positive role models would help them make better choices.

Cultural connections appear to serve as a protective factor for youth. A 2007 study on the impact of traditional language use on youth suicide in BC First Nations found that youth suicide rates effectively dropped to zero in those few communities in which at least half the band members reported a conversational knowledge of their own "Native" language. [42]

Table 5: Percent of Respondents who Identify Factors as a Barrier to Helping YOUTH

	Across Province	Treaty 6	Treaty 7	Treaty 8
co-existing mental health or emotional issues	73.1%	65.7%	89.2%	63.9%
negative peer influence (e.g. gangs)	85.2%	85.7%	89.2%	80.6%
dysfunctional or abusive family	92.6%	85.7%	97.3%	94.4%
unstable living situation	85.2%	82.9%	97.3%	89.9%
not in school or poor school engagement	89.8%	57.1%	97.3%	52.8%
fetal alcohol syndrome	69.4%	68.6%	89.2%	69.4%
learning disabilities	75.9%	68.6%	89.2%	69.4%

Respondents made a few comments that barriers to helping youth included lack of family support, self-esteem issues, poor relationships in their community, and lack of purpose/spirituality. A large number of individuals complained that in their communities, there was little or no after school activities for youth – no sports activities, no cultural activities, and no educational activities. Additionally, several individuals mentioned that there were just not enough treatment centres for youth in Alberta.

Despite these concerns, respondents made reference to many strengths and assets in their communities that were good for youth. Some respondents stated they had good youth counselling and an Alateen program in their community. Those communities near urban centres mentioned access to cultural and recreational resources in the city. Some mentioned activities organized by their wellness centre or the school. There clearly seemed to be strong differences between various communities in regards to resources for youth to keep them positively engaged in social, emotional, recreational, educational and family activities.

In 2004, AADAC developed the Illicit Drug Community Response Model. This model recognizes that community involvement is a key factor to identifying and addressing local drug issues. Collaborative implementation and evaluation across local, provincial and national levels of the community response model will contribute to a more timely and considered response to drug issues, and will provide further opportunity to strengthen community capacity.

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42 Science Direct. Cognitive Development 22 (2007) 392–399 Aboriginal Language Knowledge and Youth Suicide. Darcy

Hallett a,b,*, Michael J. Chandler b,, Christopher E. Lalonde c,

In a study to examine healing work in Aboriginal communities in Canada, the authors discuss a relatively new approach, called multi- systemic therapy (MST) that currently focuses on at-risk youth. "Essentially what it does is it transforms the web of relationships around a young person. Studies show that young people living in the same community with the same range of services available to them have dramatically different outcomes (Leschied & Cunningham, 2000). The variable is the on-going presence of a healing mentor who is on-call around the clock for 4-6 months. They coach, cajole, mirror, encourage and provide structure for young people. They teach significant adults and systems to work with and communicate with the young person in new ways. They support families to learn and practice accessing existing resources and applying new insights" (p28). [43]

In focus groups, youth were asked what needed to happen in their community to make it healthier. The majority of the youth responded that more workshops, conferences, and community meetings are required to raise awareness of addictions and alcohol and drug misuse. The majority of the youth also felt that more youth programs and recreational activities are needed in the community; including more support for youth and activities to motivate youth to get involved in the community.

The majority of the youth also felt that there needs to be more communication in the community, and with youth in particular, on the issues of alcohol and drugs abuse and that the issues should be put before the people of the community. It was also indicated that youth would benefit from personal development and personal growth training and opportunities to learn about their culture, history and traditions through gatherings, sharing circles and cultural activities. The youth also responded that the community needs to recognize and honour people in the community for their achievements.

The majority of the youth felt that the involvement of parents in their lives and issues is important to them, and that all the teachings, awareness and education on alcohol, drugs and addictions start from home. The youth stressed the important of having more family and community events to interact with each other in a positive manner. The youth felt that all these issues were important in making the community healthier; however, advertising, posters and flyers are equally important to get people out to the events.

When asked what it takes to mobilize a community into doing things on their own, the majority of the youth responded that more recreational activities are needed in the community for youth including dances, hiking, camps, and outings/trips. The youth also felt that youth centers would be beneficial whereby youth can drop by for activities and games, and that resources will be available to them on issues affecting their everyday life. The youth also felt that crisis centers, crisis intervention drop in centers and after care programs would provide community members with the support they need to assist them in combating their addictions. The youth also indicated that community people

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43 Mapping the Healing Journey, The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities APC 21 CA (2002) Four Directions International Lethbridge, Alberta.

http://www.fourworlds.ca/pdfs/Mapping.pdf

need to feel safe when accessing services and participating in community events. And that the community should make it safe for members by providing more security and to address issues of bullying in order that children will feel secure enough to get involved in community events and activities. The majority of the youth felt that social activities, community gatherings and powwows are important to provide support and getting people out to socialize. The youth felt that elders should be brought into the schools more to talk to them about alcohol and drugs and that more workshops are required in the community. The youth felt that all these issues were important in getting the community to do things on their own; however, advertising, postings and flyers are equally important to get people out to the events and to provide people with transportation.
When asked what the NNADAP worker can do to activate the community, the youth responses consisted of the following:

- More community meetings and workshops regarding alcohol and drugs
- Creating awareness through community newsletters and bulletins
- Creating awareness of the dangers of alcohol and drugs
- Alcohol and drug prevention
- Drug Abuse Resistance Education (D.A.R.E.)
- Youth groups
- Health workers being more visible in the community
- Arts and crafts programs
- Sober events such as sober dances and sober walks such as National Addictions Awareness Week (NAAW)
- More access to health centres
- Documentaries and videos made accessible to community members on the dangers of alcohol and drugs
- Fund raising events
- Promote individuals getting more involved in the community
- Motivational speakers in schools to talk about smoking, and alcohol and drugs
- More interaction with youth such as youth involvement in planning community events and activities
- Recreational activities such as basketball, volleyball, baseball and day camps
- Elders to share wisdom with youth
- Setting up task force in the community for drugs and gang related issues
- Counselling services
- More funding for programs

Recommendations

Recommendations have been organized into those pertaining to Prevention vs Treatment services as well as recommendations for various kinds of Organizational Supports.

<u>Prevention Services</u>

- Increase community awareness and education about the affects and social determinants of drugs, alcohol and services on youth. Involve community in developing solutions.
- Invite the youth to participate in the organizing and hosting of alcohol and drug free activities
- Include youth in identifying the issues that need to be addressed

- Develop youth leadership councils
- Provide youth with the leadership training opportunities
- Provide youth with training in group facilitation and problem solving
- Strengthen traditional cultural practices and language skills, involving youth in cultural activity
- Engage community support systems to assist the youth to develop a strategic plan to address alcohol and drug misuse
- Facilitate relationships between Elders and youth, to share knowledge and history and culture
- Community support for youth groups (leadership, financial and mentorship)

Treatment Services
- Increase the number of youth treatment centres
- Expand youth treatment continuum to include more prevention and aftercare
- Implement multi- systemic therapy (MST) to transform the web of relationships around a young person.

Organizational Supports
- Increase funding for youth programs (for staff and activities)
- Support communities to include a youth specialist's worker as part of the wellness team
- Increase employment opportunities for youth

Promising Practices for Youth [44]

Following are some promising practices for youth prevention/intervention. These programs vary in terms of available evidence supportive of effectiveness claims**.**

In March 2007 the **Aboriginal Youth Suicide Prevention Strategy** (AYSPS) announced a new education, awareness and training grant program designed to help communities address youth suicide through the promotion of protective factors. The AYSPS is pleased to report that 35 out of 47 applications received funding. Grants ranged from $3,052 to a maximum of $5,000. A total of $171,946 was awarded to applicants.

Since 2006, **Pine River Institute** (located outside of Toronto) has provided an intensive residential treatment centre for youth in crisis. It targets young people who have exhausted other interventions, offering a new, creative approach. At Pine River, family-centered wilderness combines with therapeutic and academic programs in a unique, holistic treatment and educational model. They remain supportive of families long after the program ends. The guiding principles of Pine River are based in research, including relevant literature, advice from specialists, and consultation with industry experts. Program and outcome evaluation research shows that Pine River works. Ongoing outcome research shows a significant decrease in substance use as well as in crisis indicators for participants. It reveals significantly improved physical and family health,

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44 Prevention of Aboriginal Youth Suicide: An Alberta Approach—Spirit of Hope Volume 11 Issue 2

http://www.justice.gov.ab.ca/downloads/documentloader.aspx?id=47997 accessed May 08-2009

over 90% regular attendance at school, and increased engagement in work, volunteer positions, and structured leisure activities. The outcomes from Pine River's research are incorporated into ongoing program development. These outcomes include feedback from alumni students and families, as well as professionals in the community working with students before treatment.

In May 2006, the Alberta Mental Health Board (AHMB) launched **Grip Magazine.** What's great about Grip magazine is that it tackles the issues that youth care about in an open, honest manner. Additional information and resources for youth are found on its website www.griponlife.ca. Youth can also be a part of the Grip Youth Advisory Council. The council provides advice to Grip's editors about the direction and content of the magazine and website and helps to identify the issues facing today's youth. This is a unique opportunity for youth to meet and interact with other youth from across Alberta and get a behind the scenes look at the publishing world. To ensure the perspectives of Alberta's youth are well represented, Grip is looking for youth from different communities in Alberta who represent a wide range of interests and backgrounds.

Mamawoketeyowitan* Pilot Site Is a new pilot site for the AYSPS in Hobbema. This program supports youth suicide prevention and intervention by providing positive nurturing programs through self well-being, leadership, and personal development including, and most importantly, to be a proud first nation community member of the four nations in Hobbema. The Ermineskin Cree Nation, Louis Bull Tribe, Montana First Nation, Samson Cree Nation and Pigeon Lake Reserve are located 100 kilometres south of the City of Edmonton, with a population of 18,000.

Eden Valley is looking forward to its third year of **the Alberta Future Leaders Program.** The program uses sport, recreation, and leadership development as prevention and intervention tools to address the needs of Aboriginal youth. Two qualified summer youth workers facilitate the program.

Piikani Suicide Prevention Program. An on-Reserve program that delivers awareness, community preventative activities, resource referrals, counselling, training and youth enhancement activities in and around the community and schools. The program is currently run through Piikani Child & Family Services as the host agency. In conjunction with the Piikani Youth Chief & Council nominations and elections, six Piikani high school graduates go to an Indigenous Leaders Forum in Victoria. The selection of youth is based on an essay writing contest surrounding indigenous governance and its applicability today. The community also hosts a suicide awareness 5km walk/run race that raises raise awareness of the issue and provides an opportunity for a positive community gathering while exemplifying preventative measures of combating depression and suicidal tendencies. Through the months of July and August 2007, training was provided to 10 Piikani youth in the Peer Health Mentors Program. The training encompassed understanding holistic notions of health and well being, so that these youth could be mentors and resources in the community for suicide. The program provided various outdoor wilderness training activities throughout the summer for youth, including a Blackfoot cultural camp for the community. The project recruits and works closely with youth in the area of suicide prevention by raising awareness and education through workshops and group gatherings. Urban Aboriginal youth are involved in traditional and cultural teachings which then are linked to suicide prevention. A series of cultural camps are held during the summer months with opportunities to connect with Elders. The community strongly believes in connecting youth to their cultural roots assists them in

making healthy choices throughout their life. They are also committed to assisting in the prevention of suicide amongst their people

Hinton Friendship Centre Society: Hinton Aboriginal Drug Awareness Program [45]
In partnership with the Hinton Friendship Centre, Mamawi Wichitowan Wellness Program, Aboriginal Interagency Program, Hinton Urban Multipurpose Aboriginal Youth Centres and Hinton Elders Group, this project creates awareness on the issue of crystal methamphetamines in the Aboriginal population of Hinton and surrounding communities. The Aboriginal liaison worker set up workshops for parents, Elders and other community members as well as a special youth conference, and is introducing youth activities to address substance abuse and support healthy lifestyles. The events provide resources relevant to Hinton's Aboriginal youth in a culturally sensitive environment that encourages their participation. The project was evaluated through pre- and post-conference surveys and a qualitative collection of information in the form of stories collected from the Elders.

SECTION 6.2 Women

Needs and Issues

In general, women see alcohol/drug use as a response to social, mental health or health needs or issues. Women are less likely than men to perceive their drinking as a result of difficulties (legal, financial, family or work-related) in their lives. Instead, they identify anxiety, depression and stressful events as contributors. Gomberg (as cited in Beckman, 1994b)[46] reported that the most frequent reasons given by women for seeking treatment are depression, medical problems, problems with family relationships and feelings related to children leaving the home.

The current health status of Aboriginal women has been chronicled in a number of reports. The Health Canada Women's Health Bureau, provides a concise summary of the current health realities of Aboriginal women that influence substance abuse: [47]

1. Life expectancy for Aboriginal women is 76.2 years vs. 81.0 for non-Aboriginal women.
2. The birth rate for Aboriginal women is twice that of the overall Canadian female population. Aboriginal mothers are younger– about 55% are under 25 years of age (vs. 28% for the non-Aboriginal population) and 9% are under 18 years of age (vs. 1% for the non-Aboriginal population).

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45 Contact Information: Ms. Irene Beaverbones Regional Aboriginal Liaison Program Hinton Friendship Centre Society

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46 Beckman, Linda (1994b). "Treatment needs of women with alcohol problems," Alcohol Health and Research World, 18, 3: 206 - 211.

47 Health Canada, Women's Health Bureau: The Heath of Aboriginal Women (website).

3. Mortality rate due to violence for Aboriginal women is three times the rate experienced by all other Canadian women. For Aboriginal women in the 25 to 44 age cohort, the rate is five times that for all other Canadian women.
4. Women are often the victims of family dysfunction, which result from the alcohol or substance abuse. Hospital admissions for alcohol related accidents are three times higher among Aboriginal females than they are for the general Canadian population. Over 50% of Aboriginal people view alcohol abuse as a social problem in their communities. Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) have emerged as a health and social concern in some First Nations and Inuit communities.
5. Suicide rates remain consistently higher for the Aboriginal population than the general Canadian population, as a whole, in almost every age category. Over a five year span (1989-1993), Aboriginal women were more than three times as likely to commit suicide as were non-Aboriginal women.

Low esteem is one causative factor that the majority of drug and alcohol addicts share. Those who possess low self-esteem are typically challenged in four key areas: they feel they lack personal power, they feel as though they are insignificant to others, they feel they lack virtue and often feel unloved, and they hold themselves as incompetent in one or more areas of life.[48]

Recent Canadian research (Health Canada, 1995; Health Canada, 1997, Canadian Centre on Substance Abuse and Centre for Addiction and Mental Health, 1999) identifies the following patterns of substance use among women:

- Alcohol is the most common substance used and misused by women
- Women, in comparison with men, are less likely to be current drinkers, and more likely to be former drinkers or lifetime abstainers
- Among women who are current drinkers, 6.2% report the occurrence of an alcohol-related problem in the past year
- The most common problem that women associate with "problem" alcohol use is related to impacts on physical health
- Women most frequently drink with a spouse or partner
- In any age group, women are more likely than men to report the use of medications, especially psychoactive medications such as sleeping pills, tranquillizers and anti-depressants. The age categories reporting the heaviest use are 45 to 54 and 65+
- Marijuana and hashish are the most common drugs used illegally by women. Except for marijuana, lifetime illegal use of drugs is relatively rare among Canadian women. Illegal use of drugs decreases with age and is almost non-existent after age 45
- Cocaine, crack, LSD, amphetamines and heroin are used primarily by sub-group populations (e.g. street involved women). Because general population surveys usually miss these groups, the overall use of these drugs may be under-reported
- In 1995, there were 804 deaths in Canada attributable to illicit drugs. One hundred eight (13%) were women

[48] Dr. Joseph Robino, Center for personal reinvention, Boxford MA,

In community focus groups, (approximately sixty-five percent were women) participants were asked if they thought alcohol and drugs were a problem in their community. Every one of the participants responded that alcohol and drugs effected their community in some manner. Approximately seventy-five percent of the communities indicated that the most prominent drugs abused are crack and cocaine; however, other drugs such as, methamphetamine, marijuana, ecstasy, and prescription drugs are widely used. .

The majority of the women felt that alcohol and ecstasy are big problems in the community; especially amongst youth and that in some communities young kids are being used as drug runners for the drug dealers in the community. One participant commented that "The children are being intimidated and forced to sell drugs for the drug lords." Overall, the women felt that there are a lot of drug dealers in the community.

The majority of the women felt that children are being neglected and that in some communities there are high rates of child apprehensions. The majority of the women felt that alcohol and drug misuse contribute to children being removed from their homes and placed in group homes and foster homes. The majority of the women also believed that alcohol and drug misuse impacted the family structure, resulting in broken home and families.

In those communities that reported that substance abuse was high, these women felt that there are high rates of crime in the community such as theft, break and enters and vandalism so that people can support their alcohol and drug addictions. The women also spoke of violence and abuse in their communities. In general most women felt that alcohol and drug abuse contributed to physical, mental and sexual abuse of women, children and elders in the community and that incest is also happening within the community.

Women also commented that because of substance abuse (mainly drugs) they thought that prostitution was on the rise and there are "sugar daddies" in the community trading drugs for sexual purposes to young girls and women. The women also indicated that there is a higher rate of prevalence of fetal alcohol affects in the community, due to alcohol and drug misuse during pregnancy.

A few communities in Treaty 6 indicated that there are financial implications to alcohol and drug abuse, insofar as people selling and pawning items from their homes to support their addictions; they even go as far as selling and pawning off cultural artifacts.

In addition, there continues to be reports of solvent abuse amongst a group of individuals, some of whom are known as "The Backstreet Boys". These are men who frequent the neighbouring towns in the wooded area. Lysol and Listerine are the solvents most commonly abused. .

The majority of the women felt that children are not listening to their parents and have no respect for their parents and the parents have lost control and authority over their children. The majority of the women also felt that there is a loss of cultural identity and respect for traditions.

When women were asked what group of people in the community are most affected by alcohol and drug abuse, all women responded that youth, children and elders are all

affected. The majority of the women indicated that some elders are financially abused and that youth are affected through peer pressure, teen pregnancies and sexually transmitted diseases. The majority of the participants also felt that the whole community and all age groups are affected, including families and individuals who do not abuse alcohol and drugs and parents. In some communities, women felt that individuals who do not abuse alcohol and drugs are the ones being abused by their children or other family members and they see the affects of alcohol and drugs on their family and loved ones.

The majority of the women felt that elders and mentally and physically challenged people are being abused financially, emotionally and physically by family members.

Women also felt that teenage girls are affected by using alcohol and drugs during pregnancy and youth are engaging in unprotected sex resulting in high rates of sexually transmitted diseases including HIV/AIDS. The majority of the women also felt that family relationships and structures are affected and there are high incidences of extramarital affairs. A large number of women commented that they felt that young families are not looking after their children and that "people do not know what honour means." They also thought that parenting skills have deteriorated and substance abuse worsens an already chronic problem.

Fillmore and Dell discuss the findings of a study on women and self-harm and substance abuse. They begin with the premise that substance abuse is a form of self harm and that it is a form of coping and a survival technique from emotional pain and distress rooted in violence and childhood trauma and abuse. Fillmore and Dell conducted interviews with First Nations and Inuit women who were in treatment centers.[49] They found that illicit drug use amongst criminalized Aboriginal women is a serious health concern in Canada. The study examines how women's healing is impacted by their view of themselves as an Aboriginal drug user within Canadian society.[50]

The political oppression of Aboriginal women contributes to their experiences with poverty, low status and exposure to violence. Authors Bourassa, McKay–McNabb and Hampton examine the impact of the Indian Act, tying it to external pressures faced by Aboriginal women. They assert that the "fight for change must focus on particular concerns involving internalized racism and sexism rather than arriving at vague concepts that in the end do not improve Aboriginal women's health" [51]

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49 A collaborative three-year research project, spearheaded by Carleton University, the National Native Addictions Partnership Foundation and the Canadian Centre on Substance Abuse, was funded in January, 2005 by the Canadian Institutes of Health Research, Institute of Aboriginal Peoples' Health.

50 Fillmore, C. & C. Dell (2005). Community Mobilization for Women and Girls Who Self-Harm: An Environmental Scan of Manitoba Service Fry Providers. Manitoba: Elizabeth Society of Manitoba. http://www.pwhce.ca/pdf/self-harm.pdf

51 Bourassa, Carrie, Kim McKay-McNabb and Mary Hampton. "Racism, Sexism and Colonialism: The Impact on the Health of Aboriginal Women in Canada." Canadian Woman Studies/les cahiers de la femme. Special Issue: Women's

In large group discussions the NNADAP Workers identified the primary need to be met in order for women to address substance abuse is to have childcare and to address their concerns for reuniting with their children that are in foster care**.** Women reported that it is difficult to attend appointments, treatment and aftercare support programs if there isn't childcare support available. There is one treatment centre in Alberta that provides family treatment services providing the children are under school age (Beaver Lake Wah Pow Treatment Centre). Specific skill building training and education opportunities in parenting and traditional parenting skills, basic life skills such as cooking, active living, and traditional arts and crafts activities were seen as fundamental to recovery from addictions. NNADAP workers reported that women need support services in the form of women's groups, sharing circles and mental health awareness. It was noted that women in particular are naïve to mental health issues such as depression, PTSD, co-occurring disorders, suicide and the affects of low esteem.

NNADAP workers made the comment that women often feel that they have nowhere to turn to and have very little emotional support. The feelings of isolation, the lack of support services and poor coping skills contribute to substance abuse and neglect.

The majority of substance abusers are young women under 30 years of age. For that reason, survey respondents were asked to specifically comment on what were the most serious problems among young women. Survey respondents identified alcohol use, marijuana use, smoking cigarettes, junk food binging, prescription drugs, and crack/cocaine as the most serious addictions experienced by youth women.

Table 6 provides a percentage of respondents who felt there were many problem and chronic users in their Treaty. In terms of Regional differences, there were more respondents in Treaty 7 perceiving alcohol, prescription drugs and junk food binding to be a problem, while a high percentage of respondents in Treaty 6 reported marijuana use to be a greater problem. Over 30% of the respondents in Treaty 7 perceived methamphetamines as a problem with many youth.

Table 6: Percentage of Respondents who Perceive there are Many Problems to Chronic Users among **YOUNG WOMEN** in Community [52]

Health and Well-Being, vol. 24, no. 1 (Fall 2004), pp. 23-29.

[52] For the purposes of this survey, young women are considered to be between the ages of 19-30, in other referenced studies it may be a general category and exact ages may differ slightly.

USING	Across Province	Treaty 6	Treaty 7	Treaty 8
Alcohol	83.4%	77.4%	92.1%	80.6%
Marijuana	75.0%	89.2%	63.1%	76.4%
Solvent Use	18.0%	8.6%	29.4%	17.1%
Methamphetamines	24.3%	26.5%	30.5%	16.2%
Prescription Drugs	60.2%	51.3%	86.4%	45.9%
Ecstasy/Hallucinogens	26.2%	18.8%	23.5%	37.1%
Crack/cocaine/heroin	60.8%	65.7%	62.2%	57.1%
Cigarettes	95.6%	92.1%	100%	94.6%
Junk Food Binging	68.2%	51.3%	86.1%	68.5%
Gambling	57.8%	48.5%	66.7%	61.1%
Anorexia or Bulimia	16.5%	6.0%	37.9%	9.1%

Several co-occurring issues with substance abuse were perceived to be common among young women in their communities. More than 87% of the respondents identified sexual promiscuity, depression or anxiety, suicidal thoughts and aggression towards others as serious issues. Alarming was that 92% or more of the respondents in Treaty 7 perceived suicidal thoughts and depression/anxiety to be a co-occurring disorder among young women who are using alcohol and drugs.

Gender specific research on addictions has uncovered that women's recovery is best facilitated when it is done among other women, not in isolation, as this environment facilitates trust and commonality within the group. Other findings include trauma, which is extremely prevalent among female alcohol and other drug (AOD) users, and can be caused by sexual abuse, physical abuse, emotional abuse, domestic violence, witnessing abuse/violence, and/or stigmatization of incarcerated women, women of color, poor women, lesbians, and women with mental illness. Treatment programs need to be sensitive to the unique needs of lesbians, specifically issues related to discrimination and homophobia, sexual identity issues, isolation, and possible shame.

As a result, women internalize the post traumatic stress disorder (PTSD) and this causes depression and anxiety resulting in poor interpersonal skills and low self-esteem, avoidant coping skills, shame and guilt.

Table 7: Percentage of Respondents who Perceive **YOUNG WOMEN**, Who Use Alcohol and Drugs, are also exhibiting Other Co-Occurring Problems.

	Across Province	Treaty 6	Treaty 7	Treaty 8
sexual promiscuity	87.2%	86.8%	91.7%	82.9%
suicidal thoughts	74.3%	63.2%	91.7%	68.6%
thoughts problems	56.0%	47.4%	61.1%	60.0%
Aggression to others	78.9%	73.7%	86.1%	77.1%
harmful to others	54.1%	50.0%	66.7%	45.7%
conflicts with police	60.6%	44.7%	72.2%	65.7%
depression or anxiety	89.0%	81.6%	94.4%	91.4%

In general, not many survey respondents (8%) perceived young women in their community who are using alcohol and drugs to be motivated to engage in support or

treatment. Only 9% of respondents in Treaty 6 felt young women were motivated, 8 % in Treaty 7 and 5.8% percent in Treaty 8.

Many studies agree that women with drug addictions, alcoholism, eating disorders, sex addictions and co-occurring disorders benefit from gender-specific treatment programs because substance abuse in women has a distinctive aetiology, disease progression and specific treatment needs. Research shows that for men and women substance abusers and the consequences of their addiction are substantially different and include low self-esteem, lack of traditional job skills, depression, eating disorders, social isolation and lack social support networks, and a strong value system.[53] Studies of women's recovery have been found to be very different from men.

Pregnant Women

The use of alcohol and drugs during pregnancy is an important health issue in Canada. Until recent years, little was said about the effects of alcohol and pregnancy, which could be due in part because, in the past, it was felt that women did not have problems with alcohol. Today, public media campaigns and health promotion have focused on preventing harm due to alcohol to the unborn child. Generally, there is an increased awareness of Fetal Alcohol Spectrum Disorder (FASD) among First Nation women.

Alcohol use during pregnancy can cause a variety of developmental, behavioural and cognitive impairments in unborn babies. It is now known that FASD is completely preventable, providing the mother does not take alcohol during pregnancy. The reported rates on FASD are alarming for First Nations; this may be, in part, due to the focus on this demographic group. Canadian studies of FASD prevalence rates have focused on Aboriginal communities where rates of alcohol abuse and dependency are known to be high.[54] This may disproportionately over represent Aboriginal people. Regardless of the possible over representation, among many First Nation communities there are concerns that the rates are under reported, in part, due to a lack of diagnostic capacity and effective assessment tools. Furthermore, those services that are available are not evenly available across the country. In general terms, Health Canada's Framework for Action on FASD reports that the incidence for FASD is estimated to be nine in 1,000 live births.[55]

Focus group respondents identified women and young women in particular, to be affected by alcohol and drug misuse in their communities. They stated that young women may not know they are pregnant and continue unhealthy lifestyle practices such as drinking alcohol, using illicit drugs, using tobacco and having poor eating habits. Respondents said that the alcohol and drug abuse affects the mother, the child, family members and the community as a whole. This was seen especially troubling when the child is born with FASD. Many stated that there simply weren't the resources, financial or medical, within First Nation communities to support children with FASD. Seniors spoke

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53 http://www.treatment-centers.net/womens-recovery.html

54 Tait, C.L. (2004). Fetal Alcohol Syndrome and Fetal Alcohol Effects: the 'Making' of a Canadian Aboriginal Health and Social Problem. Montreal: McGill University, unpublished Ph.D. dissertation

55 Public Health Agency of Canada. (2003). fetal alcohol spectrum disorder (FASD): A framework for action. Ottawa:

of the burden it places on the family when the grandparents are left with the responsibility for raising grandchildren.

One of the high risk groups for pregnancy and drinking is the youth. It is known that the rate of aboriginal adolescent pregnancy is four times higher than non-aboriginal youth. Adolescent girls are a high risk group for a number of reasons, such as age, lifestyle, and limited knowledge. As well, girls may not seek medical attention until they are into the second trimester. For the young mother, there are a number of health and social consequences that accompany pregnancy which include medical complications, inadequate social situations, unemployment, low income, poor nutrition, low birth weight babies and the potential for a baby to be born with FASD.

Unlike the general population, in First Nations communities, adolescent pregnancy is not stigmatized and often the child stays within the family system. Adolescent pregnancy is a trend that has increased and with it has come other social ramifications that place additional burdens on grandparents who are struggling on limited incomes and little support. The seniors who participated in the community focus groups commented that this was not how traditional families functioned. Traditionally, the grandparents were support to the family system but the primary caregivers to children were the parents. Today, many grandparents have taken on the responsibility of raising grandchildren. Aboriginal women have been identified as having poorer pregnancy outcomes than other Canadian women, but information on risk factors and outcomes has been acquired mostly from retrospective databases.[56]

A study on pregnancy and aboriginal women found that the overall rates of alcohol consumption were lower among First Nation adults living on-reserve (18 years and over) but heavy drinking was higher among First Nations than the general population. 10.2% of First Nations females compared to 3.3% of the general population reported heavy drinking on a weekly basis.[57] This increases the risk of FASD.

An Alberta Study (2004) of substance use patterns among Alberta women of child bearing years (ages 18 to 44) found that women who use substances may also be experiencing other health issues and problems. It was reported that Alberta women who were pregnant at the time of the survey were much more likely to say that drinking had interfered with their lives than Alberta women who were not pregnant. For example, 28.1% of women who were pregnant at the time of the survey reported having emotional problems due to alcohol use versus 9.9% of women who were not pregnant.[58] The percentage of Alberta women who reported drinking during their last pregnancy was 9.2%.

According to Alberta Health and Wellness, 1.7% of Alberta women who had a live birth between 1998 and 2000 used street drugs during pregnancy. Women who used street

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[56] Wanda M. Wenman, Michel R. Joffres and Ivanna V. Tataryn and the Edmonton Perinatal Infections Group. A prospective cohort study of pregnancy risk factors and birth outcomes in Aboriginal women

[57] ibid

[58] Alberta Alcohol and Drug Abuse Commission. (2004). Windows of opportunity: A statistical profile of substance use among women in their childbearing years in Alberta. Executive Summary. Edmonton, Alberta, Canada: Author.

drugs during pregnancy were younger and more likely to have low-birth-weight or preterm babies [59]

In looking for solutions to addressing pregnancy and alcohol and drug misuse, it is helpful to understand the reasons that may influence a woman's choice to use alcohol or drug during pregnancy. Table 8 presents information based on studies that show that co-existing conditions exist in pregnant women who use alcohol.

[59] Alberta Health and Wellness, & Alberta Medical Association. (2002). Alberta reproductive health: Pregnancies and births. Edmonton, AB: Author.

Table 8 Summary of Co-existing Conditions Experienced by Pregnant Women Who Use Alcohol [60]

Table 8	
sole parenting	violence, abuse, sexual exploitation, trauma
child(ren) in custody/changes in custody	involvement in the criminal justice system
low income/social economic status/poverty	low social support
limited access to prenatal/postnatal care services	previous birth of a child with prenatal and exposure to alcohol and/or other substances
feeling/experiencing loss of control	low education and literacy levels
menial, low-paying employment problems	concurrent physical and mental health
cognitive impairments, possibly due to FASD	co-existing use of other substances
unplanned pregnancy/pregnancies low self-esteem	shame
historical and cultural factors pregnancy	depression and other mental health issue(s)
older in age	heavy consumption of alcohol prior to inadequate nutrition
mother's own prenatal exposure to alcohol, tobacco or other drugs	alcohol, tobacco or other drug exposure at young age
poor early childhood environment of the women (stress, abuse, neglect)	paternal/partner alcohol and drug use during the pregnancy
physical, mental, social and spiritual imbalance	unstable housing and living conditions

There is tendency among teens and young adults to combine binge drinking and sexual activity. This group is seen as an important target for universal prevention efforts. The Social Influence Model [61] applies interactive approaches to general drug education at the secondary school level. These approaches to preventing FASD include pregnancy planning, resisting peer pressure to use alcohol or engage in sexual activity, early symptoms of pregnancy, the importance of routine physical exams for sexually active female adolescents, understanding the needs of those affected by prenatal alcohol exposure, and problems confronting parents of affected children. [62]

It was concluded in a literature review on Aboriginal women's health and addictions services that "little focused attention has been paid to the issue of providing gender – specific support to Aboriginal women with substance use problems (Poole and Trainor 2000:2)

Social marketing campaigns have been seen to have some influence on pregnant women. Hankin found that women who were at low risk reduced their alcohol

[60] Research update: Alcohol use and pregnancy: an important Canadian public health and social issue / Colleen Anne Dell and Gary Roberts.

[61] McBride, N. (2003). A systematic review of school drug education. Health Education Research Theory and Practice, 18(6), 729–742.

[62] Murphy-Brennan, M., & Oei, T. (1999). Is there evidence to show that fetal alcohol syndrome can be prevented? Journal of Drug Education, 29(1), 5–24.

consumption following the implementation of warning labels but that women who drank heavily during pregnancy did not [63]

To help prevent the effects of alcohol on pregnant women and their unborn babies, it is recommended that health care providers commit to a general message that says "being sexually active, a frequent alcohol user, and not using effective contraception places a woman at risk for having an alcohol-exposed pregnancy". [64]

The substance use literature documents stigma and resulting guilt and shame as barriers for women, in particular mothers, to accessing treatment (Currie 2001, Poole and Isaac 2001).In a number of personal interviews with experts who work with women with addictions issues, it was felt that awareness campaigns have limited impact on changing lifestyle or drinking or drug use patterns. At risk women respond best to direct one-to-one support from people who are knowledgeable about addictions and the social factors impacting their lives.

There is the general perception among a number of resource people who work with aboriginal women that the NNADAP treatment centers are reluctant to accept pregnant women because they may lack (immediate) access to emergency medical services. It was also the belief that aboriginal women were not referred to provincial treatment centres because they were to be first referred to NNADAP treatment centres. Costs to attend provincial services were seen to be as high as four thousand dollars for residential treatment and this amount exceeded what NNADAP could pay. Furthermore, the standard practice for referral to NNADAP treatment centres requires that the client participate in four office visits for treatment counselling. This was seen as a barrier for pregnant women who may have a small window of opportunity for referral. This perceived lack of access to treatment centres seemed to be a common misconception. Upon further investigation, it was confirmed that NNADAP treatment centres do accept pregnant women (one woman who was in her third trimester had recently been accepted) and that NNADAP was working with provincial services on an agreement for fees. As well, NNADAP workers have been instructed to place high priority for pregnant women and the required four pre-treatment office visits could be waived.

Personal interviews with resource people who work with pregnant women concluded that the best intervention for pregnant women was the one-to-one support provided by community and outreach programs. These programs were seen to be able to build personal relationships with women and in doing so, also built trust. It was commented that "pregnant women are suggestible", meaning that where there is trust and a supportive environment, pregnant women at risk will change their behaviour. It was the belief of these resource people that the root of substance abuse was often family violence, childhood abuse, sexual abuse, untreated mental health problems, and the women see "substance use as a panacea". One respondent commented that "every penny spent on building relationships with these women – saves millions (of dollars) by preventing future (FASD) damage and loss."

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[63] Hankins, J. et al. (2001). The impact of the alcohol warning label on drinking during pregnancy. Journal of Public Policy and Marketing, 12(1), 10–18.

[64] Floyd, L., Decoufle, P., & Hungerford, D. (1999). Alcohol use prior to pregnancy recognition. American Journal of Preventive Medicine, 17(2), 101–107.

Resources and Services Available

NNADAP workers reported to have access to a number of addictions services available for women, such as residential treatment centres, AA, NA and addictions workshops, one-to-one counselling, and referrals. Social activities that are available include family oriented activities, gym nights, round dances, parenting classes, craft night, women's retreat, women's shelter, prenatal groups, mental health, family violence workers and access to provincial services from the AADAC (Alberta Alcohol and Drug Abuse Commission).

The access to services is largely dependent on the location of the First Nation community and the number of available support services and resource people. At a glance, it appears that there are a number of services available to women when in fact the actual number of services available in each community is limited in scope. In addition to the need for improved child care resources, women's shelters, transportation and community involvement, workers reported a need for services and support for non-addicted spouses, and workers who specialize in sexual abuse. It is recognized that, overall, women require more educational opportunities along with addiction recovery services.

Alberta Health Services offers six residential treatment programs specifically for women. Four in Calgary (Aventa Addiction Treatment for Women, Enhanced Services for Women (ESW), Oxford House, Youville Women's Residence) , three in Edmonton (Enhanced Services for Women, McDougall House Association, Henwood Treatment Centre), and one in Grand Prairie (Enhanced Services for Women). [65]

In the survey completed by NNADAP and wellness workers, the perception across the province was that intervention resources for women was high in terms of assessment and referral, one-to-one counselling, and prenatal/parenting counselling. But half or less of these respondents did not think resources such as detoxification services, mental health and substance abuse treatment, and sexual abuse counselling were readily available. Concern that resources/treatment were not available was more pronounced in Treaty 6 than in the other Treatys; especially in terms of the availability of detoxification services, aftercare counselling, mental health services and sexual abuse counselling.

Table 9: Perception of Whether Resources for **YOUNG WOMEN** Are Available Within Two Weeks

USUALLY OR ALWAYS AVAILABLE	Across Province	Treaty 6	Treaty 7	Treaty 8
detoxification services	49.1%	27.8%	72.2%	44.1%
assessment and referral	83.5%	75.0%	94.3%	80.5%
one-to-one counselling	90.0%	83.7%	97.2%	88.9%
prenatal/parental counselling	81.5%	75.0%	91.2%	83.3%
residential treatment	60.2%	62.9%	70.6%	51.3%
aftercare counselling	60.4%	52.8%	67.6%	58.9%
mental health and substance abuse treatment	57.4%	40.0%	74.3%	61.1%

65 Alberta Health Services http://www.aadac.com/86_381.asp

sexual abuse	56.4%	47.2%	70.6%	55.6%

About 25% of the survey respondents across the province felt resources and treatment were very effective. And then when "somewhat effective" responses were added in, about 90% of respondents were positive about the resources/treatment. There were only small Regional differences. For the most part respondents from each of the Treatys had a favourable perception of treatment effectiveness; that it was somewhat to very effective.

Table 10: Perception of Service Effectiveness for **YOUNG WOMEN** perceived to be Somewhat to Very Effective

USUALLY OR ALWAYS AVAILABLE	Across Province	Treaty 6	Treaty 7	Treaty 8
detoxification services	87.1%	85.3%	91.6%	83.3%
assessment and referral	93.5%	88.2%	100%	91.4%
one-to-one	96.3%	97.2%	100%	91.4%
prenatal/parental counselling	87.6%	88.9%	84.8%	88.6%
parenting skills training	90.5%	88.6%	97.0%	85.7%
residential treatment	86.0%	88.5%	88.2%	80.5%
aftercare	82.7%	88.3%	80.0%	78.8%
mental health and substance abuse treatment	90.4%	91.2%	94.3%	85.3%
sexual abuse	90.9%	94.1%	93.8%	84.4%

Aboriginal scholar Madeline Dion Stout explains that when addressing the health needs of Aboriginal women, it is important to understand the needs within a contextual framework: Aboriginal women's relatively poor health status (when compared to that of non-Aboriginal Canadian women) can only be understood in the context of a range of health determinants, including socio-economic status, education and employment conditions, social support networks, physical environment, healthy child development and access to health services [66]

Key experts identified barriers to treatment in four main areas:

1. personal barriers related to a woman's personal attitudes or situations
2. interpersonal barriers related to family or peer relationships and attitudes
3. societal barriers related to broader community/societal attitudes or barriers
4. program/structural barriers related to program organization or structure

Other experts identified the following cultural barriers and lack of Aboriginal specific programming as specific barriers to Aboriginal women. Aboriginal women have specific ways of interpreting life and change that are often not understood or incorporated by mainstream programs. These typically include attention to spiritual values and participation in traditional ceremonies such as healing circles or sweat lodges. Aboriginal women may also be more comfortable with oral traditions and they value contact with elders. As well as not being culturally appropriate, most programs lack Aboriginal staff.

[66] Madeline Dion Stout, Aboriginal Canada: Women and Health A Canadian Perspective (July 1996) from "Abstract" (on web-site).

The lack of gender-specific programming is particularly important for Aboriginal women. Gender-specific programming is seen to provide more safety, freedom from harassment and the opportunity to explore past relationships more openly. Considering the domestic abuse that some women have experienced at the hands of men, requiring them to go into treatment in co-ed facilities could feel quite threatening.

Lack of community support and positive role modelling was identified as a problem for recovering Aboriginal women who may come from communities where there is a lack of support for recovery or where their own efforts in recovery go unrecognized. The use of positive Aboriginal role models needs to be enhanced. [67]

It as noted that there are many factors that make it difficult to help young women, or that interfere with prevention or treatment efforts. For all survey respondents across the provinces, 90% identified single parenthood as an impediment to prevention or treatment efforts, followed by 89% who identified abusive partner or spouse as a serious detriment, and 88% who identified negative peer influences. Eighty two (82%) of respondents also identified "less than high school education" as also a serious factor. Regional differences are interesting with Treaty 7 have the highest percentage of respondents (90% or higher) identifying a large number of factors that are interfering with helping young women who have substance abuse problems — co-existing mental health or emotional issues, negative peer influence, abusive partner or spouse, fetal alcohol syndrome, single parenthood, lack of family or community support, limited job opportunities, less than high school education and lack of housing or living place.

Table 11: Percent of Respondents who Identify Factors as Barriers to Helping **YOUNG WOMEN**

	Across Province	Treaty 6	Treaty 7	Treaty 8
co-existing mental health or emotional issues	73.9%	68.4%	94.4%	59.5%
negative peer influence	88.3%	86.8%	97.2%	81.1%
abusive partner or spouse	89.2%	86.8%	97.2%	83.3%
fetal alcohol syndrome	55.0%	42.1%	86.1%	37.8%
learning disabilities	60.4%	55.3%	77.8%	48.6%
single parenthood	90.1%	78.9%	94.4%	97.3%
lack of family or community support	79.3%	81.6%	86.1%	70.3%
limited job opportunities	79.3%	91.7%	81.1%	79.1%
less than high school education	82.0%	71.1%	94.4%	81.1%
lack of housing or living place	89.2%	84.2%	97.2%	86.5%

Respondents made a few comments on the barriers to helping young women that included lack of life skills to cope with parenting issues, coupled by difficulties in finding

67 Health Canada. Alcohol and Drug Publications. http://www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/bp_women-mp_femmes/genbarriers-obstacles-eng.php

daycare or having transportation. Lack of personal motivation to change the circumstances of their life was mentioned by a few individuals as well.

When respondents were asked about assets/resources within the community, there were a quite a few positive responses. There was mention of healing circles for women, parenting skills workshops, prenatal classes, craft centres, and other counselling resources. It seems that there are substantial resources in most communities, as long as there is a willingness to use them.

When focus groups were asked, "What needs to happen in your community to make it healthier?" all women responded that the community needs to get together with a common purpose and goal. The majority of the women felt that the community needs to put a stop to the alcohol and drug abuse and to get rid of the drug dealers. The majority of the women felt that community members need to implement a more positive and productive approach to combating alcohol and drug abuse, such as gathering spiritual leaders to come together to perform ceremonies to cast out evil spirits and to help heal the community of this trauma. The majority of the women also indicated that there is a need to bring people into the community who have training in trauma, recovery and addictions to provide and encourage personal and family stability.

The women felt that the leadership needs to get more involved in combating the alcohol and drug abuse in the community and the spiritual leaders are also required to talk to kids in the schools. The women indicated that it only takes two people to take an idea and run with it. One example cited was the work of Eric Shirt (Saddle Lake First Nation) in the formation of Poundmakers Lodge and Nechi institute.

Focus group participants were asked what they thought it would take to mobilize a community into doing things on their own. The majority said that women elders need to play a role and share stories and to teach people about honour, respect and caring for ourselves. The majority of the women felt that people from the community need to get involved in designing workable solutions that can help the community and families combat the seriousness of addictions. They indicated that there is a need to raise awareness on the effects of alcohol and drug misuse and those presentations should be made to parents and families. The majority of the women felt that leaders need to become more involved and the community needs to work together as a whole in order to deal with these issues.

In those communities where there were higher rates of suicide, respondents said that crisis intervention and debriefing in the community is important. The women felt that it takes a lot to mobilize the community and one important thing is to provide adequate funding for programs and services in relation to addictions and substance abuse. The women also felt that transportation is required for individuals to access programs and services as many community members do not have adequate transportation.

Overall, the women responded that the community needs to celebrate life more often and to show community members acceptance, love and support.

Researcher, Janet Currie, for Health Canada Drug Strategy Division, identified elements of the best practices in the treatment and rehabilitation of women with substance abuse problems [68]

> "The report describes 13 underlying principles of treatment, including the importance of offering a menu of treatment and related support options, the value of an approach that considers all aspects of a woman's life, including emotional, psychological and spiritual elements, and approaches that are women-centered, empowering and support connections between women. The importance of addressing interrelated health issues, a gender-sensitive approach, client education, the value of using a "relational" model of treatment, a practical skill-building orientation, addressing family issues, a harm reduction approach, and a realistic view of relapse prevention and management are some of the treatment methods and approaches identified as best practices by key experts and within the literature."

Women in community focus groups were asked what the community workers were doing that works well to combat the impact of alcohol and drug misuse. Following are illustrative comments from the women:

- 16 step program empowering women: this is a program that we are in right now and we come together once a week to share our stories on healing and concerns
- Grandmothers' Committee: grandmothers meet and come together just to have fun and share stories
- "Kids' group: Coyote Kids": young boys and girls between the ages of 6 to 12 come together to do cultural activities, learn about ceremonies and also have ceremonies and sweats, meet once a week
- Craft nights with women interested in doing productive measures to occupy time which is meaningful, making traditional crafts
- Women's circles
- Full Moon Ceremonies for Women
- Trauma Recovery workshops
- Grief and Loss workshops
- Wagon Drive to Lac St. Anne
- Parenting classes
- Saddle Lake Healing Lodge: NNADP Program, community wellness, family wellness/FASD family violence
- Youth camp for young girls: focusing on rites of passage and healthy sexuality
- Workshops
- Newsletter
- Healing lodge
- Boys and girls club
- AA/NA meetings

68 Health Canada Best Practices Treatment and Rehabilitation for Women with Substance Use Problems http ://www.cds-sca.com

Recommendations

1. Develop gender specific prevention and treatment programs
2. Re-profile one NNADAP treatment centre specifically for women
3. Communities to provide support and resources for childcare for women in treatment
4. Provide aftercare support to women in the areas of childcare, counselling, financial management support, life skills development, job readiness, housing and protection against family violence
5. Include discussions that raise the political awareness of women and the effects of colonization and systemic oppression
6. Provide community education, services and mentoring to support good parenting practices
7. Include transportation and childcare in community workshops and events
8. Develop and provide after care programs for women that focus on women's issues and needs
9. Increase awareness of the effects of alcohol and drugs on pregnancy
10. Provide one to one support and mentorship for pregnant women, using motivational interview strategies
11. Increase awareness among referral workers that NNADAP policies and practices place pregnant women as priorities for admission to treatment centres.
12. NNADAP Workers to receive gender specific training on addictions

Promising Practices for Women

The **Institute for the Advancement of Aboriginal Women** (IAAW) [69] is an organization that advocate for Aboriginal Women in all aspects of their lives. The organization has undertaken a number of projects, hosted community empowerment workshops and celebrate the accomplishment of Aboriginal women.

Their future goals include the establishment a virtual Centre for Well-Being and Human Rights which provide services to assist Aboriginal Women to re-integrate back into productive members of society. The efforts of the organization work to establish a network and contacts with Aboriginal Women throughout Alberta to strive for recognition of Aboriginal Women in all areas of employment, salary, and fair treatment. The following are an example of some the organization projects (both present and completed)

Aboriginal Women's Community-Based Studies Institute IAAW in partnership with the University Of Alberta Faculty Of Native Studies and the Canadian Native Friendship Centre presented 2 courses that empower Aboriginal women. The aim of the Institute was to enhance and develop strong leadership capabilities, use and enhance cultural processes, and provide skills building in creating safe and trusting environments, facilitation, advocacy, and self-esteem

Human Rights Workshops The IAAW hosted Human Rights Workshops for Women and Girls were presented to eight IAAW Chapters to bring information and start discussion on issues in their community

[69] Institute for the Advancement of Aboriginal Women #201, 10812 – 178 Street, Edmonton, AB T5S 1L3

The Aboriginal Women's Resource Kit on community planning organizational development against and personal development against them to justice, and to address the deeper problems of marginalization dispossession and impoverishment that have placed so many Indigenous women in harm's way. All levels of government in Canada should work urgently and closely with Indigenous people's organizations.

Esquao Inc. Funded by Urban Aboriginal Strategy through the Edmonton Housing Trust Fund. The Esquao Inc. project provides training and support for Aboriginal Women to start their own business. Our approach is holistic, sustained, and culturally relevant so that Aboriginal women may achieve success in the biggest sense. The program provides weekly groups meetings, training sessions in financial literacy and developing a business plan, yoga classes, a gym membership, cultural ceremonies, and connection to mentors and financing.

"Aboriginal Women's Communications & Governance Strategy" Funded by Canadian Heritage Aboriginal Women's Program This project is to develop the communications capacity of the Institute and provide support to local chapters. Through this project the hope is to have all of research and resources available online and to activate all of the local chapters.

"Strong Women, Strong Communities" Funded by International, Intergovernmental, and Aboriginal Relations This project is to develop the governance capacity of the Institute, to consult with membership on issues of concern, and to present this to the 2008 National Aboriginal Women's Summit.

"We Have Cried Enough" funded by Status of Women Canada Excerpt from Stolen Sisters - A Human Rights Response to Discrimination and Violence Against Indigenous Women in Canada (October, 2004): "Canadian officials have a clear and inescapable obligation to ensure the safety of Indigenous women, to bring those responsible for attacks against them to justice, and to address the deeper problems of marginalization, dispossession and impoverishment that have placed so many Indigenous women in harm's way." This project encompasses the concern for the deaths of all Aboriginal Women in Canada although centers on the City of Edmonton and Edmonton Police Service within the province of Alberta. Edmonton has received national attention for serial murders that have been committed in the area. Unfortunately a high number of Aboriginal Women are victims of this crime spree, which heightens the need for projects such as this one. [70]

3rd Annual Stolen Sisters Awareness Walk, was started by April Eve Wiberg from the Mikisew First Nation to bring attention to the violence against Aboriginal women, With the support of victims families, Elder Nellie Carlson, the Institute for the Advancement of Aboriginal Women, the Canadian Native Friendship Centre, the Aboriginal and non Aboriginal communities, the media, several local Aboriginal artists, and devoted volunteers, they have hosted three successful events that raised national awareness.

[70]Institute for the Advancement of Aboriginal Women. http://www.iaaw.ca/current-projects.htm

From these events, *Carla Ulrich directed a 12 minute documentary on the SSAW, called 'Stolen Sisters'. The film won a 2008 Dreamspeakers Film Festival award. [71]

SECTION 6.3 Men

Needs and Issues

The area of men and substance abuse, as specific demographic group, has not been widely studied, and studies of y*oung Aboriginal* men and substance misuse and addictions were even more limited. For the purposes of this report, data is drawn from a number of other studies on Canadian men in general. The results from the survey, personal interviews and focus groups provide a solid understanding of the issues facing Aboriginal men and their communities.

Statistics for men and substance abuse cross international boundaries. A large American study has found that men are twice as likely as women to have a substance dependence disorder, with a lifetime prevalence of almost 36 per cent for men and 18 per cent for women. In a large British study, men were three times more likely than women to be alcohol dependent and twice as likely to be drug dependent. Almost 8 per cent of British men and almost 5 per cent of women said they had been drug dependent at some time in their lives. However, for men, marriage appeared to protect them from addiction problems. The experience of the Canadian NNADAP program is that these statistics also hold true for Aboriginal men, and may actually under-represent the extent of substance abuse in men.

Respondents in the Canadian Addiction Survey were asked if they had ever used solvents and illicit drugs at least once in their lifetime. They reported that solvent use had the earliest age of onset among Albertans sampled with an average age of first use of 16.8 years. Cannabis use began on average at 18.2 years, hallucinogen use at 19.3 years, speed use at 20.1 years, heroin use at 21.0 years, ecstasy use at 22.4 years, and cocaine use at 23.8 years. Steroid use had the latest age of onset, at 25.1 years.[72]
To understand the issues associated with substance abuse among men requires examining both the harm for men as well as the harm to other members of the community as a result of substance abuse behaviour among men. These issues were discussed in the community focus groups completed as part of this study.

In total there were thirty-seven community focus groups in which 14 First Nation communities participated. Additionally, focus groups' sessions were held at each of the six treatment centres,[73] and also included personal interviews with selected community members. Communities were asked to host at least two focus groups that represented youth, men/women, seniors, and leadership and staff. Two hundred fifty community members participated in responding to questions about their thoughts surrounding

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[71] April Eve Wiberg Stolen Sisters Awareness Walk www.myspace.com/seventh_generation Facebook Search: Stolen Sisters Awareness Walk

[72] Alberta Alcohol and Drug Abuse Commission. (2006). Canadian Addiction Survey 2004, Alberta report. Edmonton, Alberta, Canada: Author.

[73] Treaty 6 (4), Treaty 7 (4,) Treaty 8 (7)

alcohol and drug abuse and the effect in their community and which group of people they thought were most affected. Approximately half of the participants were men, representing various ages with the majority being under thirty years of age.

When asked if they thought drugs and alcohol negatively affected their community, all participants responded that it did affect their communities to some degree. The majority of the participants indicated that alcohol and drug abuse results in children being neglected and it destroys families, both the immediate family and the extended family. The community participants indicated that domestic violence is a big concern throughout the community as a result of alcohol and drug misuse.

The majority of the participants felt that alcohol is the major problem in their community; however, illicit drug use such as crack, cocaine, meth (methamphetamines), marijuana, ecstasy and prescription drug abuse are also a concern. The participants also felt that there are high rates of crime in their community, such as theft, break and enters, and vandalism due to alcohol and drug addictions. The participants also felt that there is a lot of violence and abuse in the community.

Many community members thought that alcohol and drug abuse resulted in poverty, lack of education, employment and loss of income. Participants felt that there were many deaths in the communities that could be attributed to alcohol and drugs, such as suicides, car accidents, murders and drug related crimes. George (a senior) said" *Sometimes we say –'leave them, they'll learn the hard way but sometimes there isn't a second chance"*

The participants believed that alcohol and drugs misuse results in anti-social behaviour with youth and the general population. One senior (Rose) said *"The people that are selling (drugs), I wonder if they are aware of the damage they are causing. I wonder if someone can approach them and tell them what they are doing to the people. But it comes down to the money – for everyone.*

As part of the fractured families, participants felt that alcohol and drug abuse contributed to the loss of traditional and spiritual values and has caused their communities to lose their traditional values at all levels.

When asked what group of people in their community are most affected by drug and alcohol misuse, all responded that children and youth are most affected by the behaviour of the adults in the community. It was the perspective of respondents that children are being neglected by their parents and are not valued. One senior said, *"parents are the #1 teacher in the community and have to teach their kids the values – and alcohol and drugs are not a traditional value...values are traditional ways of living our spiritual belief – so many other values are great to us.*" The majority of the participants felt that there is an increase in violence and abuse, both in the home and community; including sexual assaults, street crime, vandalism, and violent crimes.

When looking at what problems are specific to young men in particular, the most serious problems reported by survey respondents are alcohol use, marijuana use, and smoking cigarettes. Two-thirds of respondents perceived crack/cocaine and heroin to be a serious problem across the province among young men. Table 12 provides a percentage of respondents who felt there were many problem and chronic users in their Treaty.

Table 12: Percentage of Respondents who Perceive there are Many Problem to Chronic Users among **YOUNG MEN** in Community [74]

USING	Across Province	Treaty 6	Treaty 7	Treaty 8
Alcohol	94.5%	89.5%	97.3%	97.3%
Marijuana	88.5%	84.2%	94.6%	88.9%
Solvent Use	18.9%	8.8%	37.1%	11.4%
Methamphetamines	33.0%	28.1%	40.0%	32.4%
Prescription Drugs	51.8%	34.2%	70.3%	54.3%
Ecstasy/Hallucinogens	37.7%	34.3%	38.2%	42.9%
Crack/cocaine/heroin	67.9%	81.1%	75.0%	56.8%
Cigarettes	96.4%	97.2%	97.3%	94.6%
Junk Food Binging	63.6%	45.9%	75.0%	74.3%
Gambling	59.6%	38.9%	65.7%	77.8%
Anorexia or Bulimia	12.0%	2.9%	25.8%	9.4%

There appears to be little Regional differences in terms of alcohol and marijuana abuse, but there are significant differences in solvent use, methamphetamines and prescription drug abusers. More respondents in Treaty 7 identified many problem to chronic users in solvent use and prescription drug abusers.

In general, not many survey respondents across the province (only 3%) perceived young men in their community who are using alcohol and drugs to be motivated to engage in support or treatment. None of the respondents in Treaty 7 and 8 felt young men were motivated.

Several co-occurring issues with substance abuse were perceived to be common among older adults in their community. More than 80% of the respondents identified depression or anxiety and aggression towards others as serious issues. Alarming was that 97%, or more, of the respondents in Treaty 7 perceived depression/anxiety paired with 76% perceived suicidal thoughts to be a co-occurring disorder among adults who are using alcohol and drugs.

Table 13: Percentage of Respondents who Perceive **YOUNG MEN**, Who Use Alcohol and Drugs, are also exhibiting Other Co-Occurring Problems.

	Across Province	Treaty 6	Treaty 7	Treaty 8
sexual promiscuity	80.9%	63.2%	94.4%	86.1%
suicidal thoughts	76.4%	65.8%	88.9%	75.0%
thoughts problems	65.5%	68.4%	72.2%	55.6%
fighting and aggression	98.2%	100.0%	100.0%	94.4%
harmful to others	87.3%	89.5%	88.9%	83.3%
conflicts with police	94.5%	100.0%	100.0%	83.3%

[74] For the purposes of this survey, young men are considered to be between the ages of 19-30, in other referenced studies it may be a general category and exact ages may differ slightly.

Resources and Services Available for Young Men

Across the province, the perception of intervention resources for young men was high in terms of assessment and referral, and one-to-one counselling. About two-thirds of the respondents felt that mental health and substance abuse treatment was available. But half of these respondents did not think resources such as detoxification services, gambling and sexual addiction counselling and after care counselling was readily available. Concern that resources/treatment were not available was more pronounced in Treaty 6 than in the other Treatys; especially in terms of the availability of detoxification services, aftercare counselling, and sexual addiction counselling.

Table 14: Perception of Whether Resources for **YOUNG MEN** Are Available Within Two Weeks

USUALLY OR ALWAYS AVAILABLE	Across Province	Treaty 6	Treaty 7	Treaty 8
detoxification services	51.8%	32.4%	83.8%	35.3%
assessment and referral	88.2%	83.3%	97.3%	82.9%
one-to-one counselling	91.7%	88.9%	97.3%	88.2%
parental counselling	63.0%	62.2%	82.9%	47.1%
residential treatment	60.6%	66.7%	69.4%	48.6%
aftercare counselling	59.8%	52.8%	66.7%	57.6%
mental health and substance abuse treatment	63.3%	50.0%	83.8%	58.8%
sexual addiction counselling	32.4%	20.6%	52.8%	24.2%
gambling treatment	51.4%	45.7%	60.0%	51.4%

About 20-25% of the survey respondents across the province felt resources and treatment were very effective. And then when "somewhat effective" responses were added in, about 80-90% of respondents were positive about resources/treatment. There were only small Regional differences. For the most part, respondents from each of the Treatys had a favourable perception of treatment effectiveness for young men; that it was somewhat to very effective. However, it should be noted that this would be the case only for those young men willing to seek treatment.

Across the province, there was a high degree of belief that these intervention and support resources were available for adults in areas of assessment and referral and one-to-one counselling. But half or less of these respondents did not think resources such as detoxification services, and sexual addiction and counselling services were readily available. Approximately 60% of these respondents felt residential treatment and aftercare services were available. There were few Regional differences in the perception of the availability of resources for adults in their Treaty.

In response to the call for more treatment resources of young men, in 2008 the Alberta Health Services added 20 new treatment beds for young adults aged 18-24. They are part of the government's actions to strengthen Alberta's communities and treat repeat offenders who have mental health and substance abuse issues in an effort to keep them out of the justice system.

Calgary's Aventa Centre will house and operate eight of the new treatment beds and Poundmaker's Lodge Treatment Centres, near Edmonton, will house and operate seven of the beds for young women and five for young men. The 20 new treatment spaces bring the total number of Alberta Alcohol and Drug Abuse Commission (AADAC) treatment beds funded by the government to 342. Last year alone, there were nearly 15,000 annual admissions in the 22 AADAC detoxification and residential treatment facilities across Alberta. Statistics are not available that identify First Nations clients

Table 15: Perception of Service Effectiveness for **YOUNG MEN** as Somewhat to Very Effective

SOMEWHAT OR VERY EFFECTIVE	Across Province	Treaty 6	Treaty 7	Treaty 8
detoxification services	78.5%	69.4%	83.8%	81.3%
assessment and referral	91.4%	88.2%	91.9%	93.8%
one-to-one counselling	92.5%	41.4%	94.6%	90.6%
parental counselling	81.0%	85.7%	77.8%	78.1%
residential treatment	84.6%	77.1%	88.6%	87.6%
aftercare counselling	76.5%	74.3%	80.0%	73.3%
mental health and substance abuse treatment	84.3%	77.1%	88.9%	86.2%
sexual addiction counselling	68.1%	59.4%	75.9%	67.9%
gambling treatment	68.0%	65.7%	63.6%	73.3%

It is noted that there are many factors that make it difficult for young men to receive the help they need, or which interfere with prevention or treatment efforts. For all respondents across the provinces, 90% identified negative peer influence, followed by 93% who identified less than high school education as a significant barrier to helping young men. Other significant factors include limited job opportunities, lack of housing or living place, lack of family or community support and co-existing mental health issues. Treaty 7 respondents are more likely to identify all of these factors as barriers to treatment.

About 25-30% of the survey respondents across the province felt resources and treatment were very effective. And then when "somewhat effective" responses were added in, about 85-90% of respondents were positive about resources/treatment. There were few Regional differences in the perception that treatment was effective for those who engaged.

Table 16: Percent of Respondents who Identify Barrier to Helping **YOUNG MEN**

	Across Province	Treaty 6	Treaty 7	Treaty 8
co-existing mental health or emotional issues	80.2%	75.7%	97.2%	66.7%
negative peer influence	93.4%	89.2%	97.2%	93.9%
abusive partner or spouse	77.4%	75.7%	91.7%	63.6%
fetal alcohol syndrome	61.3%	54.1%	88.9%	39.4%
learning disabilities	77.4%	78.4%	88.9%	63.6%
single parenthood	66.0%	62.2%	77.8%	57.6%
lack of family or community support	86.8%	89.2%	97.2%	72.7%
limited job opportunities	85.8%	75.7%	97.2%	84.8%
less than high school education	92.5%	91.9%	97.2%	87.9%
lack of housing or living place	88.7%	86.5%	97.2%	81.8%

Respondents identified that some of the barriers to helping young men were lack of motivation and peer pressure to maintain a lifestyle that involved alcohol and drugs. When respondents were asked about assets/resources in the community, there were quite a few positive responses. There was mention of job training programs, counselling and personal skills development. Some communities also have spiritual healing activities as well as activities centred on male traditional culture (e.g. hunting and fishing, pow wows). It seems that there are substantial resources in many communities, as long as there is a willingness to use them.

Although most community members are aware of the role of NNADAP, (and it appears that there is a lot happening in the community), it is important to note that many participants felt that NNADAP workers were not visible enough in the communities and that they could do more to take on leadership roles to combat alcohol and drug misuse in the community. The participants indicated that community workers need to create more awareness of the resources in the community.

The majority of the participants felt that there needs to be more recreational activities for all community members. The participants stressed that these programs and activities need to be accessible to all community members and not just selected members. The participants felt that healing programs and cultural ceremonies and teachings need to be promoted at the community level to teach the younger generation.

The participants also indicated that community bylaws on alcohol and drug use will assist in solving the problem of alcohol and drug abuse, as well as implementing curfews for the youth. The community participants felt that the leadership needs to have a clear vision and a healthy group of individuals need to come together to make this vision happen.

Community members were asked what they thought it would take to mobilize a community into doing things on their own. The majority of participants indicated that involving the entire community and more communication is required. The participants indicated that mobilizing individuals to meetings and events is a major concern, and community participation may involve incentives such as door prizes, food and give away's.

The participants indicated that more community events are required, such as recreational activities, movie nights and gatherings. The majority of the participants also indicated that more advertising is required to get people out to the events. The participants indicated that community involvement involves positive thinking and cooperation, and that more support is required at all levels. Furthermore, respondents reported that the entire community needs to heal in order to combat alcohol and drug abuse. The participants also indicated that community members need to be encouraged to do things on their own and that the cycle of dependency needs to be discouraged.

The participants stated that Elders need to be involved at all levels in teaching cultural traditions and providing support to youth, young men and women and other community members. The participants also indicated that the community members need to respect and trust one another and work together as a team to overcome the cycle of alcohol and drug abuse in the community.

John, a participant in a senior's focus group said

> *"I'm the youngest here – I remember watching the elders sitting in front of the Hudson Bay laughing and telling stories – today we don't see that – youth are sitting at home. When there were deaths, the community came together to support the family with food, songs, this is what is missing. Since I sobered up in 1989 –I tried a lot spirituality. There have been changes in lifestyle – and attitudes. I'm no different than anyone in the community – we are all trying to survive. Alcohol affects our community you loose everything – all the good things, respect, relationship) effects our children*"

Community members felt that mobilizing the community is difficult and that communities only get together and support one another after a crisis. It was the feeling of the participants that the community needs to get together in a more positive environment and to create opportunities for all members to participate.

Recommendations

1. Encourage young men to take on leadership roles in organizing community activities
2. Mentorship of young men by leaders and elders in the community
3. Traditional teachings on the culture and the role of men in their society
4. Community events (sober)
5. Organized recreational activities for young men
6. Coordinated after care support, workshops, life skills for young men, as well as men of all ages
7. Provide half way houses – shelter in the community with counselling and referral support for men who are being released from the criminal justice system
8. Job readiness and job training for young men.
9. Parenting and relationship workshops for men to learn how to be better role models for their children.

Promising Practices Community Programs - General

Nechi Institute and Poundmaker Lodge

The Nechi Institute and Poundmaker's Lodge in Alberta which have an excellent reputation for training counsellors and treating addictions (using an AA model with the

goal of abstinence), offer a wide range of services which include incorporation of traditional healing practices and other culture-based approaches. However, many Aboriginal people continue to access the medical services in urban centres for addictions treatment.

The Alexis Nakota Sioux Nation. Towards Taking Ownership: A Community Experience in Cultural Curriculum Adaptation and Implementation of a Life Skills Program. Alexis First Nation is located in west-central Alberta. Currently, the community is facing high drug and alcohol abuse rates among youth and young adults. In response, the community identified the need for a culturally appropriate evidence based drug and alcohol prevention program for school-aged children. The Alexis School and Health Department formed a partnership with researchers from the University of Alberta to find a suitable program, and scientifically monitor the success for the project.. The program has developed a life skills program for elementary and jr. high school aged children. The traditional and contemporary lessons were drawn from Elders, traditional teachings, values and customs and taught in their language[75]

Native Men Wellness Retreat – Edmonton. This retreat brought Native Men together to remember their value and to empower them for their future. In First Nation communities, men contribute but not take time they need for themselves. Some men are not satisfied with their life and wish for a better future. These men need time to look back at their accomplishments and remember that they are valued and needed to help the growth and development of their community. This Retreat was organized and planned to provide excellent speakers and topics and to hear life experiences from men who have overcome adversity and challenges. Trhough the stories of auality speakers, First Nation men can learn to relate and compare obstacles and victories empowering them. .[76]

Sturgeon Lake First Nation Ongoing suicide workshops have been occurring since 2003. These workshops 1-2 days in length (depending on the facilitator) are offered to all community members.. The goal is to educate community membes on the warning signs of suicide and the steps to take when a crisis arises. Community members are made aware of the warning signs of suicide so as to be better equipped to help someone in crisis. Elders attend workshops, lead prayers, offer advice and talk with workshop participants. Youth are included in discussions, encouraged to speak and not remain passive. [77]

Niwichihaw Aboriginal Addiction Counselling Service provides assessment, counselling, referrals and prevention services using the Medicine Wheel. This service facilitates access to traditional Aboriginal healing practices such as smudges, healing circles, feasts and Elders. This program serves Aboriginal people from the Red Deer area who are concerned about their own or someone else's problems with alcohol, other drugs or gambling as well as individuals and community groups seeking information and prevention support. The program facilitates healing from intergenerational traumas i.e. sexual abuse. As well culture plays a big part in the program: i.e. one-on-one

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75 Alexis First Nation 780-967-1090 – Liz Letendre

76 For more information please contact Shannon Souray at 780-264-4344 or sssouray@hotmail.com.

77 Sturgeon Lake Health Unit PO Box 747 Valleyview, Alberta T0H 3N0

counselling, education of the impact of residential school. Access to traditional healing such as pipe and sweat ceremonies is facilitated. Participants take part in healing/talking circles, smudging, gathering traditional medicines, drum making, craft night, etc. and attend pow wows. A 2-3 day retreat in nature is held for survivors of residential schools and their families. Elders are a resource for the staff, participate in workshops and conduct ceremonies, leading workshops and filling the role of counsellor. Youth participate in the program.[78]

Peerless Lake Healing Centre offers outpatient addiction counselling and referral. The centre is involved in a local Treaty Day Celebration and Family Camp. These events focus on traditional dress, activities, and practices to promote resiliency and prevent harmful substance use. Workshops on suicide prevention, anger management and parenting. On Treaty Day some community members dress up in traditional clothes. There are an assortment of games for everyone who wishes to participate. The Cree language is taught in the "Good For Me" program for 8 - 12 year age group. Elders, when present, will lead the gatherings in prayer. [79]

Teen Challenge Alberta is a 12 month, faith-based, residential drug rehabilitation program located near Priddis, Alberta, Canada which offers young men and adults ages 18 and over, freedom from drug and alcohol dependence. Based on Christian principles and funded entirely through donations, the program offers spiritual, academic and vocational training, equipping individuals to return to society as responsible citizens.

Teen Challenge holds a remarkably high documented cure rate. Statistics show that many secular government-funded drug rehab programs have less than a 10% cure rate post treatment. Independent research has consistently shown that over 70% of Teen Challenge graduates have remained clean and drug-free – when surveyed five years after graduation! [80]

Section 6.4 Adults

Needs and Issues

The Canadian Addiction Survey Alberta Report (2004) examined the prevalence of alcohol and illicit drug use, trends in the prevalence of substance use, patterns of substance use, risk and harm associated with substance use, and community attitudes and beliefs regarding substance use issues of alcohol and drugs. The survey represented responses from 2,401 Albertans [81]

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79 Addictions Councillor, Peerless Lake Healing Centre PO Box 133 Peerless Lake, Alberta T0G 2W0 Phone 780-869-2544

80 http://www.teenchallengeab.org/learnmore

81 Alberta Alcohol and Drug Abuse Commission. (2006). Canadian Addiction Survey 2004, Alberta report. Edmonton, Alberta, Canada: Author.

The majority of Albertans who used alcohol during the past year (80.9%) reported using alcohol only during the last year, while about 15% (14.7%) reported also using cannabis at least once during the past year and 4% (3.7%) used cannabis and at least one other illicit drug in addition to their alcohol use. The other 0.6% used alcohol and an illicit drug other than cannabis during the past year, but not cannabis itself. [82] About one-third of males (32.6%) drink five or more drinks per occasion on a monthly basis and 8.9% do so on a weekly basis. The study concluded that males are more likely to use alcohol and to use it at harmful levels. Men who consume five or more alcoholic drinks on a single occasion and women who consume four or more drinks on a single occasion are at an increased risk for alcohol-related problems. (as cited in Demers & Poulin, 2005) [83] In the CAS 2004 Alberta sample, 6.0% of past-year drinkers report this behaviour on a weekly basis and 26.5% on a monthly basis [84] The Alberta prevalence of other illicit drug use during the lifetime is significantly higher than the national average of 17.0% of all Canadians.

Worldwide, cannabis is the most widely produced, trafficked and consume illicit psychoactive substance. 44.5% of Canadians age 15 and up reported to having tried cannabis in their lifetime. [85] Results also show that "males are more likely to have used cannabis than females, with 50% having tried it, compared with 39% of females." [86] The overall rate of past-year cannabis use reported in 2004 is higher than the rate indicated in the 2002 Canadian [87]

In 2002, 1.3% of Canadians aged 15 or older reported having using cocaine or crack at least one in the past year. Males were much more likely to report past-year use than females (1.9% vs. 0.7%).[88] In the literature, ecstasy is sometimes grouped with hallucinogens because of its propensity to affect perception, emotions and mental processes.

The proportion of Albertans over 15-25 years of age reporting the past-year use of cannabis has increased from 6.5% in 1989 to 15.4% in 2004. The reported use of cocaine/crack has also increased from 1.1% in 1989 to 2.4% in the current study. 6.1% of Albertans sampled reported using speed at some point during their lifetime. Most users

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[82] Alberta Alcohol and Drug Abuse Commission. (2006). Canadian Addiction Survey 2004, Alberta report. Edmonton, Alberta, Canada: Author.

[83] Demers, A., & Poulin, C. (2005). Chapter 3: Alcohol Use. In E. M. Adlaf, P. Begin & E. Sawka (Eds.), Canadian Addiction Survey (CAS): A national survey of Canadians' use of alcohol and other drugs:

Prevalence of use and related harms: Detailed report. (pp. 20-32). Ottawa, ON: Canadian Centre of Substance Abuse.

[84] Alberta Alcohol and Drug Abuse Commission. (2006). Canadian Addiction Survey 2004, Alberta report. Edmonton, Alberta, Canada: Author.

[85] Canadian Addiction Survey (CAS) A national survey of Canadians use of alcohol and other drugs, Prevlanece of use and related harms – detailed report, March 2005

[86] David Patton and Jennifer Bodnarchuk, Cannabis Use in Canada. Presentation at Issues of Substance, Canadian Centre on Substance Abuse National Conference 2005.

[87] Substance abuse issues and public policy in Canada. IV. Prevalence of use and its consequences. Prepared by Chantal Collin Political and Social Affairs Division. April 11-2006

[88] Canadian Addiction Survey (CAS) (2005), p. 57.

of cannabis, hallucinogens and speed began use at between 15 and 19 years of age; users of cocaine and ecstasy tended to have begun use in their twenties. A group of stakeholders in Edmonton and across Alberta have studied the issue and reported that young people between the ages of 15 and 25 are the primary users of "crystal meth" in that Treaty, cutting across socio-economic and geographic lines.[89]

According to the *2005 World Drug Report*, an estimated 26 million people (0.6% of the population aged between 15 and 64) use amphetamine-type stimulants and 7.9 million people used ecstasy worldwide in 2003. In Canada, the Canadian Addiction Survey (2004) found that 6.4% of respondents reported having used speed in their lifetime (8.7% males vs. 4.1% females), and 4.1% reported the use of ecstasy (5.2% males vs. 3% females). Past-year use was less prevalent, with 0.8% of those surveyed reporting the use of speed and 1.1% the use of ecstasy. [90]

The Community Stakeholder View of Crystal Meth in Edmonton [91] study found that crystal meth is more prevalent among those 15-25 years, cutting across socioeconomic and geographic lines. In looking at the appeal to use crystal meth, young people often cite availability, price and the 'longer high' as the reason for taking the drug. One respondent in the study reported *"meth keep you high for a long time. It keep you away from reality. You're in the meth world. One 'point' (of meth) for $5 can last from eight to 24 hours"* (youth focus group)

In discussing substance use across Canada, the Canadian Addition Survey comments that the Aboriginal peoples have been disproportionately affected by the harm associated with problematic substance use and are over-represented in some inner-city populations, the sex-trade, and the prison system.[92] The national Environmental Scan of First Nations and Inuit Mental Health Services (2002) reported that addictions appear to be increasing (Health Canada).and mental health issues) and the factors affecting substance use and related problems in Canada. The Centre for Addictions and Mental Health (CAMH) estimate about 20% of people with a mental disorder have a co-occurring substance use problem.[93]

Overall, men were 2.6 times more likely than women to meet the criteria for substance dependence.[94] 25% of male drinkers are high-risk drinkers compared to 9% of female drinkers.[95]

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[89] Ann Goldblatt, A Community Stakeholder View of Crystal Meth in Edmonton: Trends, Strategies, Challenges and Needs, prepared for the Social Development Working Group of the Safer Cities Advisory Committee, Edmonton, February 2004.

[90] Canadian Addiction Survey (CAS) (2005), pp. 61-62.

[91] Stakeholder Views on Crystal Meth in Edmonton. Trends, Strategies, Challenges and Needs 2004 Prepared for the Social Development Working Group (Goldbatt, Ann)

[92] Canadian Addiction Survey: A national survey of Canadians' use of alcohol and other drugs, November 2004.

[93] Prevalence of Co-occurring Substance Use and Other Mental Disorders in the Canadian Population, Canadian Journal of Psychiatry, December 2008

[94] Statistics Canada: Canadian Community Health Survey: Mental Health and Well-being, 2002

In the national framework the study found that problematic substance abuse poses serious harms to Aboriginal people both on and off reserve and in rural and urban settings. [96] The report goes on to state that alcohol abuse by Aboriginal peoples is four times the national average and is associated with low employment, family violence and suicide. FASD and solvent abuse are also particular challenges for Aboriginal children and youth. Geographic location and social isolation of northern communities is a further disadvantage. Barriers such as language, geography and lack of culturally sensitive services pose significant challenges to accessing health care and treatment.

In a study of prescription medication use among aboriginal population accessing addictions treatment in a Native Addictions Services Treatment Centre in Calgary (Wardman el Gruebaly 2002) [97] Sixty nine percent of those surveyed (n=144) reported to used medication inappropriately. Most respondents were aged 31 to 50 years (56%), and 52% were male. Of the respondents, 48% reported that they used prescription medication inappropriately, 8% indicated appropriate use, and the rest indicated no medication use. Sedatives or relaxants were most frequently used inappropriately. Among those who inappropriately used medication, 47% used medication more than 10 times in the previous year. Common sources for those who used medication inappropriately included medication given by a friend or a stranger (52%), medication bought on the street (45%), and medication prescribed by a physician (41%). Age greater than or equal to 30 years was associated with inappropriate use. Gender, residence, and Aboriginal status were not found to be associated with in appropriate use. The study concluded that inappropriate prescription medication use was a significant problem among an Aboriginal population that sought addiction treatment, and many of these individuals accessed medication from a prescribing physician. [98]

Results related problems and needs adult and substance use

The most serious problems among adults reported by survey respondents is cigarette use followed next by alcohol use and then gambling. Fewer respondents felt there were problem and chronic users of marijuana and other kinds of drugs among adults. Table 17 provides a percentage of respondents who felt there were many problem and chronic users in their Treaty. In terms of Regional differences, there were more respondents in Treaty 7 perceiving alcohol, prescription drugs and junk food binding to be a problem.

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[95] CCSA Canadian Addictions Survey, November 2004

[96] Health Canada. (2005, August). Answering the call: A national framework for action to reduce the harms associated with alcohol, other drugs and substances in Canada. Ottawa, ON: Author.

[97] Prescription Medication Use Among an Aboriginal Population Accessing Addiction Treatment Dennis Ward man, MD, FRCPC1, Nadia Khan, MD, FRCPC2, Nadyel- Guebaly, MD, FRCPC3

98 ibid

Table 17: Percentage of Respondents who Perceive there are Many Problem to Chronic Users among **ADULTS** in Community [99]

USING	Across Province	Treaty 6	Treaty 7	Treaty 8
Alcohol	78.1%	64.1%	91.2%	79.5%
Marijuana	69.6%	60.5%	79.4%	71.1%
Solvent Use	15.2%	5.6%	36.4%	5.9%
Methamphetamines	25.2%	28.6%	40.6%	13.2%
Prescription Drugs	64.6%	55.3%	94.1%	51.3%
Ectasy/Hallucinogens	26.9%	17.6%	34.4%	30.6%
Crack/cocaine/heroin	53.6%	59.5%	64.7%	40.1%
Cigarettes	93.8%	92.3%	96.7%	92.3%
Junk Food Binging	47.7%	29.7%	64.7%	52.8%
Gambling	71.8%	50.0%	90.6%	81.6%
Anorexia or Bulimia	14.4%	2.6%	32.4%	5.1%

Several co-occurring issues with substance abuse were perceived to be common among adults in their community. More than 80% of the respondents identified depression or anxiety and aggression towards others as serious issues. Alarming was that 97% or more of the respondents in Treaty 7 perceived depression/anxiety paired with 76% suicidal thoughts to be a co-occurring disorder among adults who are using alcohol and drugs.

Table 18: Percentage of Respondents who Perceive **ADULTS**, Who Use Alcohol and Drugs, are also exhibiting Other Co-Occurring Problems.

	Across Province	Treaty 6	Treaty 7	Treaty 8
suicidal thoughts	61.8%	52.6%	75.8%	59.0%
thoughts problems	51.8%	50.0%	51.5%	53.8%
aggression to others	80.9%	71.1%	87.9%	84.6%
harmful to others	67.3%	60.5%	81.8%	61.5%
conflicts with police	69.1%	65.8%	87.9%	56.4%
depression or anxiety	88.2%	86.8%	97.0%	82.1%

In general few survey respondents (only 14%) perceived adults in their community who are using alcohol and drugs to be **motivated** to engage in support or treatment. Twenty-one (21%) percent of respondents in Treaty 6 felt adults were motivated, 6% in Treaty 7 and 15% percent in Treaty 8.

Resources and Services Available for Adults

Across the province, the perception that intervention resources were available for adults was high in terms of assessment and referral, and one on one counselling. But half or less of these respondents did not think resources such as detoxification services, and sexual addiction and counselling were readily available. Approximately 60% of these

[99] For the purposes of this survey, adults are considered to be between the ages of 31-55, in other referenced studies it may be a general category and exact ages may differ slightly.

respondents felt residential treatment and aftercare services were available. There were few Regional differences in the perception of the availability of resources of adults in their Treaty.

Table 19: Perception of Whether Resources for **ADULTS** Are Available Within Two Weeks

USUALLY OR ALWAYS AVAILABLE	Across Province	Treaty 6	Treaty 7	Treaty 8
detoxification services	49.5%	37.8%	75.8%	37.8%
assessment and referral	87.2%	83.8%	100.0%	77.8%
one-to-one counselling	88.2%	89.5%	94.1%	80.6%
parental counselling	65.4%	63.9%	81.8%	55.6%
residential treatment	68.5%	73.0%	79.4%	57.1%
aftercare counselling	60.4%	54.1%	69.7%	58.8%
mental health and substance abuse treatment	63.6%	54.1%	82.4%	58.8%
sexual addiction counselling	36.6%	29.4%	53.1%	30.3%
gambling treatment	51.9%	51.4%	66.7%	41.7%

About 25-30% of the survey respondents across the province felt resources and treatment were very effective. And then when “somewhat effective” responses were added in, about 85-90% of respondents were positive about resources/treatment. There were few Regional differences in the perception that treatment was effective for those who engaged.

Table 20: Perception of Service Effectiveness for **ADULT** perceive to be Somewhat to Very Effective

SOMEWHAT OR VERY EFFECTIVE	Across Province	Treaty 6	Treaty 7	Treaty 8
detoxification services	86.9%	83.3%	93.8%	83.8%
assessment and referral	90.7%	88.9%	96.9%	86.5%
one-to-one counselling	91.7%	94.6%	96.9%	83.8%
parental counselling	85.5%	88.9%	84.4%	82.4%
residential treatment	85.6%	86.1%	87.5%	80.0%
aftercare counselling	78.4%	80.0%	74.2%	79.4%
mental health and substance abuse treatment	83.2%	80.0%	83.3%	85.3%
sexual addiction counselling	70.3%	63.3%	64.3%	80.6%
gambling treatment	75.8%	76.5%	64.5%	84.4%

It as noted that there are many factors that make it difficult to help adults or interferes with prevention or treatment efforts. For all respondents across the provinces, 85% of then identified interfering factors to treatment were

- co-existing mental health or emotional issues as interfering with treatment,
- abusive partner or spouse as a serious detriment,
- lack of family or community support
- limited job opportunities
- lack of high school education
- lack of housing or living place.

Regional differences are only slight with more respondents in Treaty 7 noting more factors interfering with treatment.

Table 21: Percent of Respondents who Identify Factors as a Barrier to Helping **ADULTS**

	Across Province	Treaty 6	Treaty 7	Treaty 8
co-existing mental health or emotional issues	84.7%	84.2%	100.0%	71.8%
negative peer influence	63.1%	60.5%	64.7%	64.1%
abusive partner or spouse	85.6%	86.8%	91.2%	79.2%
fetal alcohol syndrome	47.7%	36.8%	64.7%	43.6%
learning disabilities	78.4%	76.3%	91.2%	69.2%
single parenthood	75.7%	68.4%	85.3%	74.4%
lack of family or community support	84.7%	86.8%	94.1%	74.4%
limited job opportunities	85.6%	65.8%	97.1%	94.9%
less than high school education	89.2%	86.8%	88.2%	92.3%
lack of housing or living place	82.9%	76.3%	94.1%	79.5%

Respondents made a few comments that barriers to helping adults included shame and denial and in some cases childcare issues.

Respondents were asked about assets/resources in the community, there were a quite a few positive responses. There was mention of healing circles, parenting skills workshops, job skill training programs and other counselling resources. It seems there are substantial resources in most communities, as long as there is a willingness to use them.

In community focus groups community members were asked to identify the services they thought worked well in the community to combat the impact of alcohol and drug misuse. The participant's responses consisted of the following:
Illustrative comments:

- Referrals
- Aftercare
- Supports
- Counselling
- Therapist referrals
- Workshops on addictions
- AA/NA/ Alanon meetings
- Traditional parenting classes
- Transportation
- Crafts night

- Elders meetings
- Cultural camps
- Crime watch
- Education in schools
- Drug and alcohol free activities
- Healing circles for men and women
- Education
- Anger Management
- Sober events and walks
- Funding
- Guidance
- National Native Addictions Week
- Violence against women workshops
- Parenting classes
- Mentorship programs
- Sharing circles on addictions
- Family programs
- Setting up committees

Recommendations

Prevention Services

1. Develop a yearly schedule for workshops on addictions
2. Establish regular AA/NA/ Alanon meetings
3. Educate the community on the prevention and treatment services available and how to access the services
4. Regular community activities such as craft nights, cultural activities and social gatherings
5. Create awareness of the risk and determinants of suicide in adults
6. Workshops on anger management and other life skills

Treatment Services

1. Develop a community aftercare program that provides support for all clients and those who are returning from Treatment Centres
2. Access and support for clients needing services of a registered therapist
3. Address high levels of depression, anxiety and aggression towards others
4. To investigate the development of resources for sexual addiction counselling

Empowerment and Engagement

1. Community education activities on topics such as traditional parenting
2. Coordinate a regular schedule for healing circles for men and women
3. Social activities that support sobriety
4. To enhance motivation to engage in support and treatment by applying motivational interviewing strategies
5. Develop job training and life skills programs specifically for older adults
6. Consider harm reduction strategy rather than total reliance on the abstinence strategy

Administrative

1. Transportation to community events

SECTION 6.5 Seniors

Needs and Issues

Among the elderly, it is not as easy to recognize signs of alcohol or substance misuse. Often retired and living alone, the usual indicators that would be seen by family, friends or the workplace go unnoticed. Diseases such as high blood pressure, stroke, dementia or ulcers are common in later life so health care providers many not be thinking of substance abuse as an underlying cause and general assessments are designed for younger people and may not be easily applied to older adults.
Most seniors do not abuse substances; however, when they do, alcohol is the substance most commonly abuse[100]. Community focus groups reported that many people have quit drinking at some point in their lives. Several spoke of the remorse they felt for the damage to their children as a result of their previous drinking. Many seniors reported to be in recovery from alcoholism but didn't readily recognize prescription drug abuse or gambling as a form of addiction.

There is no one single reason a senior may develop substance use problems. Factors such as death of a spouse, retirement, chronic health problems or losses in the social network contribute to the need to self-medicate.

One respondent in a community senior focus group admitted, (*Janet) "I really started drinking after my husband passed away and my kids moved away, when I started to cut down on drinking, they came back"*

As part of community engagement, seven community focus groups with seniors were held. Three of the community discussions were held in the Treaty 8, two in the Treaty 7, and two in the Treaty 6. A total of 49 seniors participated in the discussions and were between the ages of 55 to 80 years.
Seniors were asked to identify the types of substance abuse there was in their community. All seniors responded that alcohol and drug misuse in their communities was a primary health and social concern and has had devastating consequences. The majority of the seniors identified excessive prescription drug misuse to the extent that some people are selling prescriptions and taking pharmaceuticals in high proportions. A large number of seniors believe that prescription drug misuse is reaching epidemic proportions. The majority of the seniors felt that although alcohol abuse is still a major problem within their community, illicit drug abuse, such as crack, cocaine, methamphetamine, marijuana and ecstasy is more prevalent amongst the youth in the community.

In large discussions groups, NNADAP Workers identified the following needs:

- seniors experience many of the same emotional issues that the youth experience; abuse, neglect and feelings of isolation.
- Services are needed advocate to support in family interventions,
- seniors coordinator/ advocate are needed to assist in the development of a seniors groups and in transportation to events and workshops,
- Workshops for seniors and family members to educate and create an awareness of prescription drug use and signs of prescription drug abuse and support

[100] Health Canada - Best Practices Treatment and Rehabilitation for Seniors with Substance Use Problems http://dsp-psd.pwgsc.gc.ca/Collection/H46-2-03-295E.pdf

services for seniors taking prescriptions, of elder abuse, health promotion related to aging,
- increase in home visits, need for long-term care homes

When asked if seniors thought that alcohol and drug misuse is a problem in their own age group, most of the seniors responded that they didn't think it was a problem. However, most seniors indicated that they enjoy gambling activities and the most prevalent types of gaming involved Bingo, slot machines and card games. The majority of the seniors did not feel that gambling (some didn't see the games they played as gambling) was a big problem and indicated that gambling was used as a way of entertainment and socializing. The majority of the seniors also indicated that if alcohol and drugs are misused by seniors, it is well hidden and only a handful of seniors still abuse alcohol and drugs. However, in two of the focus groups, seniors commented that they were aware of instances where seniors are abusing crack cocaine, prescription drugs and alcohol.

Several Seniors in focus group discussions shared their experiences earlier in their life with drinking

Margaret (seniors group) "When I was drinking I didn't pay attention to my kids as they were growing up – being from the residential school – I didn't know how to be a real parent – only the way I was taught in the mission that is how I brought up my kids. Only after I sobered up I started to think about the way things really were and the way of life we used to have – we didn't see drunk people – maybe once a year – you lived in the bush – lived on the land to survive. It was nice because people used to share. Now everything that is locked up and still they break in – even if your camp is locked they break in now. Before people tied the door with string and if you stayed there you cleaned up and made sure there was wood in the box. Today there is no respect for parents. Its like the parents are never going to be forgiven – they keep getting blamed for when they used to drink. When does the blame stop? How do we find a way to deal with the loss? Communication is lacking. For me, it wasn't until I got mad and said 'I'm going to only say sorry this time then that's it

In a survey completed by NNADAP workers and other health professionals, perceptions differed somewhat. The most serious problems among seniors reported by these survey respondents was cigarette use followed next by gambling and the prescription drug abuse. Additionally, 44% of the respondents felt alcohol abuse was a problem among seniors. Table 22 provides a percentage of respondents who felt that there were many problem and chronic users in their Treaty. In terms of Regional differences, there were more than 80% of respondents in Treaty 7 perceiving prescription drugs, gambling, alcohol, and cigarettes to be a problem among seniors.

Table 22: Percentage of Respondents who Perceive there are Many Problem to Chronic Users among **SENIORS** in Community [101]

USING	Across Province	Treaty 6	Treaty 7	Treaty 8
Alcohol	44.3%	22.2%	69.7%	45.7%
Marijuana	18.4%	14.7%	33.3%	9.4%
Prescription Drugs	51.9%	37.1%	90.7%	33.3%
Cigarettes	81.3%	75.0%	84.8%	83.3%
Junk Food Binging	20.6%	5.9%	40.0%	19.4%
Gambling	59.6%	40.0%	81.3%	62.8%

An American study on seniors and substance misuse revealed that about 17 percent of adults over 65 misuse their prescription medications or abuse alcohol. Like other stages of life span development, seniors experience physical and emotional changes that result from declining health and depression occurs when there are losses of significant people in their lives. Older people process alcohol and drugs more slowly and can feel stronger effects and become dependent more easily. In fact, negative health consequences are sometimes seen in older adults at a level of alcohol or drug use that would be considered light to moderate in younger people. Substance abuse can damage many different organs in seniors. Like in younger generations, substance abuse has negative effects on self-esteem, coping skills and interpersonal relationships.

When asked about co-occurring issues with substance abuse among seniors in focus groups in their community, almost 100% of these respondents reported depression and/or anxiety to be a problem. Almost half the survey respondents also thought that aggression and thought problems were co-occurring problems.

Table 23: Percentage of Respondents who Perceive **SENIORS**, Who Use Alcohol and Drugs, are also exhibiting Other Co-Occurring Problems.

	Across Province	Treaty 6	Treaty 7	Treaty 8
suicidal thoughts	23.7%	2.9%	45.2%	25.0%
thoughts problems	48.5%	32.4%	61.3%	53.1%
harmful to others	23.7%	2.9%	51.6%	18.8%
depression or anxiety	95.9%	100.0%	96.8%	90.6%
aggression	56.7%	41.2%	74.2%	53.1%

In general few survey respondents (only 10%) perceived adults in their community who are using alcohol and drugs to be motivated to engage in support or treatment. Twenty-four (24%) percent of respondents in Treaty 6 felt seniors with a substance abuse problem were motivated to get help, 6% in Treaty 7 and 0 percent in Treaty 8.

Alcoholism has been linked to mood disorders, suicide, dementia, anxiety disorders and sleep disturbance. Not unlike the younger generations, alcohol is sometimes used by older people for self-medication, to ease the emotional pain of psychiatric or physical illness. Some people who abuse alcohol have additional psychiatric problems that are often undiagnosed.

[101] For the purposes of this survey, seniors are considered to be over 55 years of age, in other referenced studies it may be a general category and exact ages may differ slightly.

Changes in the body are naturally occurring throughout life and more so with the aging. Often there is an increase in medications including over the counter medication in seniors and when mixed with alcohol can have dramatic effects. When combined with alcohol some drugs can weaken the effect such as blood thinners, drugs used for seizure disorders, and some oral medications to treat diabetes. Alcohol can increase the effects of sedatives and decrease mental alertness and ability to move around. Injuries caused by falling can have serious health concerns for seniors.

At a workshop sponsored by Addictions Foundation of Manitoba, about 140 people (including Aboriginal, rural and other ethnic communities in Manitoba) representing seniors agreed that substance use among seniors has become a silent epidemic. Sheri Fandry, a prevention educator from the Addictions Foundation reported that about 10 percent of seniors either abuse or misuse medications and another 10 percent abuse alcohol and some mix both. Mae Petrie who works with the seniors said that illegal drugs like cocaine and marijuana were problems too, and she reported that drug and alcohol abuse are also often related to elder abuse. The Addiction Foundation predicts the problems will get worse as the population ages stating that by 2020, the number of seniors who need addiction treatment will triple.[102] Baby boomers are likely to have more contact with illicit substances than the present seniors' cohort.

When asked how alcohol and drugs affects the community, the majority of the seniors looked to problems in the family; that children are being neglected and there are high rates of child apprehensions in the community. The majority of the seniors felt that alcohol and drug misuse contribute to family breakups and fragmented family units. The majority of the seniors also felt that the intergenerational effects of the trauma experienced in residential schools is a contributing factor to the high rates of alcohol and drug misuse in the communities. The majority of the seniors felt that parents have lost parenting skills and the trauma experienced in residential school has negatively impacted all generations. Since alcohol and drugs affect parenting abilities, many seniors indicated that grandparents were left to care for their grandchildren.

The majority of the seniors said that they do not feel safe in their communities and also indicated that children do not respect them. In several incidences, many reported that they (or someone they knew) are abused by their children financially and emotionally.

The majority of the seniors felt that alcohol related deaths in their community are a common occurrence. Deaths such as suicides, car accidents, murders and other accidental alcohol related deaths impact all of the community. The seniors reported on the high rates of crime that are related to drug use. They felt that crimes such as theft and break and enters are increasing so that people could support their alcohol and drug addictions.

Although the majority of the seniors felt that all community members are affected by alcohol and drug abuse, they felt that the younger generation are most affected. The majority of the seniors indicated that alcohol and drug abuse affects employment and education of young community members. One of the most devastating perspectives offered by these seniors was that there was a loss of traditional and spiritual values in the

[102] CBC News (February 2008) Substance abuse among seniors rising: addictions foundation http://www.cbc.ca/canada/manitoba/story/2008/02/22/seniors-addictions.html?ref=rss

community. The affects of alcohol and drug abuse, according to the seniors, have caused their communities to lose their traditional values at all levels.

According to local health and law enforcement officials, the agencies and services set up to help seniors, from police departments to hospitals, aren't equipped to address many of the older adults' medical, mental health and legal problems. The systems are stove piped to meet specific needs and are not integrated in their approach; the physicians are treating medical problems, nursing homes and assisted living facilities are treating other problems and law enforcement officials are treating another problem. In First Nations, the community home care support services are critical in monitoring and tracking the health and wellness of seniors and are often the first to notice needs and declining abilities.

Resources and Services Available

Across the province, the perception that intervention resources were available for seniors was high in terms of assessment and referral, and one-to-one counselling. But only half or so of the respondents felt detoxification services, residential survivor treatment and gambling addiction treatment were available. There were few Regional differences in the perception of the availability of resources of seniors in their Treaty.

Table 24: Perception of Whether Resources for **SENIORS** Are Available Within Two Weeks

USUALLY OR ALWAYS AVAILABLE	Across Province	Treaty 6	Treaty 7	Treaty 8
detoxification services	52.0%	29.4%	80.7%	17.6%
assessment and referral	82.8%	73.6%	93.5%	81.2%
one-to-one counselling	89.1%	88.2%	93.7%	84.8%
residential treatment	68.5%	75.0%	74.2%	60.6%
aftercare counselling	60.2%	48.1%	73.3%	57.6%
residential survivor treatment	53.6%	53.3%	59.4%	51.5%
mental health and substance abuse treatment	62.6%	50.0%	77.4%	64.7%
gambling treatment	55.7%	56.2%	60.0%	57.6%
prescription abuse counselling	65.7%	62.5%	75.1%	63.7%

About 25-30% of the survey respondents across the province felt that resources and treatment were very effective for seniors. When “somewhat effective” responses were added in, about 85-90% of respondents were positive about resources/treatment. There were few Regional differences in the perception that treatment was effective for those who engaged in it.

Table 25: Perception of Service Effectiveness for **SENIORS** as Somewhat to Very Effective

SOMEWHAT OR VERY EFFECTIVE	Across Province	Treaty 6	Treaty 7	Treaty 8
detoxification services	84.4%	85.2%	87.1%	80.0%
assessment and referral	91.1%	92.3%	100.0%	80.0%
one-to-one counselling	90.1%	92.6%	96.9%	80.0%
residential treatment	85.2%	92.6%	93.3%	68.9%
aftercare counselling	77.0%	76.9%	83.9%	67.8%
mental health and substance abuse treatment	84.3%	80.8%	93.8%	75.9%
gambling treatment	76.1%	73.1%	80.6%	72.4%
prescription drug abuse counselling	79.3%	80.8%	83.3%	72.4%

It was noted that there are many factors that make it difficult to help adults or that interfere with prevention or treatment efforts. Approximately 80% of the survey respondents identified co-existing mental health or emotional issues, lack of family or community support, physical handicaps and dementia or cognitive problems as interfering or creating a barrier for treatment with seniors.

There were few Regional differences in how respondents perceived barriers to treatment.

Table 26: Percent of Respondents who Identify Barriers to Helping **SENIORS**

	Across Province	Treaty 6	Treaty 7	Treaty 8
co-existing mental health or emotional issues	78.9%	71.9%	87.5%	77.4%
abusive partner or spouse	53.7%	46.9%	59.4%	54.8%
lack of family or community support	80.0%	71.9%	87.5%	80.6%
lack of housing or living place	67.4%	56.3%	81.3%	64.5%
physical handicaps	78.9%	68.8%	93.8%	74.2%
dementia or other cognitive problems	71.6%	75.0%	75.0%	64.5%

Respondents made a few comments that other barriers for seniors were their own unwillingness to ask for help and not knowing where to go. Several individuals also mentioned that some seniors are experiencing family abuse.

When respondents were asked about assets/resources in the community, there were quite a few positive responses. There was mention of counselling, senior centre activities, home support services and various cultural activities. Many communities have resources for seniors but they simply need to get seniors to ask for help.

The community focus groups revealed that seniors are reluctant to talk about personal problems, as they are coming from a generation where keeping their problems hidden was a sign of personal integrity. Many seniors are concerned that problems will reflect poorly on their family or on their own moral character.

Seniors become involved with alcohol and gambling (casino and bingo) for a number of social and emotional reasons. It was reported that many seniors participate in such activities to help fill time and to avoid isolation and loneliness. Seniors are particularly vulnerable to problem gambling and Bingo. Casinos have embraced this clientele. Some casinos have instituted marketing campaigns that target seniors through discounts. But once a senior develops a gambling problem, experts say, he or she is far less likely to seek professional help, partly because of shame. With more casinos being built in Alberta First Nations, there is the potential explosive growth of problem gamblers. It was reported through community focus groups that often family members are aware of the problem gambling but feel helpless to intervene. Several commented that it (gambling) gave the senior a social outlet and a place to go. The presence of alcohol or drug use problems is one of the most commonly listed risk indicators in abuse and neglect of older adults[103]

A national study found that 14.6% of senior abuse in Canada occurred by abusers who were having a severe drinking bout. An outreach program for seniors with substance use problems in Vancouver, British Columbia reported that 15-20% of their clients experience senior abuse from spouse, family, friends, and neighbours. [104]

Seniors benefit from age-specific interventions, and service providers should be trained in both gerontology and substance use issues.

When asked what it will take for their community to heal, all seniors responded that elders need to be involved in assisting the community with the healing process. The majority of seniors want to be involved to talk to youth in the schools about their experiences and to educate youth on traditional teachings.

The majority of the seniors felt that more community support is required for families and individuals battling addictions. The family support can be as simple as talking to people, visiting each other and just someone to listen to their problems. The majority of the seniors felt that more traditional gatherings, feasts, sweats and powwows, and ceremonies are required to heal their communities.

The majority of the seniors felt that more education and workshops are required to increase awareness on the effects of alcohol and drug abuse on an individual and the community.

NNADAP Workers commented that the seniors needed a seniors activity centre where specific programs could be scheduled. The most repeated comment was the need to have staff who are trained in working with seniors health and emotional needs and to coordinate a mentorship program for elders. Other missing services included transportation, workshops on mental health services for seniors and other age related concerns such as making a will and the desire to pass along cultural teachings.
When events were held in the community, NNADAP Workers believed that cultural activities such as tea dances, cultural camps, traditional teachings, round dances, elders

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[103] Bradshaw, D. & Spencer, C. “The Role of Alcohol in Elder Abuse Cases”. (1999) Elder Abuse Work: Best Practice in Britain and Canada (ed. by J. Pritchard) (London, Eng.:Kingsley Publishing

[104] Pittaway, E. & Gallagher, E. (1995). A Guide to Enhancing Services for Abused Older Canadians. Victoria, B.C.: Office for Seniors & Interministry Committee on Elder Abuse.

working with children through story telling, healing circles, rites of passage ceremonies, sweat lodge ceremony were always well attended.

The following are comments made in senior focus groups:

> *Janet "More education on how seniors should take their medication. some one to tell me what the pills are and what they are for. One time I took a pill and it made me sick, I take it to the nursing station now to check what is for.*
>
> *Rose "I went to a diabetes workshop in Edmonton a few months ago. I learned how to take my pills and insulin – I learned a lot. We are told things like how and when to take the insulin at bedtime. We need more workshops on diabetics. More people are needing this kind of information. When I was there 3- days I was feeling better then I came back here and it was different"*

The majority of the seniors felt that the community needs to promote healthier lifestyles such as physical activity, sober events and recreational programs to motivate the community to become more involved in sober events. The majority of the seniors also felt there needs to be a stronger police presence at all levels and that the leadership needs to provide support for alcohol and drug initiatives in the community.

Seniors were asked what people in their community do to stay healthy, and the majority of the seniors responded that having an active life style is very important. Doing simple things such as walking, working in the yard and house cleaning were identified as activities that seniors can do. The majority of the seniors also felt that nutrition is an important part of their daily routines, especially since a lot of seniors are battling diabetes and other health problems. The majority of the seniors also felt that socializing, feasts and family get togethers are important for their mind and well being; it gets them out of the house and keeps them active in the community. The majority of the seniors also said that they stayed healthy by participating in cultural events, round dances, gatherings, elders committees, sweats and ceremonies.

Seniors were asked to comment on how they saw their role as seniors in the community. The majority of the seniors responded that they saw it as their responsibility to educate the young people and to go to schools to talk to youth. Many seniors felt that leaders are responsible for everything, but felt that their (leaders) were not getting involved in combating the alcohol and drug abuse in the communities. The seniors felt that they are there to advise the leadership and some reported that their community had Elders' committees whereby Chief and Council use Elders as resources and seek their advice in decision making. The seniors felt that they need to work together to educate the young and to rid their communities of alcohol and drug dealers. The majority of the seniors also felt that all elders must be treated equally and not just a selected few. Seniors reported that the invitation to present, speak or to advise was not always extended to all seniors; sometimes it was the same few seniors that were asked to participate. One senior commented that "we must step out of this harmful attitude (of excluding some community members) and allow input from others who can also offer wisdom from their life experiences."

The majority of the seniors would like to have more interaction with the community by having more gatherings where children and Elders interact together and do things

together. Many seniors saw their role as advisors to the youth, community and the recovering addict.
Seniors were asked to identify the kind of addiction services that seniors needed. The majority of participants responded that more activities and gatherings are required where seniors can socialize with each other. Almost all the seniors felt that they require positive supports such as financial support and planning, transportation, and home care.

Seniors said they wanted and needed more information on alcohol and drugs through community information sessions and workshops. Several commented that they still like to learn new things and ideas. The majority of the seniors felt that they were not educated on issues such gang activity, fetal alcohol effects, HIV/AIDS, STD's and Elder abuse and aging.

The majority of the seniors also felt that awareness is important and they would like to have more workshops, programs and training on alcohol and drug abuse and other health issues affecting their community. They commented that if they knew more about these issues, they might be able to help out in the community more often.

The majority of the seniors felt that they would benefit from having professional therapists available to assist them in dealing with grief and loss of loved ones, especially when the cause of death was alcohol and drug related or by suicide.

The seniors felt that more support, aftercare programs and facilities are required in the community for the recovering addict. Seniors commented that those who were shut-in's, who were less mobile, or who didn't have family support would benefit from more home visits. The seniors were aware that many felt lonely and that these ones weren't looked after very well.

In discussing healing and recovery one senior focus group respondent observed,

> *(Margaret) "In the Mission God was a punishing god – now my God loves me. To be healthy you have to learn to understand your own faith and own spirituality."*

Recommendations

1. More training and education, better collaboration among services providers and the development of comprehensive programs that can address older adults' many needs
2. Community education to reach all segments of the community on aging and changing needs of the aging
3. Outreach services in seniors homes
4. Peer-led social groups to help build social relationships that are not based on substance misuse
5. For services to be effective, seniors benefit the most from age-specific interventions, and by service providers trained in both gerontology, family and substance use issues
6. For community programs to provide transportation and/or outreach services, and adopt a client-centred, holistic treatment approach that improves overall quality of life
7. Facilitate relationships between the senior and their physician for ongoing medical care and assessment and effective service delivery

8. Build collaboration among health and social services professionals to create a comprehensive continuum of care for seniors.
9. Develop resources, public education and information specific to seniors
10. Develop community awareness initiatives on aging and substance use problems
11. Develop new assessment tools to accurately reflect the needs of seniors
12. Use a client centered holistic approach to develop community-based treatment programs provided in the broader context of support for health and the activities of daily living
13. Develop a community strategic health promotion program for seniors

Promising Practices for Seniors

Following are some of the promising practices for involving seniors in meaningful roles in their communities or addressing substance abuse issues experienced by this demographic group**.**

The Grandmothers Guide The Grandmothers Guide is founded on the belief that families and communities need the grandmothers' wisdom, knowledge, and prayer. In order to do this, the grandmothers need to be affirmed of their gifts and what treasures they are to our families and communities. Due to the high demands currently placed on grandmothers it is also important to assist grandmothers in looking at their self care and the practice of healthy lifestyles

For the last two years Grandmothers Guide has been running with retreat style workshops across Alberta with grandmothers from Treaty 6, 7 & 8. At every retreat, the grandmothers have asked to have a large gathering of grandmothers. This year, the group hosted the first Grandmothers Guide Conference with well over 200 participants.[105]

Niyak Wapataman (Watching the Future) addresses the negative impacts of sexual and physical abuse of residential schools. The project attempts to restore a balance by establishing healing circles, workshops and traditional activities. This three-year project provides consistency and continuity in the process of healing by building a solid foundation in addressing the Legacy of Physical and Sexual Abuse. The goals of the project are to promote mental health prevention and information sharing a) to increase ability to recognize mental health problems and gambling, and b) to create self-worth/esteem. Key components include culture, education and information and letting the community members know that someone cares. Role of the Elders is to pass on history and traditional teachings. Elders teach at the Head Start program and tell stories and teach crafts at local schools. [106]

Chief Mountain Residential Healing Impact The proposed healing centre program is a project designed to be a component of and consistent with St. Paul's existing culturally based holistic treatment program and philosophy. The program addresses the healing needs of St. Paul's aboriginal clients affected by sexual and physical abuse in residential schools including intergenerational aspects through: Community Outreach; Monthly In-

[105] For more information contact www.visions.ab.ca/gmg

[106] Phone 780-597-3777 Email rorr@onehealth.ca

Home Family Workshops; Public and General Seminars; provision of a five-week Treatment & Healing Program; provision of Cultural, Cognitive and Therapeutic Group sessions on a six week basis; and Participant Discharge and Aftercare Planning. [107]

SECTION 7 MENTAL HEALTH AND RELATED ISSUES

Needs and Issues

The Aboriginal Framework for Mental Health begins the report with a reference to the Assembly of First Nations (2001) summation of the rights and responsibilities for living, health and wellbeing given to First Nations people from the Creator. The declaration asserts the freedom, language and traditions of indigenous people in Canada. These are the principles discussed in many other articles and studies this report examined. Specifically mental health is defined by First Nations people within the spectrum of holistic wellbeing.

In the paper on Restoration of Well-Being for Canada's First Peoples, Bill Mussel (Chairperson of the Canadian Native Mental Health Association) discusses the aboriginal view of mental health, stating, "Aboriginal perspectives on mental health differ from those of the mainstream"[108] It is because of these very different views on wellness/illness that different solutions must be sought. The solutions begins with first understanding the effect colonization has had (and continues to have) on the mental health of aboriginal people. He concluded by saying " Promising solutions include decolonizing education for all Canadians, cultural safety training for health and human service workers, and strengths based life-affirming approaches that build community and individual capacity".

To understand the present, it requires that one understand the past. This belief is at the heart of many traditional teachings and is used as a foundation for problem solving. The traditional underpinnings of aboriginal world view are founded on the basis of community, family and individual holistic health/wellness. This speaks of the inter-relationship and interdependence between the natural environment, individual identity, status and place in the world through the connection to ancestral territories and the community. Wellness, from an aboriginal perspective is about balance between the four life areas (mental, physical, emotional and spiritual). These concepts are embedded and embodied in cultural traditions, laws, customs and everyday practices of every tribal group. While across Canada there is much diversity in cultural practices, language, values and belief systems, there are also many commonalities including a belief system based on the concept of holism.

The Canadian Population Health Institute echoes many of the same principles as those discussed above in the study on health determinants that affect Aboriginal people.(CIHI, 2004 p.75)) stating that programs and services must be based on principles that include:

1. Ongoing impacts of colonialism
2. Relationship between housing and health
3. Legacy of the residential school system

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[107] Executive Director, St. Paul Treatment Centre PO Box 179 Cardston, Alberta T0K 0K0

[108] Canada Native Mental Health Association. Bill Mussel. Restoration of Well-Being for Canada's First Peoples. Accessed May 2009 http://www.caot.ca/pdfs/PaperfAbMentalHealth.pdf

4. Climate change and environmental contaminants that impact (Inuit) health
5. Community control and self-determination

These similarities may be a statement that the gap between the aboriginal ideologies and the non-aboriginal world is not as wide as it was twenty years ago; where services were offered by paternalistic agencies determined in the Anglo European medical model approach to health.

In Mental Health - Canada

- 1 in 5 Canadians will experience a mental illness in their lifetime. The remaining 4 will have a friend, family member or colleague who will.[109]
- About 20% of people with a mental disorder have a co-occurring substance use problem [110]
- 1 in 10 Canadians 15 years of age and over report symptoms consistent with alcohol or illicit drug dependence[111]
- Young people age 15-24 are more likely to report mental illness and/or substance use disorders than other age groups[112]
- Only one-third of those who need mental health services in Canada actually receive them [113]
- While mental illnesses constitute more than 15% of the burden of disease in Canada, these illnesses receive only 5.5% of health care dollars [114]

First Nations Mental Health

It is well known today that the social determinants of health (education, employment, income, housing etc) are worse for aboriginal people than those of non-aboriginal people and this affects the degree to which the aboriginal communities can meet the needs of their people. In Alberta, First Nations people had higher rates than the general population for seeking mental health problems through physician visits, emergency rooms and hospital admissions rather than through mental health outpatient clinics. (Alberta Health and Wellness, 2004, p.25)

In Canada the suicide rate among First Nations in 2000 was nearly three times the 2001 Canadian rate.[115] Many of these suicides were by young people (under the age of 30). In

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[109] Health Canada. A Report on Mental Illness in Canada, 2002.

[110] Prevalence of Co-occurring Substance Use and Other Mental Disorders in the Canadian Population, Canadian Journal of Psychiatry, December 2008

[111] Statistics Canada: Canadian Community Health Survey: Mental Health and Well-being, 2003

[112] Statistics Canada: Canadian Community Health Survey: Mental Health and Well-being, 2003

[113] Statistics Canada: Canadian Community Health Survey: Mental Health and Well-being, 2003

[114] Institute of Health Economics, How Much Should We Spend on Mental Health?, September 2008

[115] Healthy Canadians – A Federal Report on Comparable Health Indicators 2006

http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2006-fed-comp-indicat/2006-fed- comp-indicat-eng.pdf

a study of First Nation health use in Alberta (2005) it reported that First Nation children and adolescents were 1.6 times more likely to visit a physician office for a mental health disorder with males seeking treatment more often than females (21). [116]

The Alberta Mental Health Board reported that First Nation people had 3 times more episodes in psychiatric treatment centres than the matched control group.(23) [117] In 2000 First Nations accessed health services for most forms of mental disorders at higher rates than the general population for such disorders as anxiety, affective disorders (depression) substance abuse disorders, childhood and adolescent disorders and schizophrenia (p17)[118] In the same study it found that First Nations were seven times more likely to see a physician for a substance abuse issue and more males than females sought treatment (it peaked in the 30-39 years age group)

Not all addictions are to substances. Gambling addiction is a growing concern among many First Nations. In each of the community focus groups, gambling was identified as a problem that affects personal, family and community wellness.

One senior in a focus group commented that *"there's alcohol, drug and gambling addictions here – we see the drug dealers in the casino parking lot. I gamble, but I don't go every night"* Another commented (Sam) *"we don't want a casino here – that will be just one more problem we have to fix"* and Michael said *"people spend money they don't have on scratch tickets, bingos and at VTS, then they wonder why they can't pay their bills, sometimes I think it's just like alcohol used to be – kids go with out food so the parents can gamble"* An adult daughter (Sophie) expressed a concern about the amount of money her mother spends on bingo – *"I've gone with her sometimes and she'll will spend almost one hundred a night – she buys tickets and extra cards for every game"*

Dream Chaser was a study conducted by the Nechi Institute (1999) to study the prevalence of gambling and to determine the cultural and social factors that related to problem gambling. The study found that of the 500 aboriginal adults, 88% were presently gambling, over 20% admitted to having a problem with gambling. Problem gamblers have a lower level of education and a lower income, however pathological gamblers were reported to have a higher income and are more likely to live on a reserve. Gamblers who were identified as pathological gamblers said that they gambled to win, to get out of the house, to forget problems, to be alone, indicating greater alienation. Only 29% have sought help for their gambling problem.[119]

In another study it found that problem gamblers start gambling early in life. Twenty-two percent started gambling before age 16 and fifty percent started at age 19. Other social factors included; 60% former drinkers and drug users were experiencing problems in

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[116] Cardinal JC, Schopflocher DO, Svenson LW, Morrison KB, Laing L. (2004) First Nation in Alberta; A focus on Health Service Use. Edmonton: Alberta

[117] Cardinal JC, Schopflocher DO, Svenson LW, Morrison KB, Laing L. (2004) First Nation in Alberta; A focus on Health Service Use. Edmonton: Alberta

[118] ibid

[119] Nechi Training and Research Institute – Dream Chasers (1999) http://www.nechi.com/research/gambling.php#link1

gambling.[120] For many, bingo was the first experience with those who become gamblers later in life. Focus group participants felt that Bingo had been normalized and felt that those people who were addicted to Bingos, scratch tickets and Video Lottery Terminals (VLT) did not believe it to be harmful. Many accepted the fact that people go to bingos and casinos because it 'gets them out of the house' and it was a way to socialize with other people. Those focus group participants who went to bingos regularly were most often seniors who also revealed they felt lonely a lot of the time. Many were not aware of the amount of money they spent on a weekly basis. Adult children who spoke about gambling as a concern also said they accepted their relatives gambling behaviour and didn't feel they had a right to interfere; that it {bingo} keeps them involved in the community and took pressure off the rest of the family.

The more severe the gambling problem, the more evidence there is of a connection between gambling and mental health issues. Respondents in the *Bingoland* study, reported they spent more money & time than intended; gambled to be alone and to forget problems; felt nervous about money spent; started gambling earlier; know more people with gambling problems; had been in trouble with the law; They also tend to live on the reserve, attended residential school and had grieving losses in their lives.

Suicide is a mental health issue connected to substance abuse. Finkelstein (1997) notes that women who misuse substances are at high risk for suicide ideation and completion [121] . Among women, mental health disorders are commonly associated with and exacerbated by substance use. Almost two thirds of women alcoholics have mental health problems (Halzer and Pryabech as cited in Beckman, 1994b). The most common disorders are anxiety, depression, phobias and panic disorders. Women alcoholics also report experiencing more depressive symptoms than male alcoholics physiologically (although alcohol itself has a depressant effect). However, depressive symptoms may persist after sobriety (Turnbull and Gomberg as cited in McCrady and Raytek, 1993).
The results from the community survey, personal interviews and community focus groups indicate that most people believe that substance abuse and mental illness are co-occurring disorders. Many were not able to use those words to explain the condition but many of the comments suggest people in the community suffer from low self-esteem, feelings of hopelessness, loss of personal power, acceptance of the status quo and depression. Socio-economic factors of high unemployment, lacking job skills and low educational attainment contribute to these factors and reduce community members' ability to compete in the general job market. First Nations living on reserve have limited access to mental health professionals, transportation difficulties and misdiagnosis and limited knowledge about mental health services were cited as barriers and puts further limitations on those needing mental health services.

Provincially across all demographics groups (youth, young men, adults, seniors) survey respondents indicated that:

- Seniors and adults were reported to exhibit the highest rates of depression respectively 95.9% and 88.2%

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[120] Nechi Training and Research Institute. Bingoland (1994)

[121] Finkelstein, Norma, Cheryl Kennedy, Katharine Thomas, and Marie Kearns (1997).Gender-Specific Substance Abuse Treatment. Alexandria, Vir.: National Women's Resource Center for Prevention of Alcohol, Tobacco and Other Drug Abuse and Mental Illness

- Fighting and aggressive behaviour and other destructive actions were reported highest in the young men and youth 98.2% and 85.7% respectively
- Young men were seen to have the highest rates for conflicts with police
- Youth (90.2%) were seen to have the highest rates for vandalism or other destructive actions

Resources and Services Available

A number of addiction and mental services are available from Alberta Health Services and through the programs offered to all Albertans. The (Alberta) Aboriginal Mental Health Framework [122] identifies key issues facing Aboriginal people and presents a spiral model [123] as the basis for implementing the strategic directions that were identified in focus group discussions for the development of the Provincial Mental Health Plan in 2003. (They are captured as key points in the PMHP Appendix A (pp 34-35). The next step will be to bring the Aboriginal Mental Health Plan to First Nation communities and agencies and Regional Health Authorities to identify the actions steps needed to implement the Frameworks' strategic directions

The FNIHB funds mental health activities and services in the form of short-term crisis intervention, counselling, treatment and prevention programming are available through the following four initiatives and programs: (See Section 9 Addictions and Mental Health Care Systems for more detail on these programs)

- Brighter Futures Initiative
- Building Healthy Communities Initiative
- Non-Insured Health Benefits Program
- National Native Alcohol and Drug Abuse Program

There were reports of mental health services in some communities such as Fort Chipewyan and Hobbema that have contracted mental health experts to provide service on a regular basis. These services were seen as positive steps to address the needs.

Hobbema Health Services entered into a funding agreement with the FNIHB a number of years ago and funds were allocated so the community could contract with four licensed therapists on a full time basis to provide services to the Hobbema communities. Unfortunately the funded budget has remained unchanged for the past ten years, while wages have increased. This limits the programs ability to secure therapists at the same high level of speciality they were once able to attract.

At present there is no national health policy for First Nations people. Alberta, through the development of the Aboriginal Mental Health Framework, has identified a number of considerations that will support policy development to occur in Alberta. Aboriginal people are eligible to access mental health services at community mental health clinics, hospitals, and psychiatric institutions however there are significant concerns regarding

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[122] Aboriginal Mental Health Framework for Alberta www.ambh.ab.ca/publications

[123] The Spiral Model is adapted from Becoming an Ally Breaking the Cycle of Oppression by Anne Bishop, 2002, Fernwood Publishing, Halifax. Also called the Action-Reflection Model or the Conscientization Model Adapted from: The "Core Model" of Learning, Centre for Christian Studies, Toronto, Ontario CUSO Education Department, Basics and Tools: A Collection o/Popular Education Resources and Activities (Ottawa: CUSO, 1988) Arnold, Burke, James, Martin, Thomas, Educating for a Change (Toronto: Between the Lines, 1991)

access, cultural appropriateness or skilled and knowledgeable professionals who are aware of the unique needs of Aboriginal people. The community members who participated in focus group discussions said they wanted the option to use and have culturally appropriate mental health services provided by those who practice cultural safety [124] and to validate Aboriginal practices on healing by making traditional healers and medicine available as a viable option in seeking help for mental health problems.

Recommendations

To meet the needs of First Nation people that require Mental Health Services, there are a number of challenges to overcome. The list is not exhaustive, and as the Ottawa charter for Health Promotion acknowledges, changes to the health care system must also be considered. [125]

1. Better coordination among services providers so as to address mental health conditions co-occurring with substance abuse
2. Development of a core National and Provincial Aboriginal Mental Health program
3. Better case coordination including protocols for information sharing across agencies.
4. Better coordination for children mental health needs
5. Better understanding among service providers of the distinction between urban and rural First Nation and how it affects the mental health of individuals
6. Increased training and mentorship support for people with mental illness
7. Clinical supervision for front line workers who are addressing mental health issues in their clients
8. More resources for those recovering from Residential School Trauma
9. Travel funds for those requiring specialized services outside of the local area.
10. Youth and Elders safe homes that meet the different needs of levels of supervised living
11. Service providers to be trained in Cultural Safety and to be aware of their own social location and the impact they have on program development and delivery.

SECTION 8 COMMUNITY SUPPORT TO ADDRESS SUBSTANCE USE

Needs and Issues

The adage that says “It takes a community to raise a child” can be applied to communities in their response to substance abuse. It is not the single responsibility of one person to magically solve the community health and wellness issues. The results from the survey of health and wellness workers is a reminder that the development of a community response to substance abuse requires a coordinated effort, integrated services and a committed community of services providers and community members. Problems do not occur in one area of a person’s life, the layers upon layers of social and

[124] Cultural safety goes beyond cultural awareness and sensitivity to understand others within the broadest context, including the historical, political and social factors that shape health and health care for all people.

[125] World Health Organization. Ottawa Charter of Health Promotion. First International Conference on Health Promotion, Ottawa Nov 21, 1986. www.int/hpr/archive/docs/ottawa.html

health determinants require a complete systems approach. Support is required through partnerships with services providers, consumers and their families, and policy makers. It is communities that work together that make the difference in addressing substance abuse and creating healthy living.

The silo approach to working with substance abuse and mental health as single concerns has been refuted by researchers that assert that addictive disorders and mental health are often a co morbid condition; which is they exist together. and need to be treated as such.

The data from this section comes from community focus groups, personal interviews and the community survey.

Respondents in community focus groups and personal interviews were asked to comment on what they thought needed to happen in their community to make it healthier and what it would take to mobilize the community into doing things on their own. Each demographic group spoke of the need for all community members to take a role in making changes; the youth said they thought parents should be more involved with their kids and that there should be more (supervised) safe recreational activities. Men and women commented that people need to work together and have everyone involved in different community activities. The seniors said that people need to own up to their responsibilities, that both parents should be responsible for their children and that they were prepared to support community efforts in whatever way they could. All groups said they wanted to feel valued, to be treated with respect and to feel that they belonged.

The majority of participants believed that more services were required to support people who are trying to quit their addictions and this could be done through increased integrated services such as skill training, job development, life skills training and more educational health and preventions workshops on health and wellness for all age groups. One Elder (John) said "*we need to build trust and quit blaming. Talk about the problems. Educate seniors on what is happening*" Another Elder (Jim) said "*We need everyone to come together as one."*

Almost all respondents commented that they thought that leadership (Chief and Council) could do more to combat the alcohol and drugs misuse in the community. Several respondents commented that Chief and Council and other informal community leaders and staff were very good at responding to immediate crisis and were able to mobilize the community to address the immediate threat. It was suggested that perhaps the community members should declare a state of emergency within their community and direct leadership to make alcohol and drug abuse intervention a priority issue. Overall everyone agreed that it was the community's responsibility as a whole to work toward stopping substance abuse.

Survey respondents were asked to address a number of questions about the degree to which there is community support and leadership to address the substance abuse issues in their community. It appears that for the majority of these survey respondents (70-80%) community leaders are perceived as paying little attention to the substance abuse issues in their community or speaking to the problem but doing little about it. Very few of these respondents (20-30%) seem to have leaders send a strong anti-drug message and ensure there are resources actively focused on addressing the issues.

Leadership Support

Table 27: Percentage of Respondents who Perceive there is Commitment from Chief and Council to Create a Community Free from Substance Abuse

	Across Province	Treaty 6	Treaty 7	Treaty 8
do not pay much attention to the issue	40.8%	22.2%	45.5%	55.9%
speak about addictions but have few actions to support words	79.6%	83.3%	72.2%	82.4%
have restrictions about drug/alcohol use at community events	35.9%	30.6%	42.4%	35.3%
promote cultural and social norms prohibiting substance abuse	33.0%	38.9%	27.3%	32.4%
strong ant-drug messages; many resources to help people stay alcohol and drug free	23.9%	30.6%	21.2%	17.6%

When asked about any bylaws in their community specifically focused on staying alcohol and drug free, 9 individuals said nothing while 29 individuals referred to a variety of measures. No drinking on reserve (i.e. a dry reserve) was mentioned by 14 individuals. Two individuals mentioned restrictions on liquor store hours or prohibiting liquor sell on reserve all together. Two individuals mentioned curfew laws and eviction of drug dealers was mentioned by three individuals. Eight (8) individuals referred to increased law enforcement security in general. Therapeutic strategies such as mandatory treatment and posted signs about being alcohol and drug free were mentioned by three individuals. An example of community action can be seen in the community of Fort Chipewyan. Fort Chipewyan had experienced significant problem gambling with video lottery terminals (VLT) and after a number of community meetings and leadership support, the town voted to ban the sale of VLTs in Fort Chipewyan.

It is apparent that all communities have at least some resources to address alcohol and drug abuse issues. All communities have a NNADAP worker and in at least three quarters of the communities there is also a community health representative (CHR) and a community health nurse. Most of the survey respondents in Treaty 7 said they had youth workers, while bout a half of the respondents in Treaty 6 and 8 said they had youth workers. About a third- to half of the respondents in each Treaty area said they had an elder counsellor as well.

NNADAP Workers Collaboration with Service Agencies

According to the survey respondents many of the Alberta First Nation communities have 3 or 4 NNADAP workers. Caseloads seem to vary substantially from as low as 10 to as high as 200 clients. The most typical amount however seems to be between 35-50 clients. When asked about training and development resources for these substance abuse counsellors, all but two individuals said yes they received training each year – typically more than 7 days a year (62%). However when asked about clinical supervision, only 18% said they received regular daily supervision, while 11% said they receive some supervision each week and over 70% said they received little to none clinical supervision. The level of clinical supervision was reported to be higher in Treaty 6 than any other Treaty. In order to stay healthy and prevent burnout, these NNADAP counsellors and

other wellness professionals said they practice self-care strategies, support each other as a peer system and participated in the retreats and workshop provided by NNADAP.

Table 28 provides data on how NNADAP workers collaborate with other service providers in their community. A least two thirds of these respondents said they attend meetings with other service providers and make referrals to each. This was consistent across all Treaty areas. But only half of them said they do case conferences together with other service provides and slightly less said they work closely together in the provision of services.

Table 28: Extent to Which NNADAP Workers Collaborate with Other Social and Health Workers in their Community

	Across Province	Treaty 6	Treaty 7	Treaty 8
not at all	11.1%	14.3%	9.7%	8.3%
attend meetings together occasionally	61.1%	65.7%	58.1%	58.1%
make referrals to each other	66.7%	60.0%	71.0%	70.8%
do case conferences together on some families	52.2%	62.9%	51.6%	37.5%
work closely together on most cases in provision of services	46.7%	40.0%	58.1%	41.7%

NNADAP counsellors were asked questions about the resources they use. Well over 30% of the respondents mentioned referring clients to St Paul's Treatment Centre – a residential centre mentioned four times more often than any other facility in the province. Approximately a half of these respondents said that clients receive detoxification services prior to going off to a residential centre. Almost two –thirds said clients get pre-care counselling.

When asked what happens when clients complete treatment, more than 90% said they return to their home community and of these the majority of them are given some degree of information and support. However less than 40% of them seem to participate in aftercare counselling. This was true across all areas of the province.

The Siksika First Nation is one example of how their community responded to after care needs of those completing treatment and to prevention and support needs of community members as a whole. The Siksika First Nation has a population of 6,420 and also has a larger health and wellness staff than many other First Nation communities. The Health Director and NNADAP coordinator and NNADAP staff have developed a life skills program that provides information, addictions support, and job readiness skills. The program does not receive additional dollars to operate the program but has reallocated existing dollars, used existing staff to share in the facilitation and counselling and also works closely with external resource agencies to integrate community services into their 3 day a week six week program. The program provides information, education and circle discussion on culture, parenting, addictions and the effects of alcohol and drugs.

Community Constraints

The survey respondents were asked to identify some of the constraints within the community to addressing substance abuse and addiction issues (see Table 29). Poverty, residential school trauma and family violence/abuse were cited by three-quarters of the respondents. Unstable leadership and political conflict in the community was mentioned by 57% of respondents. Treaty 7 and Treaty 8 mentioned geographical isolation. When asked what the top three challenges were, the same three factors as above were the most significant. Housing problems also were identified by a large number of respondents.

Table 29: Community Problems that Hinder Addressing Substance Abuse and Addiction Issues

	Across Province	Treaty 6	Treaty 7	Treaty 8
geographical isolation	44.3%	22.9%	54.3%	55.6%
difficulty with transportation to detox or treatment centres	56.6%	42.9%	68.6%	56.0%
high level of poverty and unemployment	77.4%	68.6%	94.3%	69.4%
high staff turnover in social and health services jobs	30.2%	25.7%	28.6%	36.1%
no professional staff to provide clinical supervision	30.2%	25.7%	31.4%	33.3%
lack of professional counselling services for mental health issues	35.8%	42.9%	31.4%	33.3%
lack of services for physically and medically disabled clients with an addiction problem	41.5%	34.3%	42.9%	47.2%
unstable community leadership./political conflict	57.5%	42.9%	57.1%	72.2%
history of residential trauma in community	71.7%	60.0%	71.4%	83.3%
high level of family violence /abuse	68.9%	60.0%	77.1%	69.4%

When asked what strengths in the community were, mention was made of the large number of treatment resources and the commitment of the NNADAP workers and other wellness workers. A few of the respondents also mentioned strong leadership and a culture committed to health living. (What is also significant is the absence of this response by many of the respondents).

Communities have many strengths and their stories are powerful. Community interviewers were told of the many positive things happening. The following stories illustrate the experience of two communities

> ***Laura*** *said "our focus is a little different now – we stay focused on keeping the family together and trying to get services to work together. Child welfare has a summer camp for the community. We host a Mother Day BBQ on this coming Sunday and fathers BBQ on their Sunday in June. Every year have a four day camp at Hilliard's Bay. At the Provincial Park we rent an area by the lake. We started candlelight up for people who've passed away at the camp. It is fun for everyone to just have to a camp together.*

Sometimes it gets pretty packed and some just come for the day. It's all alcohol and drug free. We also have organized activities and games".

"We also have a community kitchen and the young moms are allowed to invite an elder. We are talking about having a dad's kitchen then bring people together and have a community meal they cook. We are bringing in the food handling course for men and young fathers. Things are starting to happen in our community."

***Alba** said "There are some people in our community that religious and we have an annual gathering where we take a group of people on a wagon train - a pilgrimage that is held every year at Lac St. Anne – it takes about 10-12 days. We camp out every night along the way and at Fort Assiniboine we have a traditional feast. Some people ride in the wagon train that is pulled by horses, some drive and share their vehicles. We share stories and remember the past elders who took the journey years ago and were sick and wanted to go to the lake for healing. It takes all day to get from one camp to the next. There are about 5-9 horses and wagons and others from outside the community join up with us. This will be the 9th yr – it started in 2000. We are planning for big celebration for 10th year. We brought in a NNADAP Worker to talk to the youth. Its all drug and alcohol free. We hire a driver and bus to pick horses and wagons, for the return trip. The family members are picked up by family. When we get there, there is a whole city of tents and trailers" and "* we have an elders home – they gather *there to play pool, darts, cards, mingling, right now it is equipped for residential living, has 2 bedrooms, 2 baths, full basement, large pantry, large room for socializing. There is TV area. It was set up for socializing. Sometimes we used the building for visiting guests."*

Respondents were asked to provide suggestions on what was needed to help their community. Responses below are illustrative. An aftercare program was mentioned by seven individuals. At least a dozen individuals wanted more treatment counsellors and/or treatment facilities – especially a residential centre for youth and for adults. A couple of people made mention of a recreation facility. Others made mention of specific resources for the mentally ill, or those with anger issues or sexual abuse victims etc.

In a study of BC First Nations, Chandler and Lalonde concluded in their report that local control over cultural continuity was a protective factor against suicide in First Nations Youth. They found that "Failures in constructing a sense of ownership of one's personal and collective past, and some commitment to one's own future prospects, were associated with a dramatically heightened risk of suicide. In the absence of a sense of personal and cultural continuity, our ongoing studies show that life is easily cheapened,

and there is the possibility of suicide. " [126] Six such markers of cultural continuity were initially identified: 1) a measure of achievement of self-government, 2) had litigated for Aboriginal title to traditional lands, 3) had accomplished a measure of local control over health, education and policing services, 4) had created community facilities for the preservation of culture, 5) local control over child welfare, 6) involvement of women in band governance (with at least more that 50% female).

Survey respondents offered many ideas on how communities can address substance abuse issues in their community. Several individuals made reference to changed attitudes and a commitment to healthy living; a commitment that they wanted to see in their leadership, "*committed sober leadership*". There was a lot of talk of people getting together, working together; *we all need to work together, "outlaws" more protected than law abiding citizens, 100% chief and council support.*

Illustrative comments

- *need an after care program*
- *a large new facility to accommodate everyone; a residential treatment facility*
- *how do we make a change in the lives of people? Maybe by changing attitudes/behaviours*
- *positive thinking*
- *sober leadership, recreation building*
- *better aftercare treatment and community support*
- *aftercare treatment*
- *interagency group to practice what they preach - stay committed*
- *recreation building for sports*
- *more support*
- *front line workers need training in sexual abuse, have more stakeholders meetings*
- *1 - 2 more aftercare facility, NNADAP workers*
- *better access to detox and aftercare facilities, salary increase*
- *detox/aftercare facilities*
- *focus on aftercare, more group/family counselling, policy re:dry reserve, curfews, focus on employment/education*
- *qualified youth support coordinators/workers, recreation*
- *eliminate waiting times for treatment, detox facility, more training for staff*
- *getting information on who provides what service and how to access these services*
- *we all need to work together, "outlaws" more protected then law abiding citizens, 100% chief and council support, more money for mental health to provide services and trained staff*
- *better access to closer treatment facilities - easier for family to be involved*
- *highly motivated staff, loyal/dedicated to job, more training*
- *motivational training for staff*
- *step up and follow thru with what you say*
- *more support from higher up, more up-to-date resources for our programs*
- *more mental health workers, therapists*
- *harm reduction programs thru AADAC program use*

[126] Chandler, Michael and Christopher E. Lalonde. 2008. "Cultural Continuity as a Protective Factor against Suicide in First Nations Youth", Horizons. March. Vol. 10, No. 1.

- *more NNADAP counsellors*
- *everyone work toward alcohol and drug prevention*
- *open up after care facility again, drug-free workforce in our community*
- *following thru with choices, evaluation of front line workers - lack of energy, motivation, blaming*
- *aftercare*
- *economic development, structured youth master plan, parental support*
- *to have more programs and resources for all ages, for community programs and to have more youth centres/programs*
- *all agencies should work more closely with each other*
- *committed sober leadership, community centre on reserve, treatment centre for all categories, drop-in centre for all*
- *committed sober leadership, health facility needs to be expanded*
- *my community needs an overhaul in community pride - we have the people, we need the power*
- *community would be alcohol and drug free if there was no social assistance*
- *need recreation worker for evening events, laptop and projector to deliver workshops*
- *anger management training/classes*
- *trauma treatment centre - long-term, worker exchange program*
- *after care, recreation time, positive ways to teach kids and families*
- *more workshops done by community members*
- *things to elevate us for these tough times*
- *what this community needs is more workers and a new building*
- *In order for NNADAP workers to work effectively in communities, people need to quit overlooking us and understand our issues*
- *hire youth addictions worker, take into account literacy levels, underlying issues like physical, sexual, emotional, spiritual abuses*
- *increase # of workers to handle growing population*
- *a team approach, ACFN,MCFN, Métis - forget about money*
- *recreational place for youth and adults*
- *more activities geared toward 10 and under kids*
- *need social workers in town permanently*
- *detox services, youth programs, recreational facilities*
- *motivational speakers, more group sessions and activities, rodeo or team sports, youth program like in Hobbema, spiritual guidance*
- *community based program with increase staff and community leadership and commitment*
- *more funding for youth programs, commitment of leadership to reduce dependency in all aspects*
- *strengthen cultural pride and self-esteem thru community programs that focus on supporting each other and learning marketable skills*
- *more workshops on community wellness*
- *need an aftercare facility, more family programming in evenings*
- *have positive role models come talk to all people on a regular basis - maybe repetition may help change people eventually*
- *more community gatherings and less gossip, working together as a community*
- *build treatment centre, parenting courses*
- *community to work together to help people with addictions problems which leads to family abuse*

- *communicate and work on community's vision and goals and get all ages to agree to the vision, work on power and control issues*

Recommendations for Communities

1. Demonstrated commitment from leadership
2. Community policies and by-laws to support efforts to address substance use at community functions
3. Resources allocated to support preventative, intervention and after care support for those recovering from addictions.
4. Review of mental health services available on –reserve

SECTION 9 ADDICTIONS AND MENTAL HEALTH CARE SYSTEMS

Provincial Services – System of Care

Alberta Health Services (AHS)[127] is responsible for delivering health services to the 3.5 million people living in Alberta. This is accomplished with a staff of 90,000 health professionals. First Nations in Alberta represent 3.8% of the total population (112,792). There have been many changes in the structure in the past year due to the creation of Alberta Health Services (AHS) that was announced by the Minister of Health and Wellness (Ron Liepert) on May 15, 2008.

The restructured AHS organization brings together 12 formerly separate health entities in the province: nine geographically based health authorities [128] and three provincial entities working specifically in the areas of mental health (Alberta Mental Health Board), addictions (Alberta Alcohol and Drug Abuse Commission) and cancer (Alberta Cancer Board).

The Alberta Health Services is governed by a board that is led by a chairperson (Ken Hughes) and has 14 board members. Currently there are 8 Executive Vice Presidents (EVP) that work with the President and CEO. The board reports directly to the Minister of Health and Wellness Alberta Health Services. As of April 1, 2009, the former Alberta Alcohol & Drug Abuse Commission and 11 other provincial health authorities have joined together to form Alberta Health Services (AHS). The new formal structure will come into effect on June 1, 2009.
Alberta has 56 community health councils that are geographically based and some that focus on specific health topics. The health councils are advisory bodies that work with their respective communities to identify health needs and to help set priorities for their communities.

The Addictions, Substance Abuse and Gambling department is one of eight rural, public and community health departments that are under the guidance of the EVP for Rural, Public and Community Health (Pam Whitnack).

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[127] Alberta Health Services. http://www.albertahealthservices.ca/57.htm Accessed May 19-2009

128 Chinook Health, Palliser Health Treaty, Calgary Health Treaty, David Thompson Health Treaty, East Central Health, Capital Health, Aspen Regional Health, Peace Country Health and Northern Lights Health Treaty

Addictions and Mental Health Services

There are a large number of addictions and mental health services available for Albertans.[129] AADAC also provides funding for programming and services specific to Aboriginal people. These include crisis services, outpatient treatment, short-term and long-term residential treatment, priority access for pregnant women, information, prevention, community education and addictions-related training programs.

Table 30: Provides a summary of the types of services available.

Table 30 Addiction Service Programs in Alberta	
Addiction Services Network	3
Adolescent Outpatient	1
Adult Outpatient Addiction Counselling	1
Adult Rehabilitation Intensive Addiction Treatment	10
Addiction Shelter Services	5
Adult Long-Term Residential Treatment[130]	18
Adult Outpatient Addiction Counselling Services	51
Adult Residential Intensive Addiction Services	10
Assessment and Treatment Services	15
Concurrent Disorders Unity & Programs	2
Detoxification Services	11
First Steps (for women & children)	1
Health Promotions Campaigns for Healthy Living	10
Health Promotions Program	4
Mental Health & Addictions	1
Opioid Dependency Program	2
P.A.R.T.Y. Program (youth grade 9)	4
Prenatal Services	16
Regional Addiction Counselling	1
Safe works (for IV drug users)	4
Street works Free Needle Exchange	5
Substance Abuse later in life (SAILL)	1
Substance Use prevention & education services	44
Youth Outpatient Addiction Counselling Services	41

[129] Alberta Health Services. Addictions and Substance Abuse http://www.albertahealthservices.ca/293.htm Accessed

May 19-2009

[130] A number of the residential treatment programs are aboriginal specific

Table 31 presents 12 Treatment Programs and Services that are Aboriginal-specific treatment programs are available at the following organizations and these programs receive funding from AHS (formerly AADAC):

Table 31: Aboriginal Specific Addictions Services[131]

Action North Recovery	High Level
Métis Indian Town Alcohol Association	High Prairie
Native Counselling Services of Alberta Addiction Program	Wabasca
Peerless Lake Healing Centre	Peerless Lake
Bonneyville Indian Métis Rehabilitation Centre	Bonneyville
Elizabeth Métis Settlement Addiction Program	Cold Lake
Fishing Lake Métis Settlement Addiction Program	Fishing Lake
Nechi Training & Research Institute	Edmonton
Niwichihaw Addiction Counselling Service	Red Deer
Poundmakers Lodge Treatment Centre	Edmonton
Rocky Native Friendship Centre	Rocky Mountain House
Sunrise Native Addiction Services	Calgary

Alberta Health Services: Aboriginal Health Program[132]

The Aboriginal Health Program team assists with the development of partnerships and programs throughout Alberta Health Services in the Edmonton area to enhance the accessibility, quality, and cultural-appropriateness of healthcare services for Aboriginal people served by the Edmonton area. The Aboriginal Health Program works in four areas:

1. *Development and implementation of best practices in Aboriginal Health* including clinical service, applied research and outcome evaluation.
2. *Increased capacity to recruit and retain Aboriginal workers within the health workforce*.
3. *Enhanced use of Telehealth* to better serve rural and remote communities and provide care and services closer to home for Aboriginal people.
   Improved communication and education with Aboriginal people and communities and also to help physicians and health staff better understand and respond to the health needs of First Nation, Métis, and Inuit people.

Aboriginal Health Programs & Services:

Aboriginal Care Coordinators help Aboriginal patients and families throughout their hospital stay and connect them to the health services and programs in their home communities. Available at Alberta Hospital Edmonton, Glenrose, Grey Nuns, Misericordia, Royal Alexandra, Stollery, Sturgeon, University of Alberta Hospitals, and West View Health Centre. Patients can request Aboriginal Care Coordinators' services through

131 http://www.aadac.com/documents/aboriginal_services_chart.pdf

132 Alberta Health Services. Regional Aboriginal Health Program http://www.albertahealthservices.ca/2225.htm

doctors or nurses at the site. An Aboriginal Care Coordinator is available for community mental health and community care (home care) clients by asking mental health and community care staff.

Aboriginal Cultural Helpers provide spiritual support for patients and families. Available at Alberta Hospital Edmonton, Grey Nuns, Misericordia, Royal Alexandra, University of Alberta Hospitals through Pastoral Care Services.

Federal Programs

First Nations Inuit Health Branch

The Federal Government has a fiduciary responsibility to provide health services to First Nations people and does so by contributing towards these expenditures through Canada Health Transfer payments to each province. In addition, the Federal Government provides some health services to First Nations (and Inuit) such as public health activities and health promotion. Many health services and health promotion activities are provided directly by individual First Nation governments through negotiations, transfer agreements, land claim agreements and other mechanisms.

The federal government provides a limited number of health programs that are accessible to eligible First Nation people regardless of status and residency. The programs and services provided by FNIHB are guided by the principles of the Blueprint on Aboriginal Health a 10 year Transformative PLAN.[133] (2005) The Blueprint is a national document which provides guidance on initiatives to improve the health status of Aboriginal peoples and is to be implemented at the local, district, Regional, provincial and territorial levels, responsive to needs. The Blueprint was developed by the partnership between Federal, Territorial and Provincial governments and Aboriginal organizations and services providers. Health services involve a number of different services available to individuals (preventative, diagnostic, therapeutic).

Health Canada's First Nations and Inuit Health Branch use contribution agreements to flow funding for health programs and services for First Nations people on reserve, and Inuit in the North. The contribution agreements fall within the following authorities:

- Children and Youth
- Chronic Disease and Injury Prevention
- Communicable Disease Control
- Environmental Public Health and Research
- Health Governance and Infrastructure Support
- Mental Health and Addictions
- Primary Care
- Supplementary Health Benefits

Through the FNIHB program, Supplementary Health Benefits includes the Non-Insured Health Benefits (NIHB) which includes prescription drugs, over-the-counter medication,

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133 Health Canada. http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2005-blueprint-plan-abor-auto/plan-

eng.pdf

medical supplies and equipment, short-term crisis counselling, dental care, vision care, and medical transportation. The annual budget for NIHB is 898.2 million.[134] The Alberta NIHB is 131 million dollars.

In addition to providing funds for NIHB and Substance Abuse Treatment, several community based programs are funded and provided through community based programs with First Nations. These family based programs include services for pregnant women (Canada Prenatal Nutrition Program) Aboriginal Head Start (for children under the age of 6), Infant development program (children birth to 2 years), Brighter Futures, Fetal Alcohol Spectrum Disorder (FASD), and Maternal and Child Health,

Substance Abuse Services is included in the Mental Health and Addiction agreement. Treatment programs that help aboriginal people to heal and recover from alcohol and substance abuse are funded by Health Canada through the National Native Alcohol and Drug Abuse Program (NNADAP).

Mental Health and Addictions

The following information provides a list of programs available under the FNIHB Mental Health and Addictions program:[135]

Brighter Futures program The overall purpose of the Brighter Futures program is to improve the quality of, and access to, culturally appropriate, holistic and community-directed mental health, child development, and injury prevention services at the community level to help create healthy family and community environments. Program clients: all members of First Nations and Inuit communities.

Building Healthy Communities This program is designed to assist First Nations and Inuit communities (which include individuals and families) and territorial governments in developing community-based approaches to mental health crisis management. Activities include assessments, counselling services, referrals for treatment and follow-up treatment, aftercare and rehabilitation to individuals and communities in crisis. Program clients: First Nations communities, individuals and families.

Indian Residential Schools Resolution Health Support Program The Indian Residential Schools (IRS) Resolution Health Support Program provides access to mental health, transportation services and emotional support services for eligible former Indian residential school students through the Health Canada Regional offices. Program clients: Eligible clients include former IRS students resolving claims through the Independent Assessment Process and their families, former IRS students receiving Common Experience Payments and their families, and those participating in Truth and Reconciliation and Commemoration events.

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134 First Nations Inuit Health Branch – Non- Insured Health Benefits 2008 annual report. http://www.hc-sc.gc.ca/fniah-spnia/alt_formats/fnihb-dgspni/pdf/pubs/nihb-ssna/2008_rpt-eng.pdf

135 First Nation Inuit Aboriginal Health Programs and Services. Website http://www.hc-sc.gc.ca/fniah-spnia/finance/agree-accord/prog/index-eng.php#child_enf (Accessed May 20-2009)

Labrador Innu Comprehensive Healing Strategy The Labrador Innu Comprehensive Healing Strategy (LICHS) is a long-term strategy designed to improve health and social outcomes in the two Labrador Innu communities of Natuashish (formerly Davis Inlet) and Sheshatshiu. The strategy was developed in the aftermath of a gas-sniffing crisis in the Labrador Innu communities in the Fall of 2000. Program clients: members of the Mushuau Innu and Sheshatshiu Innu First Nations residing in the communities of Natuashish and Sheshatshiu, Labrador.

National Aboriginal Youth Suicide Prevention Strategy (NAYSP)
As a program, the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) supports a range of community-based solutions and activities that contribute to improved mental health and wellness among Aboriginal youth, families, and communities. Program clients: First Nations youth living on reserve, Inuit youth, off reserve Aboriginal youth.

National Native Alcohol and Drug Abuse Program - Community-based Program
The National Native Alcohol and Drug Abuse Program (NNADAP) community-based program provides prevention, intervention and aftercare and follow-up services in 500 First Nations and Inuit communities. Each First Nation in Alberta employs at least one NNADAP worker; there are a total of 103 NNADAP Workers in Alberta. Some larger First Nation communities may have more than 3 NNADAP workers in one community. The role of the NNADAP worker is to provide assessment, referral and counselling support to First Nation community members.

National Native Alcohol and Drug Abuse Program - Residential Treatment
The Residential Treatment component of NNADAP is a national network of 50 treatment centres operated by First Nations organizations and/or communities that provide culturally appropriate in-patient and out-patient treatment services for alcohol and other forms of substance abuse. Program clients: First Nations and Inuit who have been assessed as requiring residential treatment. In Alberta, there are nine treatment centres of which two are designated for youth (under 18 years of age) (See appendix for a list and description of all NNADAP funded treatment centres in Alberta). All Alberta treatment centres offer residential care and one centre (Beaver Lake Wah Pow) provides services to families (with children under school age).

Youth Solvent Abuse Program (YSAP) The Youth Solvent Abuse Program is a community-based prevention, intervention, aftercare and in-patient treatment program that targets First Nations and Inuit youth who are addicted to, or are at risk of, inhaling solvents. Program clients: First Nations and Inuit youth who are addicted to, or at risk of, inhaling solvents.

***Indian and Northern Affairs Canada (INAC*)** does not provide funds for health or substance abuse. Social programs through INAC include social assistance for those First Nations living on-reserve and may include Family Violence prevention. INAC however, does have an Urban Aboriginal Strategy under the direction of the Office of the Federal Interlocutor

Urban Aboriginal Strategy [136]
The Urban Aboriginal Strategy (UAS) is a community-based initiative developed by the Government of Canada to improve social and economic opportunities of Aboriginal people living in urban centres.

Through the Urban Aboriginal Strategy, the Government of Canada partners with the Aboriginal community and local organizations, municipal and provincial governments and with the private sector. These partnerships support projects that respond to local priorities and advance the UAS national priority areas of: improving life skills, promoting job training, skills and entrepreneurship and supporting Aboriginal women, children and families.

The Urban Aboriginal Strategy (UAS) was first developed in 1997, to help respond to the needs facing Aboriginal people living in key urban centres. Through the UAS, the Government of Canada seeks to partner with other governments, community organizations and Aboriginal people to support projects that respond to local priorities.

In 2003 and 2004, the UAS was allocated $50 million over a four-year period to build on existing partnerships while providing additional funding to community pilot projects in a small number of cities to learn what works well and what does not.

In 2007, Canada's New Government decided to set priorities and make a long-term commitment on Aboriginal issues by investing $68.5 million over five years to help respond effectively to the needs of Aboriginal people living in key urban centres.

Today, about 50 percent of the Aboriginal population lives in Canada's larger cities. The UAS operates in thirteen cities whose Aboriginal population represents more than 25 percent of Canada's total Aboriginal population. The thirteen designated cities include: Vancouver, Prince George, ***Lethbridge, Calgary, Edmonton***, Prince Albert, Regina, Saskatoon, Winnipeg, Thompson, Toronto and Thunder Bay.

The UAS has proven effective in leveraging monetary and in-kind contributions. To illustrate, between 2003-2006, the Government of Canada invested $28.7M through the UAS, levered an additional $9.6 M from other federal departments and an additional $21.8M from partners outside of the federal arena ($9.2M from provincial governments; $1.6M from municipalities; $4.2M from Aboriginal organizations and $6.8M from other sources, non-profit sector, community foundations, private sector, etc).

SECTION 10 COMMUNITY WIDE ISSUES AND NEEDS

NNADAP Wellness Consultants

The Addictions and Mental Health program in Alberta has three full-time (NNADAP) Wellness consultants that work with NNADAP Workers in each of the three Treaty areas. These positions report to the Team Leader for Addictions and Wellness Program.

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136 Indian and Northern Affairs Canada Office of the Federal Interlocutor

http://www.ainc-inac.gc.ca/ai/ofi/uas/bkg-eng.asp#tphp

Personal interviews were conducted with each Wellness Consultant to discuss their role in the NNADAP program, the needs of the community and of the NNADAP workers, the challenges they experience, community mobilization and recommendations for change.

The Wellness Consultants (WC) plays a key role in communication between NNADAP workers and changes to the NNADAP program. There are 103 NNADAP workers working in First Nation communities. They act as coordinators and facilitators and when needed will also provide direct support to treatment centres and may temporarily backfill a position for a NNADAP worker who is attending training. The Wellness Consultant is the 'go to' person for the NNADAP workers who need orientation, assistance with information on addictions, assessments and referrals and at times, the support and resource person for crisis management. In some ways, the Wellness consultant has the expertise to perform the duties and offer support that the supervisor would normally provide.

The response to the question about which group was most affected by substance abuse generated different responses that were as unique as the individual. One consultant believed that if you were a First Nation person – you were affected. "You can't ask that in the First Nation community – we are all affected." Another Wellness Consultant responded that it depended on the location of the community. That the more rural and remote the community, the higher the rate of solvent abuse among the young. Among the seniors, prescription drug abuse was high and not always talked about because "it was seen as okay to use it because it was ordered by the doctor." Crack use among the youth and young adults was more of a problem for those communities that were closer to small towns and cities. Finally, one WC observed that in some communities the problems were more evident and "the women in the community were more likely to admit they had a problem than the men were."

Bullying among youth was seen as problem by one Wellness Consultant, who stated that, "We've had some youth suicides – not because they had addiction problems, it's because they didn't fit in and they tried to live a good life away from the alcohol and drugs." There isn't a community that has been spared the ravages of substance abuse. "Even those that are strong culturally – they are still affected. The poorer families, the less educated, but that's not to say that people who had jobs aren't practising – they just hide it better.' Those at the leadership level, and others that are employed, are known to use crack – "they can afford it." One story hinted at bigger problems - that money was the motivating factor for selling drugs. The Wellness Consultant recounted an example in one community in which "one young man who was addicted to crack was also a dealer and he had a good job too…he said that he was bank rolled (to start selling drugs) by some band staff that were looking to make an investment:"
The financial gain is not something that is openly talked about by community members.

Wellness Consultants agreed that one of the biggest challenges that NNADAP Workers face is the high expectation from the communities. One Consultant said "The community expectations are great…they are funded as prevention workers and are often expected to be crisis workers." The wages do not attract people with degrees and higher skills. "There is a lot of talk about modernizing the NNADAP – there needs to be a lot more money put into it to attract those people with higher skills". Some people are working in NNADAP positions that do not have formal training. Conversely, it was observed that

Alberta is one of the provinces with the highest number of certified addictions workers and is seen as a leader in the country for skilled and certified NNADAP workers. The role of the Wellness Consultant is stretched by trying to accommodate all addictions workers in large geographic areas; seventy percent of their time is said to be spent in the community. Priority is given to newly hired NNADAP workers and those who need immediate assistance and resources.

Wellness Consultants agreed that it was the communities' responsibility to address substance abuse issues and the communities need a lot of support. "There are so many things that need to be addressed by leadership – social problems are not a priority." Another Consultant responded that, "Communities must be accountable and have ownership, to come up with their own solutions to fit their needs. " One consultant observed that, "In my area, the First Nation communities are excellent at crisis response – when there is a crisis they work together – and when there is no crisis everything slips back to the way it was – until something energizes the community again – we need consistency."

NNADAP workers report that they are frustrated at the low attendance for community events on substance abuse. The new form of program funding that gives individual communities autonomy to spend their budgets as determined by the priorities of their communities was seen as a positive change. The clustering of programs and funds gave the communities an opportunity to look at programs to do more holistic planning.

There was a positive response from the Wellness Consultants in their comments on creating change in the communities. "I have seen tremendous change in the past 5 years – the NNADAP workers are better trained and their confidence levels have changed – they believe in what they can do, and when leadership buys into it , you'll see better results." 'Things are getting better,' one Consultant commented optimistically, "in 17 years, the quality of counsellors has changed – the certification and the profile of the NNADAP worker has been recognized by the community – there is more unity, and the community perception of the treatment centre has changed too." The renewal of cultural practices was seen as a positive change in community programs, one Wellness Consultant said, "There is much more emphasis on culture and historical understanding now."

There is still much work to be done in the communities to address substance abuse. One Consultant lamented, "The government needs to better at listening to the communities. Most of the programs come from Ottawa." Another commented that, "It depends on which (political) party is in power – social programs are cut from the wrong area and it affects service delivery processes." The broader perspective of addictions and mental health were expressed by the following comment, "We keep talking about empowerment, a lot of our attitudes and behaviours are so systemic of the Residential School system (IRS) – addictions are a symptom – we can't separate IRS and community wellness – they are all related to other issues."

It could be said the Wellness Consultants are like the canary in the coal mine; they are the eyes and ears of the communities in which they work. The information they receive comes directly from the front line NNADAP workers. When community intelligence and surveillance systems are combined with up-to- date information on program changes that are happening at the Regional and national level, the results and feedback are

positive and immediate. The specialized knowledge of substance abuse, addictions recovery and community development as seen from an Aboriginal perspective of wellness makes the team of Wellness Consultants an integral part of the Addictions and Mental Health department.

The following recommendations reflect the needs of NNADAP workers and the NNADA program from the perspective of the Wellness Consultants broader comments and that would enhance the efforts in for prevention in the community.

Recommendations

1. Increased resources (books, videos, pamphlets etc) for community
2. Allocate funds to purchase resources
3. Social marketing messages and merchandise to use in the community as incentives in community programs
4. Equitable salaries for NNADAP workers that is comparable to the provincial wage scale
5. Develop more pre-treatment and after care programs
6. Funds to support communities that want to offer aftercare programs
7. Extend the time available at detox centres
8. Aftercare programs that involve the family
9. Increase in family programs in the community
10. Define the scope of the NNADAP role and provide sufficient financial resources to match the skills
11. Visible support from leadership
12. Development of strategic plans for each community based on community needs
13. Collaboration among community services
14 Training and support for NNADAP Workers for specialized training (e.g. family services)
15. Training for Intake Workers on FASD screening
16 Training for Treatment Counsellors on working with FASD clients
17. Treatment program to be standardized at six week program
18. Recognition of the need for longer duration at detox centers (for some clients) and the need for more aftercare programs
19. Most clients would benefit from having family involved as part of the treatment program

SECTION 11 EMERGING INTEGRATIVE STRATEGIES

Integrative and Comprehensive Community Strategies

Addiction Treatment Modalities

The Institute of Medicine [137] describes treatment modalities as "the specific activities that are used to relieve symptoms or to induce behaviour change." The three categories of addiction treatment modalities include: Biological modalities– focus on improved detoxification regimens, pharmacology (anticraving medication, neurobiology, antagonist

[137] (1) Source: Institute of Medicine (1990). Broadening the Base of Treatment for Alcohol Problems. Washington, D.C., National Academy Press.

medication, methadone treatment), nutrition, exercise, complementary therapies, and brief biological interventions [138] Psychological modalities– range from cognitive-behavioural to psychoanalytic therapy, family therapy, humanistic, existential, transpersonal, strategic, and other psychological modalities such as group and residential modalities. [139]
Social modalities - includes brief interventions, harm reduction, and recovery management. [140]

The following are examples that represent the psychological and social modalities:

Communities that Care

One of the most promising approaches to community based drug abuse prevention is that of the *Communities That Care* drug reduction strategy developed in the United States.[141] The Communities that Care program has most commonly been used to address youth substance abuse, violence and mental health issues but has also been applied to address other community based substance abuse related issues. The *Communities That Care* strategy uses community mobilization processes to reduce risk factors and increase protective factors against drug abuse. Mobilization consists of four phases:

1. community key leader recruitment and orientation
2. community advisory board formation
3. risk and resource assessment by the community board to identify priority risk factors
4. youth survey and other community problem analysis
5. action planning and implementation of family, school and community interventions which have been developed by the community and which reduce risk factors and enhance protective factors.

In the strategy, a minimum of three interventions are developed based on priorities established using the problem data. The following general prevention principles form the core of the *Communities That Care* strategy:

- interventions should focus on known risk and protective factors.
- interventions should target risk and protective factors which are appropriate for different levels of development.

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[138] For more information see http://www.sunshinecoasthealthcentre.ca/biological-modalities.html

[139] ibid

[140] ibid

[141] Peterson, P.L., J.D. Hawkins, and R.F. Catalano. 1992. "Evaluating comprehensive community drug risk reduction interactions: Design challenges and recommendations." Evaluation Review. Vol 16, pp. 579-602

- prevention of drug abuse should start early, including major components that are delivered before drug use initiation occurs.
- interventions should reach people at high risk.
- interventions must address multiple risk factors across multiple domains - individual, family, school, peer group and community.

A foundational element of the Communities that Care strategy is engaging and empowering community members to understand the risk and protective factors in their community, to complete an asset mapping of the their community resources to address these problems and to take ownership of solutions to change conditions in their community.

A program of coordination, training and guidebooks are available to facilitate the community processes. For more information, go to the following website. http://ncadi.samhsa.gov/features/ctc/resources.aspx

Sheway Program Model for Pregnant Women with Substance Abuse Disorder [142]

Sheway's Program Model (Vancouver, BC) is based on the recognition that the health of women and their children is linked to the conditions of their lives and their ability to influence these conditions. Services are provided in response to the needs of pregnant and parenting women

Sheway's **GOALS** fall into four core areas:

- To engage women in accessing prenatal care and a range of other supports during pregnancy
- To promote health, and nutrition of women and their children accessing prenatal and postnatal care at Sheway in the period up to 18 months following birth.
- To provide education, referral and support to women to help them reduce risk behaviors, in particular to reduce or stop use of alcohol and other drugs during pregnancy.
- To support mothers in their capacity as parents and caregivers.

Service Philosophy

- Provides services in a flexible, non-judgmental, nurturing and accepting way
- Uses a woman centered approach that supports women's self-determination, choices and empowerment
- Offers respect and understanding of First Nations culture, history and tradition
- Uses a harm reduction approach
- Offers a safe, accessible, welcoming drop-in environment
- Links women and their families into a network of health-related, social, emotional, cultural and practical support

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[142] Sheway Project. 3639 Hawks Ave. Vancouver, BC V6A 4J2 (604)-658-1200 www.vnhs.net sheway@vrhb.bc.ca

Harm Reduction

Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence.

- Accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well being--not necessarily cessation of all drug use--as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

Sheway partnership and Current Governance Model

Sheway is a partnership, funded and staffed by the Ministry of Children and Family Development (MCFD), Vancouver Coastal Health Authority (VCHA), YWCA, Vancouver Native Health Services (VNHS) and the Ministry of Housing and Social Development (MHSD). There are also a number of other funding sources including PHSA that funds positions through the YWCA, VCH and VNHS along with grant funding from a variety of federal and other programs. Sheway is an unincorporated entity.

The governance model adopted when Sheway opened was a Council with representation from YWCA, Vancouver Coastal Health Authority (VCHA), Ministry of Children and Family Development, Vancouver Northern Health Services and more recently Ministry ofHealth and Social Development. The Council meets periodically but has no legal status and no designated officers. The VCHA employed Sheway Manager (or on site Coordinator) liaises with Council.

This shared governance model was intended to provide a unique type of support for Sheway. Council members are to help “home” organizations understand Sheway and the complexity of the service model, collaborate for innovative solutions to challenging problems, and liaise with other evolving programs/services.

Healthy IDEAS Model for Seniors

(Identifying Depression, Empowering Activities for Seniors) An evidence-based depression program

Much of the material written on aging and substance misuse also considers co-morbid factors such as depression, memory loss and prescription misuse. The elderly don’t

always abuse prescription drugs intentionally, sometimes the abuse is the result of a desire to lessen the pain, because they forgot that they had already taken their medication, or because they don't understand the interactions of the drugs; it just happens. We heard from participants in focus groups that seniors have said they often don't know what the medication they take is for. We also heard several stories of people feeling depressed and alone.

The Healthy IDEAS is a community depression program designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations. The program incorporates four evidence-based components into the ongoing service delivery of care management or social service programs serving older individuals in the home environment over several weeks. [143]
Healthy IDEAS was initially developed by Baylor College of Medicine's Huffington Center on Aging as part of the Model Programs Project sponsored by the National Council on Aging (NCOA) and funded by the John A. Hartford Foundation.

Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) is an evidence-based program designed to detect depression and reduce the severity of depressive symptoms among community-dwelling older adults.

This model program was developed as a depression self-management program through a Houston academic-community partnership led by interdisciplinary faculty at Baylor College of Medicine. Support came from the National Council on Aging and the John A. Hartford Foundation. One of the goals of the Health IDEAS program is to connect the aging and behavioural health networks.

This program incorporates four evidence-based components including screening and assessment, education for older clients and family caregivers, referral and linkages to appropriate health professionals and behavioural activation. Behavioural activation is a brief and uncomplicated approach to reducing depressive symptoms.

Care managers assist clients in identifying pleasurable or satisfying activities and adding some of these activities back into their lives. The care managers monitor progress, help to adjust goals as needed, and reinforce positive behaviour.[144]

Healthy IDEAS in the home environment. The presence and severity of depressive symptoms determines the scope and duration of the program for each client. After the initial assessment and education visit, the intervention typically involves two or three face-to-face visits and five or more telephone contacts related to depression self-care over a period of three to four months. Assessment in changes of the client's mood is determined with repeat administration of the Geriatric Depression Scale (GDS).

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[143] National Council on Aging. (NCOA) http://www.healthyagingprograms.com/content.asp?sectionid=71&ElementID=12

[144] Healthy IDEAS for Older Ohioans, Mindy Cayton, Area Agency on Aging 8
http://www.oacbha.org/includes/downloads/march088pagerfinalrev.pdf

The Matrix Model

The Matrix Model [145] is an evidenced based model proven to be effective with alcohol dependence, methamphetamine dependence and other commonly addictive substances. It is recognized by the National Institute on Drug Abuse as a comprehensive treatment program that uses a scientifically based approach.

The Matrix model uses cognitive behavioural counselling and motivational interviewing techniques proven to be effective in treatment for substance addictions. The Matrix Model has also been used with multiple ethnicities including Native Americans on and off reservations, Asians and Pacific Islanders. Some programs will apply the Matrix model and add programs specific supports such as the 12-step and bio-psychosocial materials to augment the Matrix Model.

The Matrix Model intensive outpatient treatment was developed with an awareness of the diversity of factors that contribute to drug and alcohol problems. To produce the best opportunity for success, the needs of the individual patient are considered in the design of each treatment plan. At Matrix Institute, the elements chosen to create optimal treatment for adults and adolescents include strategies and methods that have been demonstrated to be effective in helping people who are abusing drugs or alcohol. These elements are listed below and are included within all Matrix treatment programs.

- **Therapist Support -** Matrix outcome reports have consistently found that the empathetic and directive support of a professional therapist is critical in developing a successful program of recovery.

- **Group/Individual Participation -** Matrix follow-up research has identified participation in group activities during treatment to be highly related to long-term success. The regular 4 month *Matrix treatment protocol* consists primarily of group sessions. Also available are the Individualized *Intensive Treatment Program* and the 6 week *Early Intervention program*, which is an individual session only program designed for people who are at the earliest stages of readiness for treatment.

- **12-Step or Other Spiritual Group Involvement -** Numerous outcome reports with patients in inpatient, rehab or outpatient treatment have demonstrated that those patients who are involved in 12-Step and/or other support group recovery activities have far better outcomes than patients who are not involved in this recovery program.

- **Relapse Prevention and Education -** Substance abusers benefit from learning information about how they have become addicted, how they have been affected by their addiction, what they need to do to prevent a relapse and what to do if they should return to drug and/or alcohol use

- **Family Involvement -** There is substantial research that clearly indicates superior treatment outcome for patients whose families are involved in the treatment process.

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[145] Matrix Institute (800) 310-7700 123464 Santa Monica Blvd, Los Angeles, CA http://www.matrixinstitute.org

- **Structure –** Outpatient addiction treatment requires an explicit framework giving patients a clear understanding of the treatment schedule and requirements.

Wellbriety Model

The White Bison is a non profit organization based in Colorado Springs. The treatment program is based on traditional teachings that are based on the philosophy that culture is prevention.

- Mother Earth is governed by a set of Principles, Laws and Values
- Leadership exists to serve the people first
- Leadership existence is to ensure that information (Truth) is given to the people
- Changes are the result of implementing Natural laws
- All Native people believe in a Supreme Being
- In the Elders and teachings as a guiding force to direct ourselves, families and communities
- That there is a natural order running the universe
- That our traditional ways were knowledgeable about the natural order
- When the community leads, the leaders will follow
- Alcohol and drugs are destroying us and we want to recover
- That change comes from within the individual, the family and the community
- That within each person, family and community is the innate knowledge for well being
- The solution resides within each community
- Interconnectedness - it takes everyone to heal the community
- Healing will take place through he application of cultural and spiritual knowledge
- Alcohol is a symptom...not the cause, drugs are a symptom...not the cause, Domestic Violence is a symptom...not the cause. To "heal a community" it needs to deal with the cause
- That the Circle and the Four Directions are the Teachers

The program moves forward applying the Four Laws of Change

1. Change is from within
2. In order for development to occur, it must be preceded by a vision
3. A great learning must take place
4. You must create a Healing Forest

Wellbriety Training Programs for Families [146]

Families of Tradition This training explores historical trauma, family dynamics, relationships, roles parenting, conflict management, and the development of trust and respect in the family. This tree day program is based upon the traditional teachings of the Elders from many different Native American communities. One of the primary themes for this program is teaching parents

[146] White Bison Wellbriety 6145 Lehman Drive, Suite 200 • Colorado Springs CO 80918 • http://www.whitebison.org

how to use Family Talking Circles and how to create a vision for a healthy family. The curriculum is designed for 16 weekly sessions.

Fathers of Tradition This three day program is designed to be implemented by Native American men who are interested in becoming healthy fathers and who want to help other men become healthy fathers. It can be set up in community centers, family services centers, churches, local neighbourhood centers, in homes, at schools, in treatment centers, or half-way houses. The curriculum is designed around principles and teachings of the Elders from a variety of Native American communities. Participants are encouraged to create a circle of 100 Native American fathers (of all ages) to promote sacredness of fatherhood. .

Fathers and Sons of Tradition This three day program teaches fathers how to engage their sons in an ongoing series of activities and lessons that develop character, values and bring father and son together in meaningful cultural activities. The program uses the Sons of Tradition curriculum is designed to be implemented year round on a weekly basis.

Mothers and Daughters of Tradition This three day program teaches mothers how to engage their daughters in an ongoing series of activities and lessons that develop character, values, and bring mothers and daughters together in meaningful cultural activities. The program uses the Daughters of Tradition curriculum plus adds useful tips for parents who want to work with youth. This curriculum is designed to be implemented year round on a weekly basis.

Warrior Down: Families in Recovery This three day program demonstrates how to set up a community based system to provide social, emotional, instrumental and informational support to families that are reuniting after family members return from treatment, incarceration or foster care. An important component of this curriculum is intergenerational healing

Multi-systemic Therapy (MST)

In a study to examine healing work in Aboriginal communities in Canada, the authors discuss a relatively new approach, called multi- systemic therapy (MST) that currently focuses on at-risk youth.

“Essentially what it does is it transforms the web of relationships around a young person. Studies show that young people living in the same community with the same range of services available to them have dramatically different outcomes (Leschied & Cunningham, 2000).

The variable is the on-going presence of a healing mentor who is on-call around the clock for 4-6 months.

They coach, cajole, mirror, encourage and provide structure for young people. They teach significant adults and systems to work with and communicate with the young person in new ways.

They support families to learn and practice accessing existing resources and applying new insights" (p28). [147]

[147] Mapping the Healing Journey, The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities APC 21 CA (2002) Four Directions International Lethbridge, Alberta. http://www.fourworlds.ca/pdfs/Mapping.pdf

SECTION 12 CONCLUSION

The goal of the Regional needs assessment was to identify the addictions and mental health needs of First Nations people in Alberta. A ten member advisory committee comprised of Regional representatives from each of the three Treaty areas and two representatives from the First Nations Inuit Health Branch provided input and direction into the project. Just under 400 participated in community surveys, personal interviews and focus groups. Fourteen First Nation communities supported the project by hosting 28 focus groups; each of the treatment centres hosted an additional 8 focus groups.

There was agreement among the community groups that indeed alcohol and drugs create problems in the community and have devastating effects on all members within the community.

The community survey found that the most frequently abused substance over each of the demographic groups was alcohol. It was reported by community participants that alcohol and marijuana use had almost become normalized among the youth. Survey respondents perceived that there was an increase in the use of illicit drugs such as methamphetamines, prescription drugs, ecstasy and crack/cocaine among youth. Adults in general were perceived to have more problems with prescription drugs than the other demographic groups.

There continues to be hesitation and uncertainty among community members about what needs to be done. One Elder in a focus group commented that in their language, they use the word "kiam" when discussing community problems; "*It means leave it alone,"* she said, "*Tha*t *sometimes that's not the best word...but that's what we do.*" Others in the discussion agreed that approach hasn't worked, other than it avoided potential conflict. A majority of the respondents in focus groups' discussions, most prominently, the seniors, expressed the opinion that it was the role of Chief and Council to take a leadership role to protect the community from violence often associated with substance abuse.

There were many contributing factors to the misuse of alcohol and drugs, and the socio-economic factors are well known determinants of health. It is pleasantly surprising to notice that more people are talking about determinants of health and really understanding how each socio-economic factor is connected to wellness and quality of life. Community members were articulate in their discussions on the relationship between low education, low income, poor health and inadequate life skills. It wouldn't be too optimistic to surmise that this is a shift from a decade ago when the majority of people saw that the substance misuse itself was the problem. It was also evident by the many comments that community members are shifting their thinking (however subtly) from expecting solutions to problems to be the responsibility of leaders and service providers, to needing the community as a whole to be part of the solution. Surprisingly, several of the youth said they believed that it was the responsibility of individuals to make changes in their lives if they didn't like what was happening. One woman said, *"We need to declare a state of emergency on alcohol and drugs and focus the community resources to address that issue."*

Overall, most people believed that resources and treatment were effective resources. The area they felt was most lacking was in aftercare services and that people who are in recovery go back to the community that has the same problems.

Key findings remind us that Aboriginal people already make positive efforts to make changes to protect their health and we are challenged to find ways to enhance this trend. Other findings remind us to pay attention to some important hidden groups such as social support needs of the seniors, pregnant women, gender specific treatment, youth needs for support, and recognition and thirst for cultural knowledge and identity.

In Aboriginal tradition, the health and well-being of an individual flows, in large part, from the health and social make-up of the community. This infers that not only must substance abuse be understood in terms of social behaviour, but that its solutions lie in collective action of the communities.

At a conference (2003), the International Council on Alcohol and Addictions (ICAA) (the world's oldest alcohol/drugs organization) research stated that treatment works only if it is appropriate to the circumstances of the individual, such as the stage of the problem, conditions, personality characteristics, need, mode of delivery, goals and motives; and if it is then delivered as designed, by trained knowledgeable staff.

An area seldom spoke of in NNADAP circles is an open discussion on harm reduction strategies, the rationale behind it and the development of a strategy for First Nations that include a harm reduction approach. The harm reduction approach is used extensively internationally and is now a part of the Canada Drug Strategy**.** It is based on the idea that many people around the world drink but not all people have severe problems, it is recognized that culture influences these beliefs and attitudes alcohol use as well. With the harm reduction approach, the goal is to teach normalization of moderation, based on the positive statistic that the majority of the world's people who drink do so in moderation. The NNADAP relies heavily on the 12 Step AA programs which are based on abstinence. Harm reduction approaches may be helpful to some and are a part of the harm reduction continuum.

Throughout the research and community engagements, there was not one mention of a harm reduction strategy. First Nation communities have built the entire addiction program based on the belief of complete abstinence. This belief follows a medical model approach that alcoholism is a disease and is untreatable without complete abstinence.

For many community members, this is a non-starter and they may be turned off by what they may perceive as an over zealous moral message that 'everyone who drinks alcohol has a problem'. It alienates people who might otherwise be open to hearing more about the effects of alcohol and drugs and that it is often more a sign of stress and coping strategies than of a disease. As discussed in the section on mental health, it is important to also keep in mind the other co-occurring disorders that may also be present with or without the substance abuse; thus, community programs based solely on abstinence may be missing an opportunity to meet the needs of these people. It would be an interesting discussion for communities to have among the wellness staff and with community members.

In closing, the addiction and mental wellness field would be well advised to examine other integrated community approaches to addressing substance abuse and mental health issues, such as the Section 13 on the *Community that Cares* model and the *Wellbriety* program that has culture and tradition as the foundation.

SECTION 13 RECOMMENDATIONS and DISCUSSION

This section presents the recommendation in four sections: NNADAP Governance and coordination, NNADAP Capacity, Priority Services for Targeted demographics, Mental health and Integrated NNADAP programs.

NNADAP Governance and Coordination

The Chief and Council and program managers are responsible for the overall management and sustainability of the NNADAP program within their scope of duties.

Recommendations

1. Continue existing NNADAP governance structure ensuring a continued flow of information from the Team Leader, Co-management Committee, Wellness Coordinators to NNADAP workers and vice versa, ensuring the NNADAP workers at the field level provides feedback.
2. Clarify the delineation of provincial government services vs NNADAP services
3. Strengthen involvement of First Nation community leaders in supporting the NNADAP Program in addressing the community substance abuse issue.
4. Leadership to demonstrate public support for the efforts of the Wellness and Addictions recovery activities
5. Community by-laws that prohibit the sale of alcohol on-reserve
6. Community by-laws that places parameters around the public consumption of alcohol and drugs
7. Leadership and management to review financial budgets and consider the re-allocation of funds to support prevention, treatment and after programs that create awareness, provide education and build skills

NNADAP Capacity Issues

Included in this section are the recommendations from the Alberta Treaty NNADAP Workers Training Needs Assessment (2008)[148] Included in this section is a summary of the recommendations made in the final report.

These recommendations are based on the assumptions that what NNNADAP workers need in training and skill development would allow them to operate at the level of capacity needed to perform the duties as outlined in their job descriptions.

Recommendations

1. Ensure NNADAP Workers are hired with education, essential skills and psychological aptitudes to work in complex community environments with clients

[148] FNIHB. Alberta Regional NNADAP Training Needs Assessment (2008) Final Report

who have multiple substance abuse and mental health disorders. Bridging programs and certificates in community addiction training is desirable as a minimum standard of employment.

2. Before being permitted to practice, NNADAP counsellors should be required to undergo an examination by an independent board of addictions specialists of actual competencies in core areas and in areas of specialty.

3. Foundational Training should be provided to NNADAP workers working in rural, urban and treatment centre environments.

4. Advance Training should continue to be provided in clinical skills, knowledge of the substances, how to deal with mental health issues, case management and record keeping and technology use and community development skills.

5. NNADAP Workers to receive gender specific training on addictions

6. NNADAP Workers to receive training on how to work with different demographic groups

7. NNADAP workers receive mandatory clinical supervision by a person trained in clinical supervision for a minimum of 2-3 hours per week for one year to discuss casework and other professional issues in a structured way and to identify ongoing training needs.

8. It is common practice for mental health professionals to have their own counsellor/therapist to assist in maintaining personal wellness. It is recommended that NNADAP workers follow these same practices and have access to counselling support from an outside professional

9. Provide NNADAP Workers with administrative supervision in the areas of case records, referral procedures, continuity of care, and accountability. This could be done through the workplace supervisor or from services provided by NNADAP consultants.

10. Require NNADAP Workers to have continued education credits as part of ongoing training and professional certification.

11. Offer equitable salaries for NNADAP workers that is comparable to the provincial wage scale

Priority Services for Targeted Demographic Groups

YOUTH

Prevention Services

1. Increase community awareness and education on the affects of drugs, alcohol and services available through community awareness events –
2. Increase school programs that teach the effects of alcohol and drugs
3. Apply strategies from the a social influence model that engages the students to better understand actual alcohol and drug use

4. Development of youth gender specific community prevention strategies

Treatment Services

1. Increase the number of youth treatment centres
2. Create gender specific youth treatment centres
3. Expand youth treatment continuum to include a community support system and recovery management strategies (ie. recreational and cultural activities)
4. Determine the recommended length of the treatment cycle for youth
5. Treatment Centres to work closely with the referral agent to prepared an aftercare plan that supports the new skills and attitudes learned

Empowerment/Engagement

1. Invite the youth to participate in the organizing and hosting community forums to discuss social issues
2. Include youth in identifying the community issues (personal, social, substance abuse) that need to be addressed
3. Develop youth leadership councils
4. Provide youth with the leadership training opportunities
5. Provide youth with training in group facilitation and problem solving
6. Strengthen traditional cultural practices and language skills
7. Engage community support systems to assist the youth to develop a strategic plan to address alcohol and drug misuse
8. Facilitate relationships between Elders and youth, to share knowledge and history and culture
9. Community support for youth groups (leadership, financial and mentorship)

Administrative Services

1. Increased funding for youth programs (for staff and social activities)
2. Support communities to include a youth specialist's worker as part of the wellness team
3. Increase employment opportunities for youth
4. Enhance support for community action by developing a communication strategy and social marketing messages

WOMEN

Prevention Services

1. Development of gender specific community prevention strategies
2. Increase awareness of the effects of alcohol and drugs on pregnancy
3. One to one support and mentorship for pregnant women based on using motivational interview strategies

Treatment Services

1. Development of gender specific treatment programs
2. Re-profile one NNADAP treatment centre specifically for women
3. Communities to provide support and resources for childcare for women in treatment

Empowerment and Engagement

1. Provide aftercare support to women in the areas of childcare, counselling, financial management support, life skills development, job readiness, housing and protection against family violence

2. Include discussions that raise the political awareness of women and the effects of colonization and systemic oppression
3. Community education, services and mentoring to support good parenting practices
4. Include transportation and childcare in community workshops and events
5. After care programs for women that focus on women's issues and needs

Administrative

1. Increased awareness among referral workers that NNADAP policies and practices place pregnant women as priorities for admission to treatment centres.
2. NNADAP Workers to receive gender specific training on addictions

MEN

Treatment Services

1. Develop gender specific treatment services that include client learning opportunities for developing a better understanding of men and addictions.

Empowerment and Engagement

2. Encourage individuals to take responsibility for taking traditional leadership roles in organizing community activities
3. Facilitate relationship between young men and elders by organizing activities that provide opportunity for sharing circles
4. Develop a mentorship program among men of all ages and facilitate opportunities for job shadowing, skill sharing and for supporting sobriety
5. Traditional teachings on the culture (ceremonies, celebrations, songs, stories) and the traditional role of men in their society
6. Increase number of community sober events
7. With the involvement of men, develop a community plan for organized recreational activities
8. More public education events on substance abuse and the continuum of care framework
9. Through social marketing messages and program updates, sensitize the community to the needs of people in recovery
10. Coordinated after care support, workshops, life skills, sharing circles
11. Integrate services with other service providers to develop job readiness and job training
12. Safe houses for men - shelter in the community with counselling and referral support

Administrative

Provide funds to support a men's group

ADULTS

Prevention Services

1. Develop a yearly schedule for workshops on addictions
2. Establish regular AA/NA/ Alanon meetings
3. Educate the community on the prevention and treatment services available and how to access the services
4. Regular community activities such as craft nights, cultural activities and social gatherings

5. Create awareness of the risk and determinants of suicide in adults
6. Workshops on anger management and other life skills

Treatment Services

1. Develop a community aftercare program that provides support for all clients and those who are returning from Treatment Centres
2. Access and support for clients needing services of a registered therapist
3. Address high levels of depression, anxiety and aggression towards others
4. To investigate the development of resources for sexual addiction counselling

Empowerment and Engagement

1. Community education activities on topics such as traditional parenting
2. Coordinate a regular schedule for healing circles for men and women
3. Social activities that support sobriety
4. To enhance motivation to engage in support and treatment by applying motivational interviewing strategies
5. Develop job training and life skills programs specifically for older adults
6. Consider harm reduction strategy rather than total reliance on the abstinence strategy

Administrative

1. Transportation to community events

SENIORS

Prevention Services

1. Community education to reach all segments of the community on aging and changing needs of the aging
2. Peer-led social groups to help build social relationships that are not based on substance misuse
3. Facilitate relationships between the senior and their physician for ongoing medical care and assessment and effective service delivery
4. Develop resources, public education and information specific to seniors
5. Develop a community strategic health promotion program for seniors

Treatment Services

1. More training and education, better collaboration among services providers and the development of comprehensive programs that can address older adults' many needs
2. For services to be effective, seniors benefit the most from age-specific interventions, and by service providers trained in both gerontology, family and substance use issues
3. Build collaboration among health and social services professionals to create a comprehensive continuum of care for seniors.
4. Use a client centered holistic approach to develop community-based treatment programs provided in the broader context of support for health and the activities of daily living

Empowerment and Engagement

1. Engage seniors in community coaching, mentoring and teaching roles in the community

2. Life skills education for seniors
3. Raise awareness of substance problems, negative affects of gambling addiction and prescription drug use.

Administrative

1. Develop new assessment tools to accurately reflect the needs of seniors

COMMUNITY

Prevention Services

1. Increased communication with community members to keep them informed of program activities
2. For community programs to provide transportation and/or outreach services, and adopt a client-centred, holistic treatment approach that improves overall quality of life

Treatment Services

1. Integrated community based treatment services
2. Development of a community strategy to address substance abuse and related issues

Empowerment and Engagement

1. Community commitment to accepting ownership of substance abuse issues and to working together to finding solutions
2. Declaration to protect community members from the harm caused by substance abuse
3. Provide financial resources and support for community champions to lead community change

Administrative

1. Coordinated services with social services providers
2. Case conferencing with other service providers to develop client prevention, treatment and after care support plan
3. Build collaboration among health and social services professionals to create a comprehensive continuum of care

Recommendations for Persons with Mental Health Disorders

To meet the needs of First Nation people that require Mental Health Services, there are a number of challenges to overcome. The list is not exhaustive, and as the Ottawa charter for Health Promotion acknowledges, changes to the health care system must also be considered. [149]

1. Better coordination among services providers to develop and implement a client based treatment plan that addresses co-occurring and mental health substance abuse issues.
2. Development of a core National and Provincial Aboriginal Mental Health program that identifies key goals, philosophy and components of the program

[149] World Health Organization. Ottawa Charter of Health Promotion. First International Conference on Health Promotion, Ottawa Nov 21, 1986. www.int/hpr/archive/docs/ottawa.html

3. Better case coordination including protocols for information sharing across agencies.
4. Better coordination of mental health services available for children mental health needs
5. Better understanding among service providers of the distinction between urban and rural First Nation and the impact on mental health issues and to access to services
6. Increased training for community workers and professionals and mentorship opportunities to support professional development in the area of mental health and to become aware of mental issues and the cultural context.
7. Clinical supervision and support by licensed professional to front line community workers to support the development and implementation of a client wellness plan.
8. Travel funds for those requiring specialized mental health treatment services outside of the local area.
9. Increase in the number of Youth and Elders community living homes available that meet the different level of needs for supervised living
10. Service providers to be trained in Cultural Safety and to be aware of their own social location and the impact they have on program development and delivery.

APPENDICES

Alberta Services Map
AUDIT Screen Test
NNADAP Salary Grid (FNIHB – Alberta Treaty 2004)
Literature Review (documents provided by the First Nation Addictions Advisory Panel – documents not included please see separate file


AADAC direct services centres
Community services funded by AADAC
High Level
Peerless Lake
Fort McMurray
Peace River
Wabasca
High Prairie
Slave Lake
Grande Prairie
Valleyview
Calling Lake
Athabasca
Lac La Biche
Cold Lake
Bonnyville
Whitecourt
St. Paul
Barrhead
Grande Cache
Fishing Lake M.S.
Edson
St. Albert
Sherwood Park
Edmonton
Hinton
Vegreville
Stony Plain
Lloydminster
Leduc
Camrose
Jasper
Drayton Valley
Wetaskiwin
Wainwright
Rocky Mountain House
Red Deer
Stettler
Drumheller
Airdrie
Cochrane
Calgary
Strathmore
Canmore
High River
Brooks
Medicine Hat
Claresholm
Fort Macleod
Taber
Lethbridge
Crowsnest Pass

Australian Government
Department of Veterans' Affairs

Alcohol Screen (AUDIT)

THE RIGHT MIX

Light Beer 425ml 2.9% Alcohol	Full Strength Beer 285ml 4.9% Alcohol	Wine 100ml 12% Alcohol	Fortified Wine 60ml 20% Alcohol	Spirits 30ml 40% Alcohol	Full Strength Can or Stubbie 375ml 4.9% Alcohol
					

The guide above contains examples of ***one standard drink***.

A full strength can or stubbie contains ***one and a half standard drinks***.

Introduction

Because alcohol use can affect health and interfere with certain medications and treatments, it is important that we ask you some questions about your use of alcohol. Your answers will remain confidential, so please be as accurate as possible. Try to answer the questions in terms of **'standard drinks'**. Please ask for clarification if required.

AUDIT Questions Please tick the response that best fits your drinking.

						Score	Sub totals
	Never	*Monthly or less*	*2 - 4 times a month*	*2 - 3 times a week*	*4 or more times a week*		
1. How often do you have a drink containing alcohol?	☐ Go to Qs 9 & 10	☐	☐	☐	☐	☐	
	1 or 2	*3 or 4*	*5 or 6*	*7 to 9*	*10 or more*		
2. How many standard drinks do you have on a typical day when you are drinking?	☐	☐	☐	☐	☐	☐	
	Never	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*		
3. How often do you have six or more standard drinks on one occasion ?	☐	☐	☐	☐	☐	☐	☐
4. How often during the last year have you found that you were not able to stop drinking once you had started?	☐	☐	☐	☐	☐	☐	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	☐	☐	☐	☐	☐	☐	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	☐	☐	☐	☐	☐	☐	☐
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	☐	☐	☐	☐	☐	☐	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	☐	☐	☐	☐	☐	☐	
	No		*Yes, but not in the last year*		*Yes, during the last year*		
9. Have you or someone else been injured because of your drinking?	☐		☐		☐	☐	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	☐		☐		☐	☐	☐
						TOTAL ☐	

Supplementary Questions	*No*	*Probably Not*	*Unsure*	*Possibly*	*Definitely*
Do you think you presently have a problem with drinking?	☐	☐	☐	☐	☐
	Very easy	*Fairly easy*	*Neither difficult nor easy*	*Fairly difficult*	*Very difficult*
In the next 3 months, how difficult would you find it to cut down or stop drinking?	☐	☐	☐	☐	☐

D0710 - 8/03 - Pt of 2

How to score and interpret the AUDIT

The World Health Organization's Alcohol Use Disorders Identification Test (AUDIT) is a very reliable and simple screening tool which is sensitive to early detection of risky and high risk (or hazardous and harmful) drinking. It has three questions on alcohol consumption (**1 to 3**), three questions on drinking behaviour and dependence (**4 to 6**) and four questions on the consequences or problems related to drinking (**7 to 10**).

The **Supplementary Questions** do not belong to the AUDIT and are **not** scored. They provide useful clinical information associated with the client's perception of whether they have an alcohol problem and their confidence that change is possible in the short-term. They act as an indication of the degree of intervention required and provide a link to counselling or brief intervention following feedback of the AUDIT score to the client.

Scoring the AUDIT

- The columns in the AUDIT are scored from left to right.
- **Questions 1 to 8** are scored on a five-point scale from **0, 1, 2, 3,** and **4**.
- **Questions 9 & 10** are scored on a three -point scale from **0, 2** and **4**.
- Record the score for each question in the **"score"** column on the right, including a zero for questions **2 to 8** if 'skipped'.
- Record a total score in the **"TOTAL"** box at the bottom of the column. The maximum score is 40.

Consumption score

Add up **questions 1 to 3** and place this sub-score in the adjacent single box in the far right column (maximum score possible = 12). A score of 6 or 7 may indicate a risk of alcohol-related harm, even if this is also the total score for the AUDIT (e.g. consumption could be over the recommended weekly intake of 28 for men and 14 for females in the absence of scoring on any other questions). Drinking may also take place in dangerous situations (e.g. driving, fishing/boating). Scores of 6 to 7 may also indicate potential harm for those groups more susceptible to the effects of alcohol, such as young people, women, the elderly, people with mental health problems and people on medication. Further inquiry may reveal the necessity for harm reduction advice.

Dependence score

Add up **questions 4 to 6** and place this sub-score in the adjacent single box in the far right column (maximum score possible = 12). In addition to the total AUDIT score, a secondary 'dependence' score of 4 or more as a subtotal of questions 4 to 6, suggests the possibility of alcohol dependence (and therefore the need for more intensive intervention if further assessment confirms dependence).

Alcohol-related problems score

Any scoring on **questions 7 to 10** warrants further investigation to determine whether the problem is of current concern and requires intervention.

AUDIT Total score	*Dependence score*	*Risk level*	*Possible Interventions*
0 - 7	below 4	Low-risk	• Use 'Right Mix' materials to reinforce low-risk drinking, particularly for those who previously had alcohol problems or whose circumstances may change. • Harm reduction advice may be appropriate for those in susceptible groups (see 'Consumption Score' above).
8 - 15	below 4	Risky or hazardous level. Moderate risk of harm. May include some clients currently experiencing harm (especially those who have minimised their reported intake and problems).	• Brief intervention – feedback of AUDIT and harm reduction advice may be sufficient Ideally also: – setting goals and limits – a motivational interview – self-monitoring of drinking – use of "The Right Mix" self-help guide
	4 or more	Assess for dependency	• Counselling may be required.
16 - 19	below 4	High-risk or harmful level. Drinking that will eventually result in harm, if not already doing so. May be dependent.	• Brief intervention (all components) is a minimum requirement. • Assessment for more intensive intervention. • Counselling using CBT principles and motivational interviewing in individual sessions and/or in groups. • Follow-up and referral where necessary.
	4 or more	Assess for dependency	
20 or more	below 4	High-risk Definite harm, also likely to be alcohol dependent. Assess for dependence.	• Further assessment preferably including family and significant others. • More intensive counselling and/or group program. • Consider referral to medical or specialist services for withdrawal management. • Pharmacotherapy to manage cravings. • Relapse prevention, longer-term follow-up and support.
	4 or more	Almost certainly dependent. Assess for dependency	

09/19 -ARG- P2of2

NADAP SALARY GRID (Provided by FNIHB (Feb 2004)

PAYGROUP	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5	LEVEL 6
A	$37,706	$42,419	$47,132	$49,489	$51,963	$54,561
				$50,726	$53,262	$55,925
						$57,323
						$58,756
B	$29,326	$32,992	$36,658	$38,491	$40,415	$42,436
				$39,453	$41,426	$43,497
						$44,585
						$45,699
C	$23,462	$26,394	$29,327	$30,793	$32,333	$33,950
				$31,563	$33,141	$34,798
						$35,668
						$36,560
D	$23,462	$26,394	$29,327	$30,793	$32,333	$33,950
				$31,563	$33,141	$34,798
						$35,668
						$36,560
E	$20,529	$23,095	$25,661	$26,944	$28,291	$29,706
				$27,618	$28,999	$30,448
						$31,210
						$31,990
F	$18,853	$21,209	$23,566	$24,744	$25,982	$27,281
				$25,363	$26,631	$27,963
						$28,662
						$29,378
G	$20,110	$22,623	$25,137	$26,394	$27,714	$29,099
				$27,054	$28,406	$29,827
						$30,572
						$31,337
H	$17,596	$19,796	$21,995	$23,095	$24,249	$25,462
				$23,672	$24,856	$26,099
						$26,751
						$27,420

Paygroup A: Treatment Centre Executive Director
Paygroup B: Treatment Centres Program Coordinator & Community-based NNADAP Coordinators
Paygroup C: Treatment Centre Counsellors & Community-based NNADAP Workers
Paygroup D: Financial Officer
Paygroup E: Program Attendant & Night Supervisor
Paygroup F: Administrative Assistant
Paygroup G: Maintenance & Cook
Paygroup H: Daycare Worker, Janitor, Driver & Security

Literature Review (documents received from the National Advisory Committee)