ANNA

Atlantic NNADAP Needs Assessment

Final Report

Submitted June 21, 2009

Change

Community

Context

Culture

www.circleworksconsulting.com

Executive Summary

This report takes an approach to recovery that is holistic, balanced, and places the struggles of the individual in the broader context of health and healing for First Nations and Inuit in the Atlantic Region.

Background

Today, there are four nations of Aboriginal people living in the Atlantic Region: Mi'kmaq (NFLD, PEI, NS, and NB), Maliseet (NB), Innu and Inuit (Labrador). Throughout the Atlantic Region, there are approximately 35,000 First Nations and Inuit, 25,000 living in their communities. For the entire region, there is one Regional Medical Officer based in Nova Scotia. Several First Nations and Inuit organizations participate in advocating for improved health services for their membership including the Confederation of Mainland Mi'kmaw, the Union of Nova Scotia Indians, the Union of New Brunswick Indians, the Mawiw Council, the Atlantic Policy Congress, the Mi'kmaq Confederacy of Prince Edward Island, the Nunatsiavut Government, the Mushuau Innu Health Commission and the Federation of Newfoundland Indians. There are two addictions specific organizations, the Regional Addiction Partnership Committee (RAPC which is a working group of Treatment Center Directors and representatives from Prevention from across the 4 Atlantic Provinces) and NADACA (Native Alcohol and Drug Abuse Counselling Association), that coordinates addictions services for 11 of the 13 Nova Scotia bands.

Between the First Nations and Inuit communities there are large differences in the administration of and access to health, mental health and addictions services which are linked to geographic isolation, specifics of colonial history experienced, access to provincial services, struggles for autonomy of particular bands and confederacies, and ability to maintain or revitalize traditional cultural and spiritual ways. Smaller communities are faced with different priorities than those coming from larger communities. Generally, larger communities/provinces have more opportunities to apply for funding and resources, while within smaller communities/provinces, collaboration is a necessity for access and services. Thus there can be large differences in overall health and addiction levels, which can be

linked to population size, land base, economy, struggles for autonomy and overall health of leadership.

It is outside the scope of this report to explore all of the complex social, political, and historical realities that have resulted in the addictions levels presently plaguing First Nations of the Atlantic Region. This report addresses the specific addiction services and program needs of each territory. However, NNAPF[1] documents reinforce issues that participants in this needs assessment repeatedly addressed: the renewal process has been too slow and has lead to frustration and continued fragmentation of services. The "unstable funding environment" combined with communication between all stakeholders, including FNIHB regional management created foundation that lacked "mutual awareness and a significant degree of trust" (p. 9). Within these limitations, Circle Works undertook what we have come to refer to as the ANNA (Atlantic NNADAP Needs Assessment) process.

Methodology

In the Atlantic Region, the Circle Works team, worked collaboratively with the Advisory Group, members of the Partnership Group, Health Directors and NNADAP/NADACA workers to develop a work plan and a needs assessment design. As the Atlantic region is an extensive geographical area, a diverse population and limited time and resources, the Circle Works employed several methods of gathering information on the priorities of First Nations across the Atlantic region:

- ⊕ Direction from the Advisory Group with representation of each of the provinces and Health Canada.
- ⊕ Community engagement (Circles/meetings/focus groups)
- ⊕ Interviews (telephone and face to face)
- ⊕ Surveys (Partners, workers, community members, and youth specific)
- ⊕ Literature review of existing documents specific to Atlantic Region, and related to topics of concern generated in the community consultations (like methadone, prescription drugs, sexual violence, youth programming, and addictions training).

In total 15 meetings were held in 10 First Nations and Inuit communities: Eskasoni; Indianbrook; Elsipogtog; Tobique; Eel Ground; Oromocto; Kingsclear; Millbrook; Happy Valley/Goose Bay; and Sheshatshiu. Gatherings/meetings were held in urban locations of Charlottetown, PEI; Truro; Moncton, NB; Summerside, PEI; Halifax; and Fredericton. A focus

group on Maternal Health was held in Moncton at the Atlantic Health Conference. Comprehensive interviews were conducted with Treatment Directors, Health Directors, Community Leadership, Addictions Researchers and Policy Analysts for the region and nationally, and community members both in communities and over the telephone.

Five questionnaires were designed, with the option to complete on-line, on the phone, or in writing and submitted by fax or mail. In four communities we were able to provide the option to complete the survey face-to-face with a community liaison worker: (Eskasoni (NS), Tobique (NB) Eel Ground (NB), and Lennox Island (PEI). 1. A preliminary survey for the Partnership Group and Health Directors helped to set priorities for the needs assessment; 2. A second survey was worker-specific and circulated to addictions, health, and mental health workers; 3. A third survey was a community member survey; 4. A youth-specific survey was created; and, 5. The final was developed specifically for Detox Centers.

Limitations: The three major limitations of this Needs Assessment are time, resources and lack of availability of Aboriginal Atlantic specific statistics and research. Contract negotiation issues curtailed the amount of time the consultations had to complete the data collection. Adequate resources for travel were unavailable in a timely manner prohibiting travel to Labrador and Newfoundland. A sub-contractor in Labrador conducted two community meetings in Labrador. Due to time constraints, selected communities in the Atlantic Region were visited.

Priorities

The following priorities emerged from our surveys. They are organized according to the larger report. In the following, each priority is identified and respective actions noted. More detailed descriptions and analyses can be found in the larger document.

- **Diversity of geography, history, and tribal groups.** Due to the diversity of First Nations and Inuit history, geography, and tribal groups in the Atlantic Region, there is a need for caution in generalizing issues, healing approaches, and determining best practices and in any and all processes of negotiation and partnership with the Federal Government.
- **Accurate and detailed record keeping.** Lack of access to important health, mental health and addictions information for Atlantic First Nations and Inuit is a problem and

there is no standardized means of producing basic statistical information that would assist in understanding the trends, issues, and strengths within their own communities.

- **First Nations and Inuit approaches to health and healing.** First Nations and Inuit approaches include; spiritual teachings and an experiential, relational approach. Prevention and intervention programs that provide opportunities for participants to *experience and live* self-respect, sharing, and cooperation are inherently promoting health. All aspects of well-being are equally important and interconnected, including the physical, emotional, mental, and spiritual; that balanced well-being is throughout the lifespan; and that individual health is an aspect of the health of families, communities, nations, and the environment. Such an approach places the struggles of the individual in the broader context of health and healing for First Nations and Inuit in the Atlantic Region.

- **Gender based/balanced analysis.** A gender based analysis enables an approach which addresses specifics needs of First Nations and Inuit women and men who are affected differently by structural inequities and therefore by policy and program decisions.

- **Multiple addictions and substance abuse challenges**. First Nations and Inuit are caught in a complex web of conditions produced through colonial intervention, and became addicted to substances introduced as part of the colonial process. Participants in ANNA identified the need to address issues of multiple addictions as an important priority, including multiple substance addictions and substance addictions plus other problems such as gambling addictions, along with concurrent mental health issues including: **alcohol addiction** and the prevalence of **intergenerational FASD;** the ease of availability and the widespread misuse of **prescription drugs; illegal drugs** (designer drugs, new party drugs like GHB, cocaine and Crystalline methamphetamine or Cystal Meth); and **solvent abuse**. **Methadone**, currently promoted as a harm reduction approach to opiate-type drugs, is a controversial issue and methadone use creates a conflict between the medical use of a substance, and a traditional drug-free way of life. There are gaps in the knowledge about methadone including dependency and detoxification issues.

- **Health, wellness and cultural continuity.** Autonomy in dealing with health and addictions issues is a key to cultural connections and safety. In varying degrees traditional practices of the sweat lodge, smudging and healing circles have been blended with mainstream treatment and psychotherapeutic methods within many First Nations and Inuit operated healing centers. First Nations and Inuit approaches to healing and recovery are the most effective with First Nations and Inuit clients. There is

a need for more culturally-based approaches and the employment of First Nations and Inuit traditional addictions and mental health workers.

- **Engaging the whole community in a continuum of program and service provision.** Engaging the whole community in the provision of services and programs can help to address many interim and long-term needs of Youth, Women, Two-Spirited, and Residential School Survivors. Strengthening community-based counseling, self-help, and after-care support services closer to home addresses the issue of accessibility. A well-trained and well-resourced First Nations or Inuit defined and delivered continuum of program and service provision (including prevention, detoxification, aftercare) built around the specific needs of community members (youth, women, Two-Spirited, Elders, family, individuals struggling with addictions and mental health issues) and centered on family and community in intervention, reflects the values of First Nations and Inuit.

- **Collaboration.** Inter-agency collaboration and coordinated approaches strengthen programs and services, address training issues, make efficient use of stretched program dollars, support more community-based events, and create key collaborative partnerships. For example, many in the ANNA proposed a culturally-appropriate Atlantic-wide crisis line which may be feasible within a collaborative framework.

- **Jurisdictional issues, funding, and autonomy.** Many of the issues that are standing in the way of service providers addressing the needs of First Nations and Inuit in recovery are outside of their ability to influence directly including: jurisdictional issues and boundaries, funding formulas, and stable funding and resources to meet the service delivery needs of clients. A review of funding formulas based on the geographical logistics and cultural landscape of the Atlantic Region is essential.

- **Capacity building.** Capacity building is recognized as a key issue for the Atlantic regional by all workers and community members. In this report capacity building refers to: staff training, certification, and on-going professional development; building capacity in self determination and governance in addictions; and, working with internal and external agencies to share knowledge and experience. A training institute built on the knowledge and practice of key members of the Atlantic additions networks be developed and used as a springboard for certification and accreditation based on criteria relevant to practice within First Nations and Inuit communities in the Atlantic Region.

- **Workforce priorities:** That sustainable workforce must be knowledgeable and skilled in providing a comprehensive range of addictions services that are culturally appropriate. Issues such as staff shortages, attraction and retention of staff, worker burnout and self-care, and wage parity were consistently raised across the Atlantic region. An

independent community-based or Atlantic association could help to mediate concerns by staff, clients and community members.

- **Research gaps and program development.** There is still very little published research specific to Atlantic First Nations and Inuit Addictions. Most material collected is to meet reporting requirements for governmental financial accountability, especially for transferred programming, rather than based on a regionally driven process for research or program development as a whole. A First Nations and Inuit-specific addictions research and training institute for the Atlantic Region would help to address this gap.

- **Addiction services policies.** The policies relate to both the employees of NNADAP/NADACA and to the clients aspiring to or residing within Treatment Centers. Policy issues identified by communities and addictions service and program providers include: zero tolerance policies; fair and safe treatment protocols; lengthy waiting lists; services to off-reserve/non-status/non-aboriginal; house rules and their impact on individual healing processes; polices relating to mental health issues, suicide and prescription drug use; transportation policies; lack of gender based analysis of policies, and the impacts of policies on specific groups such as corrections and geographic discrimination. To address these policy issues we suggest a multi-level policy analysis and the creation of a position and a process be established to provide this analysis on an on-going basis.

In closing, the key question underlying the Atlantic NNADAP Needs Assessment: What are the priorities for enhancing and improving addictions prevention and treatment services for First Nations and Inuit in the Atlantic Region? Key priorities have been identified having to do with **Cultural** Healing; Historical and Structural **Contexts** of Addiction; Recovery as a **Community** process, and Challenging to **Change** the current power structures that continue to impeded FN and Inuit communities quest for healing and autonomy. Action plans resulting from these priorities appear bolded throughout the text, and are compiled in Chapter Thirteen. First Nations and Inuit, like Indigenous peoples worldwide, are now on a path of healing, including renewing the traditions and languages, strengthening families and communities and rebalancing gender roles, we hope this work contributes to that process.

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"It is not possible to comprehend and effectively respond to the circumstances a people finds themselves in without knowing something of where they have been…the past adds up to a complex conjunction of trauma and ingenuity; distress and the will to survive; cultural continuities cut across by many transformations. Looking at the actions people have taken in the face of profound social upheaval might provide clues to the kinds of social force that could be mobilized in the present in support of a future shaped by indigenous aspirations…Whatever the future brings it must entail a range of choices that aboriginal people can themselves own, including the choice to continue to pursue a culturally different way of life and a different set of values to those of the market." (Hinkson in Altman and Hinkson 2007: 11).

CHAPTER ONE: INTRODUCTION TO THE ATLANTIC CONTEXT

This report is being crafted from within an Aboriginal belief system, therefore, we will attempt to explore a broader approach to recovery that is holistic, balanced, and places the struggles of the individual in the broader context of health and healing for First Nations and Inuit in the Atlantic Region. The opening chapter, reflecting on the CULTURAL, will discuss

how and WHY First Nations and Inuit continue to move towards self-government and the revitalization of our philosophies and healing practices in the context of addictions in Atlantic Canada. The second chapter, focusing on the MENTAL will set the context for understanding WHAT the structural and historical issues are that have shaped, and confined, individuals, families, communities and organizations in the ongoing struggle to recover from the multiple addictions that have continued to plague First Nations and Inuit since colonization began. The third chapter will explore the RELATIONAL, the particular needs of specific populations that are currently underserviced (WHO), including women, youth, residential school survivors, and people struggling with a combination of issues: mental health, child welfare, physical health, and justice. The fourth chapter will outline HOW current pressures, policies and practices (PHYSICAL) restrain First Nations and Inuit from providing culturally based integrated services to achieve holistic health and wellness. We will begin with an overview of the breadth of the Atlantic context and the restraints of the NNADAP needs assessment process, which we will refer to as ANNA (Atlantic NNADAP Needs Assessment), as enacted by Circle Works, from January to April, 2009.

THE ATLANTIC CONTEXT

Today, there are four nations of Aboriginal people living in designated communities, within this cluster of lands, now known as the Atlantic Region: the Mi'kmaq (NFLD, PEI, NS, and NB), the Maliseet (NB), the Innu and the Inuit (LAB). This territory is administered as four distinct provinces, two of which are made up of at least two geographically distinct land bodies, creating at least 6 specific territories (Nova Scotia which includes the island of Cape Breton; New Brunswick; Prince Edward Island; and the island of Newfoundland which includes Labrador). The following descriptive material is adapted from *First Nations public health: A framework for improving the health of our people and our communities* by the Assembly of First Nations (2006).

Atlantic Provinces

Throughout the Atlantic Region, there are approximately 35,000 First Nations and Inuit, 25,000 living in their communities. For the entire region, there is one Regional Medical Officer based in Nova Scotia. Several First Nations and Inuit organizations participate in

advocating for improved health services for their membership including the Confederation of Mainland Mi'kmaw, the Union of Nova Scotia Indians, the Union of New Brunswick Indians, the Mawiw Council, the Atlantic Policy Congress, the Mi'kmaq Confederacy Prince Edward Island, the Nunatsiavut Government, the Mushuau Innu Health Commission, the Sheshatshiu Innu First Nation and, most recently, the Federation of Newfoundland Indians. There are two addictions specific organizations, the Regional Addiction Partnership Committee (RAPC which is a working group of Treatment Center Directors and representatives from Prevention from across the 4 Atlantic Provinces) and NADACA (Native Alcohol and Drug Abuse Counselling Association), that coordinates addictions services for 11 of the 13 Nova Scotia bands.

Table 1: Presence of Treatment Facilities/Number of NNADAP Workers in Region

NNADAP Reports 15 Workers 1 Vacant June 12/09 For Labrador					
Centre	Profiled	# of Beds	# of Workers	Length/Intake	Languages Offered
Saputjivik Care Centre North West River, NL Currently in Reprofiling	18 & over	12 NNADAP Funded	Process of hiring	5 weeks/Once per cycle	Inuktitut; English
Charles J. Andrew Youth Restoration Centre Sheshatshiu, NL	11-17 years old	10 NNADAP Funded	18 Full Time Some Casual	14 weeks/Block intake	Innueimun, English
NNADAP Reports 28 Workers 2 Vacant June 12/09 for NS					
Centre	Profiled	# of	# of Workers	Length/Intake	Languages

		Beds			Offered
Eagle's Nest Recovery House Shubenacadie, NS	17 & over	7 NNADAP Funded	3 FT Counsellors Director 2 Part Time Day/Night Worker 2 Journey of Healing 2 NADACA Prevention	5 weeks/Once per cycle	Mi'kmaq, English
Mi'Kmaw Lodge Treatment Centre Eskasoni, Cape Breton, NS	No age limit	15 NNADAP Funded	12 Workers 4 Treatment 2 Weekend 1 Night Janitor Cook/Housekeep 1 Financial	Various 2 weeks to 35 days/Daily intake	Mi'kmaq, English
NNADAP Reports 31 As of June 12/09 Workers for NB					
Center	Profiled	# of Beds	# of Workers	Length/Intake	Languages Offered
Lone Eagle Treatment Centre Elsipogtog, NB	18 & over	6 NNADAP Funded	5 full time 2 part time Includes Cook, Reception	5 weeks/Once per cycle	Mi'kmaq, English
Rising Sun Rehabilitation Centre Eel Ground, NB	18 & over	10 NNADAP Funded	8 Staff = 2 Casuals 1 Cook 1 Custodian 1 PT admin, 1 Director 2 Counsellors	5 weeks/Once per cycle	Mi'kmaq, English
Wolastoquwiyik Addiction Rehab Centre Tobique First Nation, NB	18 & over	3.5 NNADAP Funded Overall 4	7 Staff In-patient, was closed as of May 25, 09. Will hire 1 night attendant and 1 cook	Individualized Continuous	Mi'kmaq, Maliseet, English
Kingsclear FN Outpatient	18 & over	Out Patient	1	5 weeks/Once per cycle	English

Program Kingsclear First Nation, NB		Only			

NNADAP Reports 1 Worker for NFLD, June 12/09

NNADAP Reports 4 Workers for PEI, June 12/09

There are 79 workers in total with 3 current vacancies.
All Worker count data, including vacancies, confirmed by FNIH Atlantic Region June 12, 09

Newfoundland and Labrador

Newfoundland and Labrador have a total population of over 560,000 people. Newfoundland and Labrador are comprised of Mi'kmaq, Innu and Inuit. Four Health Boards are responsible for overseeing public health across this province. Currently, public health is being downsized with Medical Officers of Health being let go, as well as other public health staff. The Office of the Chief Medical Officer of Health is extremely small with only two other staff overseeing public health for the entire province.

In Labrador there are two Innu First Nations, the Mushuau Innu First Nation located in Natuashish and the Sheshatshiu Innu First Nation located in Sheshatshiu with populations of 658 and 995 respectively. In 2001, a ten-year plan, the Labrador Innu Comprehensive Healing Strategy (LICHS) was developed as a joint holistic approach, between the Government of Canada, the Government of Newfoundland & Labrador and the Labrador Innu. Five years into the plan, two evaluations were done, with the main concerns being that the Innu themselves were not being consulted on how services are to be provided, or being engaged as service providers[2].

The Inuit have negotiated self-government, Nunatsiavut; their land claim area is the northwest coast. Other Inuit in Labrador reside Happy Valley/Goose Bay and Mud Lake.. The Inuit comprise the youngest population in Canada, with 39 per cent under the age of 14. The Inuit birth rate is twice as high as the Canadian birth rate. The fact that the population is so young has an impact on the health issues, perceptions, capacity and needs of Inuit when compared to other Aboriginal groups. Newfoundland did not become a part of Federalism until 1949 and subsequently provincial responsibility for services provided to First Nations and Inuit in Newfoundland and Labrador has been sporadic to non-existent until recent decades with the establishment of self-governance.

The only community in Newfoundland that has negotiated a health transfer agreement is the Mi'kmaw First Nation of Conne River which is the largest First Nation in Newfoundland with a population of 2,468. There are nine other Mi'kmaw communties in Newfoundland who are in the process of trying to get recognition as First Nations: Corner Brook Indian Band, Elmastogoeg (Benoit's Cove) First Nations, Flat Bay Indian Band, Indian Head First Nations, Port au Port Indian Band, St. George's Indian Band, Gander Bay Indian Band, Glenwood Mi'kmaq First Nation Band, Sple'tk (Exploits) First Nation Band. A newly formed representative body, The Federation of Newfoundland Indians (FNI) represents more than 10,000 non-status Mi'kmaq in Western and Central Newfoundland.

NNADAP Services for this area include:

- ⊕ Saputjivik Care Centre (North West River). Adult in-patient. 10 bed (which has been in closed and in a review process during the time of this Assessment.)
- ⊕ Charles J Andrews Youth Treatment Center (Sheshatshiu). Youth in-patient. 12 bed.
- ⊕ Fifteen full-time NNADAP positions for Labrador
- ⊕ One full-time position for Conne River, NFLD. This position is currently job-shared between two workers.

New Brunswick

New Brunswick has fifteen First Nations comprising of six Maliseet (Kingsclear FN, Madawaska Maliseet FN, Oromocto FN, Saint Mary's FN, Tobique First Nation, and Woodstock FN) and nine Mi'kmaq (Buctouche Mi'kmaq Band, Burnt Church FN, Eel Ground FN, Eel River Bar FN, Elsipogtog, Fort Folly FN, Indian Island FN, Red Bank Band, Council of Pabineau Band) communities. Communities range in population from 46 to 2,715 with a total population of more than10,000 First Nation members on and off reserve.

Public health services are delivered through the province's two health authorities under the management of Regional Directors. Six Regional Medical Officers of Health oversee public health issues of these seven regions. A Chief Medical Officer of Health and a Deputy Chief Medical Officer of Health oversee the development of policy and regulations, and provide medical operational support to the Regional Medical Officers of Health. There is minimal focus on First Nations service delivery despite a sizeable population of First Nations.

NNADAP Services for this area include:

- ⊕ Lone Eagle (Elsipogtog) Adult In-patient. 6 beds
- ⊕ Wolastoquwiyik Healing Lodge (Tobique) Out-patient. Working towards 4 beds.
- ⊕ Rising Sun (Eel Ground) Adult In-patient. 10 beds
- ⊕ Kingsclear Out-patient only.
- ⊕ 31 full-time NNADAP positions, one for each community, which are each administered independently through their bands or tribal health authorities.

Prince Edward Island

There are only two First Nations Bands in PEI, Abegweit (Morell Rear Reserve, Rocky Point Reserve, and Scotchfort Reserve) and Lennox Island. Both First Nations are governed within the Mi'kmaq Confederacy of PEI. PEI has one Health Authority and, as such, service funding is entirely provincial. The smaller band (Abegweit), with 160 members, has negotiated a Health Transfer Agreement. The larger community (Lennox Island) has a population of 362 and has negotiated an integrated health agreement.

NNADAP Services for this area include:

- ⊕ 3 NNADAP workers (1 Abegweit and 2 in Lennox Island)(no treatment facilities)

Nova Scotia and Cape Breton

A total of 8,587 First Nations live in First Nations communities in this province and represent 13 Bands (Annapolis Valley FN, Acadia FN, Bear River FN, Glooscap FN, Millbrook FN, Paq'tnkek FN, Pictou Landing FN, Shubenacadie FN, Chapel Island FN, Eskasoni FN, Membertou FN, Wagmatcook FN, and Waycobah FN. The population of these communities varies from 62 members to 3,602.

Nova Scotia has one of the more sophisticated public health models in the Atlantic Region. The province, not the Boards of Health, employs all of the Medical Officers of Health. The province is divided into 9 District Health Authorities. Cape Breton has five First Nations communities and has designated seats for First Nations on their District Health Boards. Six of these Bands have negotiated Health Transfer Agreements and four are integrated. Aboriginal addictions services in Nova Scotia is administered through the Native Alcohol and Drug Abuse Counselling Association (NADACA).

NNADAP Services for this area include:

- ⊕ Mi'kmaw Lodge (Eskasoni). No age limit In-patient. 15 beds
- ⊕ Eagle's Nest (Indianbrook). Adult In-patient. 7 beds
- ⊕ 28 full-time NADACA worker positions.

- Two NNADAP workers in Membertou and one in Millbrook (who are currently not part of NADACA).

ATLANTIC COLONIAL CONTEXT

Between the First Nations and Inuit communities there are large differences in the administration of and access to health, mental health and addictions services. These differences are linked to geographic isolation; specifics of colonial history experienced; access to provincial services; struggles for autonomy of particular bands and confederacies; and ability to maintain or revitalize traditional cultural and spiritual ways. Among the First Nations and Inuit communities within each territory, there can also be large differences in overall health and addiction levels, which can be linked to population size, land base, economy, struggles for autonomy and overall health of leadership. It is important to realize that smaller communities are faced with different priorities than those coming from larger communities. Generally, larger communities/provinces have more opportunities to apply for funding and resources, while within smaller communities/provinces, collaboration is a necessity for access and services. All of these differences need to be acknowledged.

While the Mi'kmaq, Maliseet, Inuit and Innu, as the Indigenous Populations of the East, each have their own distinct cultural, historical and traditional territories within a broad diverse geographical landscape, the processes of colonization made no distinction in its profound effect on our cultures.

> "*Whether it was the Residential School of Nova Scotia or the Reformatory Schools of Labrador, the impact of assimilation and at times genocidal policies of the colonizers were the same. Whether it was the Centralization Policy of Nova Scotia or the Relocation Policy following the demise of the Fur Trade and subsequently also the role of Missionaries in Labrador, families became divided and their whole way of life became disrupted leaving an intergenerational legacy of survival, compounded by a broad range of substances abused, and though often misplaced, serving as a coping mechanism…With the imposition of a Eurocentric/Canadian polity and subsequent division of traditional territorial lands with provincial boundaries and a division of responsibilities between the Provincial and Federal Government, the geopolitical landscape dictates diverse complicated approaches to self-determination and our approaches to community healing and especially in the field of substance abuse is no exception*" (RAPC, 2004).

ACTION: That the diversity of geography, history and tribal groups within the Atlantic Region be recognized in any and all processes of negotiation and partnership with the Federal Government.

Scope of Document

It is generally outside the scope of this report to explore all of the complex socio-political and historical realities that have resulted in the addictions levels presently plaguing much of the Atlantic Region. Unfortunately, this report will only sporadically address the specific needs of each territory, as reporting on the Atlantic Region as a whole consumed more time and resources than provided for this project. Across Canada, more than half of the Aboriginal population lives in urban centres; in Atlantic Canada, most First Nations and Inuit live in rural communities[3]. Given that the NNADAP structure is designed to provide services specifically to First Nations themselves, this was our focus.

While our primary intent is to explore these issues within an Atlantic context, the resource and policy constraints facing Aboriginal Atlantic NNADAP services, including the renewal process itself, are also located within a broader Canadian context. National Native Addictions Partnership Foundation (2003) documents on the renewal process, reinforce what was communicated to Circle Works repeatedly in conducting this needs assessment: the renewal process has been too slow and has lead to frustration and continued fragmentation of services. The "unstable funding environment" combined with communication between all stakeholders, including FNIHB regional management created foundation that lacked "mutual awareness and a significant degree of trust" (p. 9).

Through links to the book, Coercive Reconciliation – Stabilise, Normalise, Exit Aboriginal Australia (2007), edited by Jon Altman and Melinda Hinkson links to the broader global Indigenous context will be made. On June 21, 2007 Prime Minister John Howard of Australia declared a National Emergency based on a recently released report on child sexual abuse, called "Little Children are Sacred". This National Emergency was used to strip what little autonomy the Aboriginal Australians had gained. It remains a frightening example of what happens when the truth about the devastating conditions that some Aboriginal communities face are revealed without the historical, social and cultural context being

considered. Circle Works has chosen to engage, as much as possible, in a context based document, and will open each section with a quote from Coercive Reconciliation as a reminder of how we do not want the ANNA report received.

Within these limitation of history, resources and distrust, Circle Works undertook what we have come to refer to as the ANNA (Atlantic NNADAP Needs Assessment) processes.

ASSESSMENT METHODOLOGY

In the Atlantic Region, the Circle Works team, worked collaboratively with the Advisory Group, members of the Partnership Group, Health Directors and NNADAP/NADACA workers to develop a comprehensive workplan that allow for input from as wide a group as possible. The Advisory Group, comprised of 5 community members (two from Labrador, one from Nova Scotia, one from New Brunswick and one from PEI) and 2 FNIH members, was assembled by FNIH to review the proposals, and then to give us ongoing guidance in the process. Figure 1 on the following page explains the Assessment Methodology Concept around the Wheel.

Circle Works held two teleconferences, and one face-to-face meeting with the Advisory Group during the creation of the workplan, and consulted with individual members by email and phone on an ongoing basis throughout. We created a holistic Needs Assessment design and set out to address an identified set of questions. (The workplan and the questions are available in Appendix I: Workplan). Once the initial draft of the findings was prepared it was sent for feedback to 34 people on the key informant list: Advisory Group, the RAPC, Health Directors in communities where consultations were held, and FNIH regional staff. Eleven key informants responded directly. Meetings were held by RAPC, with discussions conveyed at an Advisory Group Meeting (which including the Regional NNADAP consultant, and the FNIH Regional Manager). Two drafts were completed during the final document phase, both being sent to key informant list for feedback, and their feedback was incorporated into this final document.

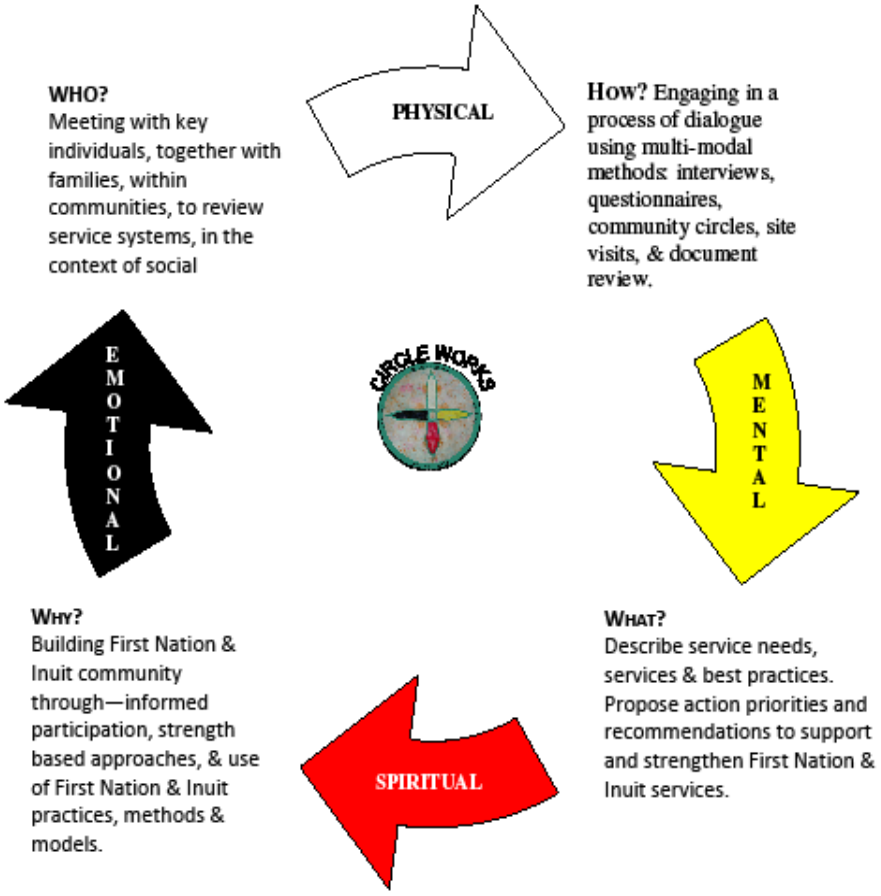


Figure 1: Assessment Methodologies

GATHERING INPUT

As we were dealing with an extensive geographical area, a diverse population, lack of available quantitative data, and limited time and resources, we decided to employ several methods of gathering input on the priorities of First Nation communities across the Atlantic region, with an emphasis on qualitative methods:

- ⊕ Direction from the Advisory Group.
- ⊕ Community engagement (Circles/meetings/focus groups)
- ⊕ Interviews (telephone and face to face)
- ⊕ Surveys (Partners, workers, community members, youth specific)
- ⊕ Literature review of existing documents specific to Atlantic Region, and related to topics of concern generated in the community consultations (like methadone, prescription drugs, sexual violence, youth programming, and addictions training).

Community Consultations

The best way to communicate with First Nations and Inuit in a manner that builds the trust necessary to discuss sensitive issues like addictions and health is face-to-face communications within the settings most comfortable for the people themselves. This is why community based engagement was our number one method of gathering input. In total 15 meetings were held in 10 First Nations and Inuit communities; Eskasoni (Treatment Centre; Collaborators; Youth (art based); and community members); Indianbrook (Treatment Centre/collaborators); Elsipogtog (Treatment Centre; Sweat Lodge; Health Center); Tobique (Treatment Centre/collaborators); Eel Ground (Treatment Centre/Healing Circle with Collaborators; Children and Youth (art based); Oromocto (Health Center/Methadone Clinic); Kingsclear (Treatment Centre); Millbrook (NNADAP/ Collaborators); Happy Valley/Goose Bay (Treatment Centre/Collaborators); and Sheshatshiu (Collaborators) in Labrador. Eleven gatherings/meetings were held in 6 urban locations, including Charlottetown, PEI (UPEI Dean of Nursing and CMPEI Health Director); Truro (Atlantic Aboriginal Health Research Project-AAHRP); Moncton, NB (Atlantic Policy Congress (APC) Health Conference (2 + 1 art-based); Summerside, PEI (Health Conference); Halifax (NADACA and RAPC); Fredericton (Gignoo and UNBI) were

attended where materials were shared and gathered regarding the NNADAP needs assessment.

Maternal Health Focus Group

In recognition of the First Nations and Inuit belief that addictions impact all stages of the life cycle, as part of the ANNA processes, a focus group on Maternal Health was held in Moncton at the Atlantic Health Conference. A workshop designed on the Medicine Wheel, looking at the impacts of addictions and holistic healing strategies for all stages of the life cycle was facilitated. Information from the session was recorded and is incorporated with the other materials collected throughout the consultation process. We will refer to compiled information from this session, which involved 34 people from 12 communities, as the Moncton Gathering.

Interviews

Additionally 25 interviews were held face-to-face while in communities, and 25 by telephone in either the planning or follow-up phase of the workplan with Treatment Directors, Health Directors, Community Leadership, Addictions Researchers and Policy Analysts for the region and nationally, and community members.

Table 2: Participants through Interviews, Community Visits & Event Attendance

Province	# of Communities Involved	# Participants Involved
New Brunswick	12 + 2 organizations*	72**
Nova Scotia	14	48
Newfoundland Labrador	4	21
Prince Edward Island	2 + 4 organizations***	36

* Gignoo House in Fredericton and UNBI in Fredericton

**This figure does not include the 52 children and youth that gathered for the art-based intervention in Eel Ground. Those in attendance that completed questionnaires are included in Table 3A.

***Aboriginal Women's Association, MCPEI, Grand Council, Native Council of PEI

These figures also do not include the 7 Chiefs who attended the presentation given at the meeting of the NADACA board; the 13 members who were present at the Atlantic Addictions Partnership meeting; or the 30+ participants who attended the information session on the NNADAP process held at the Moncton Aboriginal Health Conference. No list of community affiliation was taken or provided, so these people are not included in the community stats breakdown.

Questionnaires

We designed 5 questionnaires in total, with the option to complete on-line, on the phone, or in writing and submitted by fax or mail. In four communities we were able to provide the option to complete the survey face-to-face with a community liaison worker: Eskasoni (NS), Tobique (NB) Eel Ground (NB), and Lennox Island (PEI).

1. The preliminary survey, which was for the Partnership Group and Health Directors, was intended as input for developing the workplan, but has also proven to be excellent information in the priority setting phase. Thirty-eight partners completed this survey: (5 members of the Advisory Committee, 12 members of the Atlantic Partnership Committee (5 who are Treatment Center Directors, 4 who are NNADAP workers), 3 Health Directors, 3 people in leadership, (including the APC, the PEI Confederacy, and the UNBI), 8 Policy analysts (working for FNIH, 2 in Ottawa, 6 in Atlantic Region), and 7 researchers (including AAHR). Appendix II: Preliminary (Directors/Partners) Questionnaire
2. From the feedback on the preliminary Directors survey, a worker specific one was designed and circulated to lists of addictions, health and mental health workers. We were not able to get lists of child welfare workers or justice workers, but when identified, some workers in these fields did complete the survey. Several follow up email messages and some phone calls were made to encourage workers to complete the survey, and copies of the surveys were made available at each meeting and gathering we attended. Within the two months of the data collection period, Fifty-six workers from twenty communities completed the questionnaire. Twenty-eight were addictions workers, twenty-six were other related workers, one was unidentified. Appendix III: Community Workers Questionnaire
3. At the same time as the worker survey was circulated, a community member survey was also sent out by email. We asked workers to engage with

people they felt would have some important information for us, to complete the questionnaire through one of the available methods. Eighty-three community members responded from fifteen communities. Appendix IV: Community Member Questionnaire

4. Later during the data collection process, when we were asked to do a session with over 50 youth in Eel Ground, a youth specific survey was suggested, and so we created one based on the community member survey. Twenty-four children and youth from Eel Ground completed the survey at the community meeting, along with engaging in an art based process of communicating what they would like to see or stop in their communities to make them a healthier place. We then put this questionnaire on line, and sent a message to all of our contacts to let them know about the questionnaire and to encourage them to get youth to respond. For this specific survey forty youth responded from nine communities; twenty-nine youth responded to the community member version, 3 responded to community the community worker one. Appendix V: Youth Questionnaire

5. The final questionnaire developed was in response to the concern we heard at several meetings regarding the lack of culturally-specific Detox for First Nations and Inuit in the Atlantic Region. We designed a survey directed specifically at the Detox Centers. After speaking with a Director from each province, the survey was sent out by email, with the request to return have it completed and returned by fax. None of the Detox directors/staff returned the survey completed. Approximately 10 phone calls were made to attempt to get information from the Detox's about their service delivery to First Nations and Inuit in the Atlantic Region. Appendix VI: Detox Questionnaire

Table 3: Participants through Questionnaires: Age

Age	Community Worker	Community Member	Youth	Total	% of Total
25 & less	3	29	40	72	40%

26-50	37	38		75	42%
51 & over	16	16		32	18%
Total	56	83	40	179	

Table 4: Participants through Questionnaires: Gender

Gender	Female	Male	Two-Spirited	Total	% of Total
Worker	38	16	1	55	31%
Community	67	16	0	83	47%
Youth	23	16	1	40	22%
Total	128	48	2	178	
% Total	72%	27%	1%		

* 1 Worker did not declare gender

LIMITATIONS

The four major limitations of this Needs Assessment correspond to the limitations of NNADAP service provision and renewal process more broadly: time, resources, jurisdiction and lack of availability of First Nations and Inuit Atlantic specific statistics and research. Due to contract negotiation issues, we were unable to begin the Needs Assessment process until early December 2008, rather than August 2008 as anticipated. The deadline for the report was extended for all of Canada until May 31, 2009, and then again until the end of June. Adequate resources for travel were not provided in a timely manner, so the Circle Works team was unable to travel to Newfoundland and Labrador. A sub-contractor in Labrador was able to conduct two community meetings, and unfortunately, despite many attempts, we were unable to either visit or subcontract anyone to assist in the needs assessment in Newfoundland. We were only able to visit select communities in the Atlantic Region, and this was not all of the ones that requested meetings (ie. Natuashish, Eel River Bar, and Buctouche). We did extend the timeline for responses to the questionnaires, but more time, more community visits, and a longer time in each community, would have produced a much more accurate assessment of the specific service needs of each province and all communities in the Atlantic Region.

Significantly, when community liaison workers had enough advance notice of the visit, along with support of the key informants from the community, we had the best results in terms of turnout of workers and members to meetings (i.e. Eskasoni, Elsipogtog, and Eel Ground). Some communities had much lower numbers at the

meetings than others. Sometimes this was planned, as the intention was primarily to meet with the key personnel in the Center (i.e. Kingsclear and Oromocto). For Tobique this was primarily due to difficulties is recruiting community liaisons prior to the visit, and change of plans due to rescheduling and bad weather. For Indianbrook and Millbrook, we also had difficulties in recruiting community liaisons. However, we were able to meet with key addictions service providers in all of these locations.

Due to the diversity of First Nations and Inuit communities in the Atlantic Region, there is a need for caution in generalizing issues, treatment approaches and determining best practices. Constraints on time, resources and technologies contributed to preventing Circle Works from going as far as we would have liked in emphasizing the uniqueness as well as the commonalities among Nations and Territories. Issues in the survey design limited the data analysis phase. These included lack of a specific coded questions to identify First Nation and to specify whether the person was an addiction or other community worker; and limited ability to be able to retrieve individual responses once the data was inputted, In the writing phase, ensuring that issues specific to communities are highlighted, while maintaining confidentiality of participants, was an ongoing struggle.

According to the Assembly of First Nations (2006a) accurate information is generally not available about substance use in Canada. In the Atlantic Region, there is a documented lack of data on addictions and other health issues. While there is a substantial amount of information, it is often difficult to gather. According to Health Canada (2008), “Challenges exist in the collection and reporting of health information on Aboriginal peoples. As is also true for other groups within Canada, it is difficult to extract health data particular to Aboriginal peoples (or specifically on First Nations, Inuit or Métis) from administrative databases. For Aboriginal health reporting, this challenge is further complicated by overlapping jurisdictional responsibilities for health between federal, provincial/territorial and local governments.”

Data needs to be collected in order to have numbers to support various programs, but questions as to who owns the data and where it will be managed are common. A

process of informed consent based on OCAP principles (Ownership, Control, Access and Protection) was used to develop the ANNA processes. The version of OCAP principles used and the Consent Letter appears as Appendix VII: OCAP Principles and Appendix VIII: Consent Form.

Lack of access to important health, mental health and addictions information for Atlantic First Nations and Inuit is one of the main problems we encountered in this Needs Assessment, and is a main limitation on the results. For the most part[4] neither FNIHB or communities provided basic statistical information. FNIH staff members instructed Circle Works to seek information from Health Authorities and Treatment Directors. Directors informed us that stats are provided to FNIH on a regular basis, we should get them from Head Office. Although we were contracted by FNIH we were not allowed access to internal documents, for example the recent Mental Health Scan for Aboriginal in Atlantic Canada. One exception to this was Elsipogtog Health Authority, as their information is publically available through their local newspapers, and we were provided back copies for the last year.

> **ACTION (Research): A rich source of future data would be the creation of a more accurate, detailed and simple system of record keeping, that would be designed to assist First Nations and Inuit in understanding the trends, issues, and strengths within their own communities. This system would need to be developed by technicians in consultation with First Nations and Inuit, and funded by Health Canada.**

In the ANNA processes, individuals and communities identified similar issues: the lack of knowledge available to communities and other gaps and challenges in meeting the identified needs of their communities. These issues fit predominantly into the following categories: Lack of information on availability of resources for community-centred and community-based programs; and gaps in the knowledge about addictions (e.g., trends, issues and strategies) and the process of recovery.

SECTION ONE: CULTURE

"The struggle for Indigenous people's cultural survival amidst overwhelming destructive historical forces cannot be constructed as a contemporary political debate with contrived theatre to gorge a middle path acceptable to mainstream Australia. The advocacy for recognizing Indigenous people's cultural survival has unimpeachable integrity that cannot be compromised in the face of historic European settler hostility and frontier violence" (Dodson in Altman and Hinkson** *2007:* **24).

CHAPTER TWO: FIRST NATIONS AND INUIT CULTURAL PRACTICES ARE HEALTHY FOR FIRST NATIONS AND INUIT.

"Our voices are our medicine and our stories are our medicine and we're all a bundle of stories." Mi'kmaq Grandmother Heather Sole[5]

"Aboriginal belief systems have much to teach about a broader approach to recovery because they emphasize that all aspects of well-being are equally important and interconnected, including the physical, emotional, mental, and spiritual; that balanced well-being is throughout the lifespan; and that individual health is an aspect of the health of families, communities, nations, and the environment"[6]

HEALTH, WELLNESS AND CULTURAL CONTINUITY

Colonization and cultural contact have had complex and often devastating effects on the community structures, health and mental health status, and individual and collective identities of Canadian First Nations and Inuit. The Assembly of First Nations major National Health project's data, the RHS[7], seems to suggest that transfer polices are a

marker of community stability, which in turn can impact substance use and misuse and other health and mental health struggles. The recent Brighter Futures Evaluation found that a community's wellness is linked to the degree of local control and cultural continuity it enjoys (Health Canada, 2007).

One specific example of current research on youth suicide with First Nations in British Columbia by Chandler and Lalonde (2008). They examine the link between "cultural-continuity" – the sense of your community's long-term survival – and rates of youth suicide. Greater movement towards Aboriginal community control was found to reduce suicide risk for youth: a) evidence of having taken back from government agencies certain rights of self government resulted in an 85% reduction of youth suicide b) community-controlled educational services (52% reduction) c) evidence that particular bands had taken steps to secure Aboriginal title to their traditional lands (41%); d) community-controlled health delivery services (29%) ; and e) evidence of recognized "cultural facilities" to help preserve and enrich their cultural lives (23%) and f) community-controlled police and fire protection services (20%).

The *Exploring Health Priorities in First Nations Communities in Nova Scotia* 2008 report found that autonomy in dealing with health and addictions issues is a key to cultural connections and safety: "First Nation people need to be running our own systems – we would not be facing many of these challenges and complications if we were making the decisions and the rules about how the system operates." Both evaluations of the LICHS reported that "bureaucrats got off to a bad start by making decisions without Innu input, and showed a lot of insensitivity toward the people they're supposed to be helping" (as reported by The Star)[8].

Autonomy was a recurring theme within several ANNA community meetings, where healing was connected with self-determination. Although some communities experience significant difficulties in getting leadership on board with recovery from addictions, participants agree that healing comes from communities both owning the problem and solving it (Kingsclear, Rising Sun, Moncton Gathering, Lone Eagle).

These findings, and others, support the NNAPF[9] 2007 position statement:

ACTION: There is a growing recognition for the need to continue to move towards self government, enhanced cultural revitalization, and to have culturally appropriate programming integrated into the provision of addiction services and other health care services for all First Nations and Inuit.

CULTURE, TRADITION AND HEALING

The culture and traditions of First Nations and Inuit communities are frequently mentioned in publications dealing with health, and more specifically, mental health. There is agreement in the literature that the incorporation of traditional teachings and practices has benefits for individuals and communities, especially in terms of affirming identity and self-empowerment (Health Canada 2006, Chansonneuve 2007). However, few publications have examined questions relating to the role of traditional healing practices in addictions programs specifically, and none of them report on research examining the outcomes for individuals or communities. The body of literature describing best practices in substance abuse programs for First Nations and Inuit populations is limited; however, existing research supports the incorporation of cultural and spiritual healing practices into addictions approaches. The RHS results highlight the importance of First Nations cultures in reducing alcohol and drug use.

Indigenous knowledge is a healing practice: As one participant from Labrador said: “I find the more you say treatment the more agitated I get. I think it is a medical term that is being imposed. It is limiting how we are thinking about helping people.” Whenever possible we are going to attempt to alternate the word “treatment” and use the word “healing” or “wellness.”

Ideally, First Nations people need to both manage and provide healing. Wellness philosophies must also attempt to address the psychological impacts of historical trauma and abuse issues as many of those who access healing attended residential school, or have been impacted by others who have. As this will chapter show, the culture and traditions of First Nations and Inuit are viewed by both workers and community members as critical to healing addictions.

Blending Traditional & non-Aboriginal approaches to healing

The interim report of the Aboriginal Healing Foundation found that *"Overall, it is clear that cultural activities enhance personal and community pride and well-being, as well as providing a solid base for healing"* (Kishk Anaquot 2006). Many of its funded projects supported traditional healing and the increased involvement of healers, Elders and cultural teachings. Some projects focussed on traditional healing, many others involved culture and tradition in support roles: Elders teaching traditional ways in schools; on-the-land excursions and camps; or social activities such as feasts and dances to bring people together. In some cases, opportunities to celebrate community history and culture were seen as a way of overcoming conflict within the community. A few of the projects combine traditional and non-Aboriginal approaches to healing. It was noted that more information about the blending of traditional and non-Aboriginal approaches is needed.

Regionally we have seen, in varying degrees, that the sweat lodge, smudging and healing circles have been blended with mainstream wellness and psychotherapeutic methods within many Aboriginal-run healing centres.

Existing NNADAP Atlantic policies can support an approach that integrates Aboriginal and Western methods: "We utilize both traditional and contemporary methods of healing. Healing will be respected in the delivery of services" (p. 4). According to the Atlantic Policy Manual, treatment currently integrates: "daily spiritual practices" and post-treatment plans encourage clients to: "recognize the importance of following spiritual ceremonies" But this support is limited by lack of resource allocation and training towards incorporating First Nations and Inuit methods, and the overarching pressure from Health Canada towards use of "effective" prevention and intervention methods: "All Prevention and Intervention Methods should be recognized as effective through scientific research" (p. 4).

Efforts need to be made toward greater possibility to include First Nations and Inuit healing methods as "effective". As Aboriginal methods are often not recorded, nor do healers subject themselves to the rigours of scientific research, holistic, integrated

models will need to evolve in a spirit of collaboration rather than scientific investigation. This could include:

- ⊕ Culturally respectful research methods to examined questions relating to the role of traditional healing practices as best practices in addictions programs specifically, including outcomes for individuals or communities be explored.
- ⊕ Culturally respectful research into use of traditional approaches, and the blending of traditional and non-Aboriginal approaches.
- ⊕ Resource allocation and training towards incorporating Aboriginal methods, and elimination of pressure from Health Canada towards use of scientific research as measures of "effective" prevention and intervention methods will be required.

Cultural connections are discussed as a health priority for First Nations in Nova Scotia in the *Exploring Health Priorities* Report (2008): "We need more cultural connections – we need a worker hired to facilitate cultural awareness and activities." The Report prioritized the need to support and enhance the capacity of First Nations individuals and communities to develop and deliver their own programs and services, including: addictions and health resources and services that are timely, culturally-appropriate, and accessible; and more programs, more funding, more emphasis on recruitment of Mi'kmaq/Inuit/Aboriginal addictions service and program deliverers.

ACTION: Increase access to funds for contributing to the development of traditional activities as necessary "diversion" for successful prevention and aftercare programming.

ACTION: More sharing between First Nations and Inuit about use of traditional approaches and the blending of traditional and non-Aboriginal approaches is needed.

HOLISTIC WELLNESS

Holistic Wellness refers to Physical, Mental, Emotional and Spiritual Health. A recent report of the Aboriginal Healing Foundation explicitly states that Aboriginal belief systems have much to teach about a broader approach to recovery because they

emphasize: that all aspects of well-being are equally important and interconnected, including the physical, emotional, mental, and spiritual; that balanced well-being is throughout the lifespan; and that individual health is an aspect of the health of families, communities, nations, and the environment (Chansonneuve 2007).

Holistic Approaches

Several participants in the ANNA processes stated that there is a huge gap in the mainstream approach to addictions and this gap can be addressed through a holistic approach (PEI, Moncton, Nova Scotia, Newfoundland, NB). At the Moncton Gathering, participants evolved a holistic approach to addictions that involved:

- Traditional approaches;
- Elder/ Parent programs;
- Elder/Youth Programs;
- Continuous care programs and follow up after Treatment;
- Breaking the cycle of alcohol & drug abuse and physical, mental, sexual, emotional abuse.
- More community-based and community-inclusive programs e.g.,
    - Sports/ recreation programs;
    - Traditional gatherings;
    - Women's gatherings and support circles;
    - Traditional craft clubs;
    - Transportation.
- Family Wellness Programs that take a holistic approach (focusing on parents, children, historical trauma); As one participant stated: "We have to get back to the basics, talk to the elders, listen to the youth rather than tell them how things have been. Let's get back to ceremonies – to include the family. Everything begins at home."

Moving towards cultural holism

According to ANNA participants, holistic services for adolescents could include: "meditation not medication", self-esteem workshops, sports, crafts, alcohol and drug free social gatherings and incentives around healthy lifestyle through exercise and diet; mentoring programs; more evening programs; youth/elder conferences; more youth workers and youth centres. As one participant at the Moncton Gathering said: "We need to have a Youth Council to tell workers what their needs are."

Cultural teachings and practices, including relationship counselling and Family Resource Centres to help parents become more positive role models is a holistic strategy mentioned. More Elder involvement in the health and well-being of communities, including the provision of addictions services. One participant stated, "Even when you did something wrong in the community, you would be sat down with the elders and be told a story. From that story there would be a lesson." Holistic approaches embrace the First Nations and Inuit reality that: Healing is for all. As one participant stated, "When we are talking about a 10 year old sniffing there is reason and that needs a holistic approach."

> **ACTION: As substance abuse has not been used as a coping mechanism for the growing loss of identity and culture, programs that revitalize and reinforce culture be appreciated as a culturally appropriate form of harm reduction. Workers be hired to facilitate cultural awareness and activities appropriate to each territory and community.**

An First Nation and Inuit Approach to Healing and Recovery

First Nations and Inuit approaches include spiritual teachings and an experiential, relational approach. Prevention and intervention programs that provide opportunities for participants to *experience and live* self-respect, sharing, and cooperation are inherently promoting health. The *Six Principles of Inuit Traditional Knowledge* (Inuit Qaujimajatuqangit 2000) provide a framework for effective addictions prevention and intervention planning. Applying the *Six Principles* to addictions policy and program development ensures all aspects of services begin from a solid foundation. In summary, The *Six Principles of Inuit Traditional Knowledge*, include: Serving (Pijitsirniq); Environmental Stewardship (Avatimik Kamattiarniq); Consensus Decision-Making (Aajiiqatigiingniq); Skills and Knowledge Acquisition (Pilimmaksarniq); Being Resourceful and Adaptable to Solve Problems (Qanuqtuurunnarniq); and Collaborative Relationships or Working Together for a Common Purpose (Piliriqatigiingniq).

Examples of culturally relevant experiential-relational learning include storytelling, art therapy, talking circles, or performance art where participants have the opportunity to express powerful feelings indirectly through stories. Sharing their own stories, and

having those stories validated by others who have lived through similar experiences, is a powerful form of affirmation and healing. Healing models based on creative self expression, grounded in community and environmental responsibility have proven to be more effective with First Nations and Inuit clients than talk therapy and instructional learning (Kishk Anaquot 2003). Three art-based processes were engaged in as part of the ANNA processes, two with children and youth (Eskasoni and Eel Ground) and one with community workers (Moncton Gathering). Some images from these sessions are included in this document.

All communities in our needs assessment agreed that First Nations and Inuit approaches to healing and recovery are the most effective with First Nations and Inuit clients, and advocated for more culturally-based approaches and the employment of Indigenous traditional addictions and mental health workers. Suggestions include: Elder-Youth gatherings; Elders visiting school classrooms to give teachings about history and knowledge of the land; teaching cultural skills like survival skills, traditional medicines, traditional foods, drum making, singing, and traditional dance; social networking such as the Powwow Trail and A.A meetings; Mi'kmaq traditional teachings and traditional Ceremonies; including the Pipe, Sweat Lodges, Fasting, and Talking Circles; practices of kindness & forgiveness; and walking the Red Road—alcohol and drug free as a way of life.

Participants expressed a number of reasons for moving toward more culturally-based approaches and Indigenous traditional healing practices. These include:

- ⊕ Reclaiming culture is a healing process: *"We have to start decolonizing people to believe that Aboriginal ways are good ways. When you believe that you can believe in your own people"* (Millbrook).

- ⊕ Providing culturally-appropriate ways of practicing with others who are committed is an Indigenous understanding of collaboration: *"We need to support practices that are traditional rather than medical based or western based.* There are people in our community who have the knowledge. Do we measure our success from Western eyes or through Aboriginal eyes?" (Elsipogtog).

- ⊕ Restoring the roles of Elders and Teachers strengthens the capacity of people to solve their own problems: *"Accreditation needs to be on the grounds of what we know as Aboriginal people"* (Lone Eagle).

- ⊕ Restoring a sense of belonging: *Knowing where a person comes from (e.g., spiritual beliefs, cultural practices) is a huge part of healing* (Labrador).

- ⊕ Indigenous knowledge is a healing practice: *"I find the more you say treatment the more agitated I get. I think it is a medical term that is being imposed. It is limiting how we are thinking about helping people"* (Labrador).

- ⊕ *Locally based, culturally appropriate services will help to address the needs of Aboriginal people* (as is evidenced in the long waiting lists) trying to get into Aboriginal-specific programs (Gignoo).

Atlantic participants shared their knowledge about incorporating Indigenous ceremonies into their healing practices, including Sweat Lodge, Talking Circle, Blanket Ceremony, Sun Dance Ceremony, use of the Medicine Wheel, spaces and times to connect to Nature; available Medicine People and Elders for clients; Traditional crafting and cultural activites; bank to the land; arts and creative therapies; use of First Nations and Inuit language, and having staff on the Red Road (drug and alcohol free). See CHART ONE: CULTURAL APPROACHES TO HEALING on page 42.

CULTURAL APPROACHES TO HEALING

Sweat Lodge

Lone Eagle Treatment Center generously invited the Circle Works team to participate, with residents, in a Sweat Lodge Ceremony. In addition to spiritual and physical benefits for all, the Lodge provided an excellent opportunity to build relationships between Circle Works and Center staff. Participants from several locations shared, in the ANNA processes, why they incorporate the Sweat Lodge ceremony into the healing work (Kingsclear, Moncton Gathering, Mi'kmaw Lodge, Lone Eagle, Tobique, Eagle's Nest). The Sweat Lodge is a holistic First Nations healing practice. When asked to write in on the worker questionnaire: What is working, Sweat Lodge was a frequent response. ANNA participants noted that the Sweat Lodge targets the spiritual aspect of health; and helps people to connect with their deeper issues.

Talking Circle

Circle Works was able to participate in a Healing Circle with many workers and past clients of the Rising Sun Treatment Center. Not only was much valuable information shared, it was a great opportunity for all participants to reconnect and reaffirm their healing journey. ANNA participants talked about the importance of the use of Talking Circles as part of the healing process from Moncton, Millbrook, Kingsclear, Tobique, and the Rising Sun. Workers frequently responded to the question: What is working, with Talking Circles as an answer. "Circles give power & strength to battle this issue of addictions." Traditional methods such as Talking Circles and Sweat Lodge Ceremonies provide individuals with hope and alternatives to unhealthy lifestyles.

Blanket Ceremony

One participant shared that the candle ceremony, the inner child birthday party, and the blanket ceremonies are incorporated into programs (Eagle's Nest).

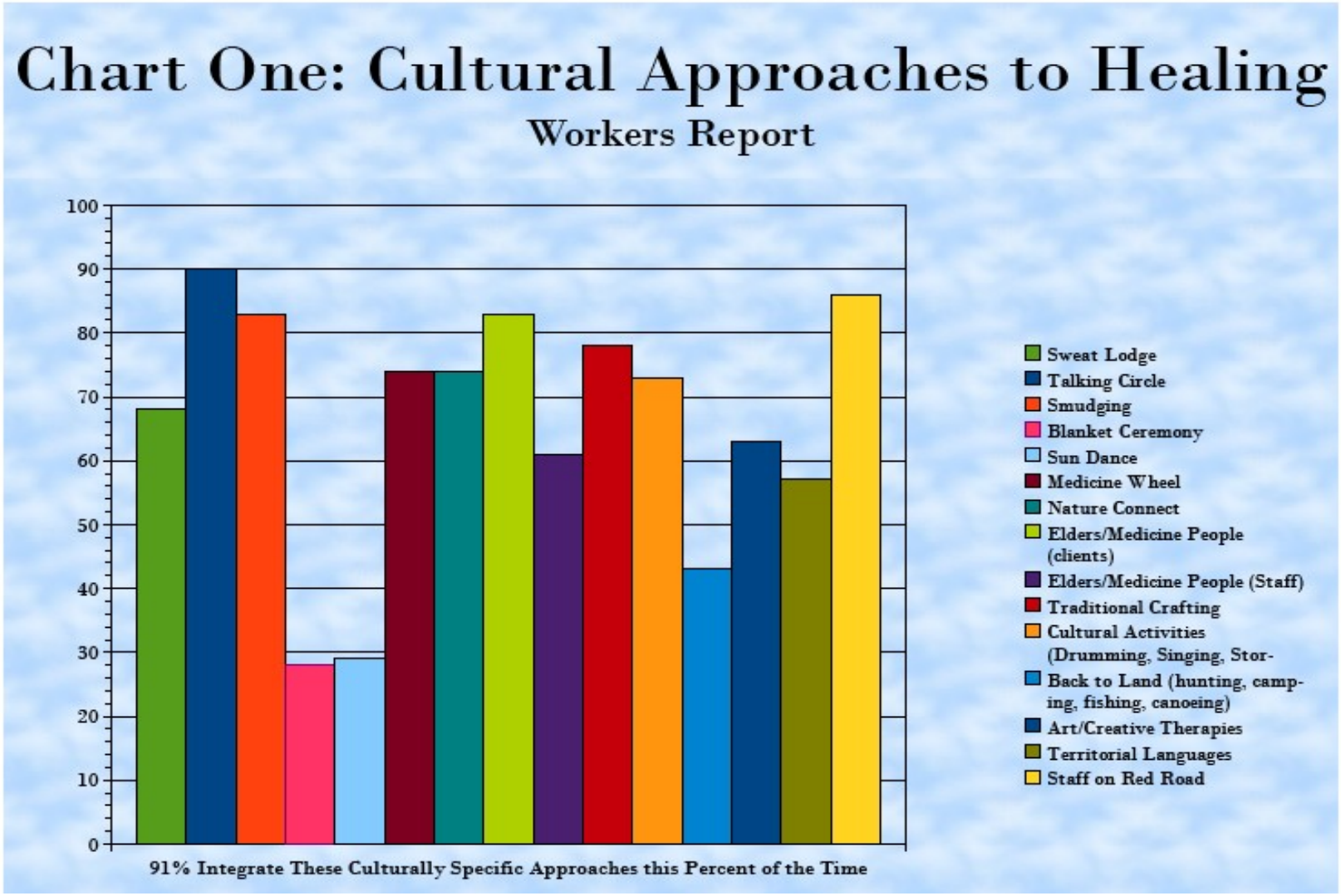
Sun Dance Ceremony

One participant shared that healing must begin in spaces where people can make a connection between themselves and Creation: "The Sundance is a men's ceremony so that men can experience a small percentage of the pain of childbirth and honour the women who came close to death in childbirth. When the sacred tree is cut for the ground we are reminded that one person alone is not enough. It takes the community" (William Nevin, Sun Dance Chief, Rising Sun Treatment Center).

Use of the Medicine Wheel

Aboriginal people from across Canada use the Medicine Wheel to map the roots of substance abuse as well as the paths to healing. The Medicine Wheel can also assist in identifying "what a healthy individual/community looks like, sounds like, feels like" (Chansonneuve 2007).

Participants in the ANNA processes shared how they use the Medicine Wheel to develop and provide services to their community in PEI, Elsipogtog, and Tobique: "using the Medicine Wheel brings balance to healing programs"; "we must include all four quadrants"; "knowing the Wheel helps workers provide better services".



Spaces and times to connect with Nature

Many ANNA participants talked about the importance of connecting with nature in the healing process, including workers from Eagle's Nest, Charles J., Eskasoni, and Natuashish. Nature has healing qualities, and as one Newfoundland worker found, youth and summer programs out on the land "promote natural highs".

As one Labrador participant stated, "People need to go out to the land to heal." Others reaffirmed this First Nations and Inuit reality: "I would say the land based programming is one of the most innovated and most effective in dealing with some of the life issues" (Natuashish). The Natuashish healing lodge delivers different land-based programs throughout the year – including suicide and grief work; mother and daughter programs; family programs and annual gatherings to strengthen connections. *"Programs that are land-based are more responsive to needs e.g., to make connection between individual healing and the land, to connect with traditional ways".*

The importance of land-based programs was summed eloquently by a Labrador participant. "A lot of people do not understand the Innu connection to the land. The Innu are there to heal and when they do, the family dynamics change. They are more connected and they share something. I feel there is resistance from Health Canada to go back to land-based programs. They do not seem to realize how essential the land base is to the Innu for us to survive."

Available Elders and Medicine People for Clients

Elders have certain gifts and carry knowledge around specific ceremonies such as Pipe Ceremonies, Sweat Lodge, and Talking Circles. Elders bring gifts of traditions and teachings to the struggles of First Nations and Inuit. They can play a vital role in the healing process.

Many participants spoke about the importance of having Elders and Medicine People available for clients. (Moncton, Labrador, Kingsclear, Lone Eagle, Mi'kmaw Lodge, Elsipogotog, Charles J., Labrador). One Elder stated, "That is what we do when people come here, we thaw their heart". Examples of Elders being included are:

- ⊕ Elders' traditional knowledge can be gathered and shared with youth;
- ⊕ Traditional healers can include more grandmothers and bringing back traditions through Elder and youth programs;
- ⊕ Gathering of traditional medicines to help impart the message that through self-care, you are less inclined to use drugs to treat your health/mental health issues;
- ⊕ Elders to speak about health and nutrition;
- ⊕ Share the success stories around Elder involvement.

Having Elders as traditional role models is vital to healing: "He is being traditional and I think it is working because people are wanting to get out and exercise, eat healthier, be more traditional. He is reaching a lot more people" (Labrador).

While participants spoke of the healing work of Elders, some also spoke about the importance of working with Older People and providing Elders with help and support (PEI, Moncton, Millbrook, Indianbrook, Labrador).

- ⊕ Older People can experience lack of culture (depending on community); financial issues; poor eating habits (nutritional vitamins); lack of spirituality due to conflicts between church, tradition, beliefs, etc.;
- ⊕ "How can we involve the Elders more, build up their confidence and skill level so they feel more valuable and have something to offer?"
- ⊕ Elders also need time out too.

Traditional Crafting

Participants identified traditional crafting as an important component of healing addictions (Mi'kmaw Lodge, Millbrook, Rising Sun, Labrador). As one participant said: "Sometimes just having a good diversion can help make recovery possible". A youth told us: "Beading was the only thing that kept me focused. It reminded me of my Granny." Beadworking, Basket-making and Drumming were all frequently mentioned as "diversion" programs. "The community takes pride in seeing the drumming of youth".

Use of First Nations and Inuit Languages

When asked to speak about what is working, many commented that regaining language and rebuilding culture are key pieces to building a strong community and strong individuals. (Rising Sun, Natuashish, Moncton Gathering). As TABLE ONE indicates,

the major of Aboriginal Treatment Centers in the Atlantic Region are able to offer clients services in the language of the territory, including Mi'kmaw Lodge.

Cultural Healing in Practice

Many ANNA participants from all across the Atlantic region shared the specific cultural approaches they use presently in their programs (PEI , Natuashish, Eskasoni, Millbrook, Rising Sun, Eagle's Nest, Indianbrook, Lone Eagle, Kingsclear, Charles J, Mi'kmaw Lodge, Moncton Gathering). As one participant reaffirmed, "Culture and healing are deeply connected. In breaking the cycle, the most important is bringing culture back, it is a process". ANNA participants shared many other examples of what traditional healing support within a program would look like, including:

- ⊕ Letting go Ceremony: which includes journaling during the program and on the last day before graduation, clients burn the journal if they wish;
- ⊕ Use of a traditional (cultural) food guide; eating traditional food;
- ⊕ Women's teachings on sacredness of life need to be taught and traditional beliefs which respected women, including Women's fire ceremonies;
- ⊕ Traditional education about parenting and family life, and traditional skills;
- ⊕ Whole family approach —combined parent and youth programs;
- ⊕ Acceptance by providing both Aboriginal and Christian spiritual approaches;
- ⊕ Feasting or community supper "some are catholic communities, so it depends on the priest";
- ⊕ Walking the traditional Innu paths, and using traditional equipment;
- ⊕ Circles of support and accountability; and
- ⊕ Herbal/Natural Meds

Other strategies for enhancing cultural services can include:

- ⊕ "We need to have a Youth Council to tell workers what their needs are." Engage youth role models to provide front-line contact with youth, and offer first voice for youth.
- ⊕ Training in healing models that are based on creative self expression, grounded in community and environmental responsibility.
- ⊕ The Sweat Lodge targets the spiritual aspect of health; and helps people to connect with the deeper issues. Resources to cover the material expenses and time of Lodge keepers as helpers.
- ⊕ "Circles give power & strength to battle this issue of addictions". Circle facilitation training as a core competency and debriefing circles as an ongoing self care method for addictions workers.

⊕ "People need to go out to the land to heal." The success of land-based programs in Labrador should be explored as a best-practice model to be used in other parts of the Region and country.

ACTION: Resources to support cultural healing practices are required, including appropriate honorariums for Elders and cultural knowledge holders who share their time, teachings and talents. Elders who are engaged in their healing journey, who are on the red road, and can offer traditional teachings to communities can be honored as Role Models and the information can be shared between communities to encourage capacity building across the Atlantic.

CHAPTER THREE: INNOVATIVE CULTURAL PRACTICES

Innovative approaches and practices have been developed at the community, tribal, and regional level to address addictions prevention and wellness needs. The best practices of leading Aboriginal health and healing programs in Canada are based on values of: Equity, Holism, Culture, and Community (Health Canada, 2006).

Examples of Cultural Innovation in Atlantic Canada

1. **Lone Eagle Treatment Center, Elsipogotog** is recognized within the Atlantic Region for its commitment to using traditional ways and values as a way out of addictions. Through use of the Sweat Lodge and Sun Dance Ceremonies, clients in the Center are encouraged to choose sobriety and a drug free life. The Sun Dance Chief, William Nevin was recently featured in a full length NFB video (2008) called *The Sacred*

Sundance: The Transfer of a Ceremony, where the traditional teachings that form the basis of the work at Lone Eagle are shared. "First was the sweat, then the pipes and sweet grass and sages, the medicine then the Sun Dance…."So what we are doing (through fasting and the Sun Dance) is getting your body ready so you can turn it off and on when you want it to. So when you are faced with a challenge you know you can get through it. These ceremonies are not easy, and some people fail if they are not prepared. When you get through the hard times it feels real good. You can say "I did it!"…Our dancers make a commitment for the rest of their life not to drink or drug and to help as many people as they can…A lot of people say that the Sun Dance doesn't belong to the eastern people. My basic argument is alcohol and drugs are not ours either yet you go after the Sun Dance and not the real problem. The real problems are the social problems of alcohol and drugs."

2. **Charles J. Andrews Youth Treatment Center,** officially opened in Sheshatshiu, Labrador May 2000, for land-based programming as part of The National Native Youth Solvent Addiction program (NNYSA): "Cultural programming begins with a belief in a world view that promotes a holistic perspective of life, placing traditional healing practices and cultural values in the forefront". [10]
3. **Natuashish Land Based Programs** for grief work and families as previously mentioned.
4. **Nogemag**[11] In partnership with the Elsipogtog Band and Elsipogtog School and in cooperation with Justice Canada, HRDC, Crime Prevention and RBC, the Nogemag C.A.R.E. project has created innovative projects, offering many different programmes to help at-risk youth from the Elsipogtog community since the summer of 2002. Programs include the Summer Cultural Camp Project on Eldership Development: *Reclaiming our Ancestral Footsteps*, which is part of NB Youth Suicide Prevention

Initiative. The camp focuses on immersion and training youth leaders in traditional life skills and spiritual teachings; instilling cultural pride and positive self identity.

CULTURAL PRACTICES THAT WORK, BY POPULATIONS

ANNA participants were asked to share what they know works, and the great majority of the answers were culturally based. Key strategies include:

- ⊕ Honouring Abstinence in the community (e.g., community celebrations, support networks);
- ⊕ Reclaiming Maliseet language is healing;
- ⊕ Elders teaching the residents spiritually, including arts and crafts, and attending local sweat lodges;
- ⊕ Land hope programming;
- ⊕ Healing with shakers and drums;
- ⊕ Talking Circles;
- ⊕ Aboriginal Twelve Step programs.

What works with Adolescents?

Holistic and culturally appropriate approaches include non-judgemental discussions of youth issues in the context of building self-esteem, problem solving, and communication skills as more likely to be more effective than programs directed primarily at "the problem". Building the capacity of youth to help each other was mentioned frequently" "Peer counsellors to be the leaders of tomorrow". "Youth peer groups are critical and their influence is huge".

Knowledge of Aboriginal culture and identity promoted through culturally-appropriate youth- specific programs like traditional dancing and drumming: "a place at the Drum encourages sobriety"; and traditional wilderness expeditions root youth in their deep connection to the land and culture. See CHART TWO: CULTURAL PROCESS WORKING FOR CLIENTS (ADULT AND YOUTH) PAGE 49

Community members, including youth, reported the significance of using cultural approaches. A higher percent indicates the item was considered most helpful by more participants. Spiritual ceremonies (47%) we considered the most helpful, followed by

Cultural activities (37%); Traditional counseling (32%); Cultural crafts (21%); Elders stories (8%); Access to language (8%); and Outdoor outings (8%).

Chart Two: Cultural Approaches With Clients

1. Cultural Activities
2. Spiritual Ceremonies
3. Traditional Counselling
4. Cultural Crafts
5. Listening to Elders Life Storie
6. Access to Worker in own Language
7. Arts & Creative Therapy
8. Outdoor Outings

Of the 46% Community Members, that answered CMQ52: *Out of the strategies used, please let us know which were found to be most helpful:* 37% wrote Cultural Activities; 47% wrote Spiritual Ceremonies; 32% wrote Traditional Counselling; 21% wrote Cultural Crafts; 8% wrote Elders Stories; 8% wrote access to Language; and 8% wrote Outdoor Outings of some kind.

ACTION: Following *The Aboriginal Mental Wellness Strategic Action Plan (AFN 2006)* goals and objectives, the development of a coordinated continuum of addictions and wellness services for and by First Nations and Inuit must include acknowledgement, recognition and funding for traditional and cultural approaches.

ACTION: Knowledge about promising traditional and cultural approaches to addictions and wellness needs to be gathered and shared as part of capacity building in training, certification of workers and accreditation of First Nation and Inuit facilities. This would include an

inventory of community members and role models as guides and Elders as a resource.

CHAPTER FOUR: CULTURAL SAFETY

While many people view cultural integration as the revitalization of traditional practices for First Nations and Inuit, it can also include expectations of cultural safety for non-Aboriginal workers: Culturally-safe social workers, counsellors, clinical therapists, psychologists, and wellness centres are a method of integrating cultural knowledge. One reasons that community healing programs such as Hollow Water are considered "exemplary" is because "provincial and federal agencies are required to adjust their role to fit the cultural framework of the communities' healing process" (Chansonneuve 2007).

A third cultural theme in the Nova Scotia First Nation Health Priorities Report (2008) was the need to support and enhance the capacity of mainstream providers to meet the needs of First Nations and Inuit in a culturally safe manner, including education on the provision of culturally appropriate services for all addictions and health care service providers. NAHO (National Aboriginal Health Organization)[12] provides a cultural safety framework that looks at "power imbalances, institutional discrimination, colonization

and relationships with colonizers, as they apply to health care" and requires workers to "become respectful of nationality, culture, age, sex, political and religious beliefs". According to this framework, "care may be deemed unsafe if the patient is humiliated, alienated, or directly or indirectly dissuaded from accessing necessary care."

Cultural Safety was the theme of the PEI Health and Addictions Gathering that Circle Works was invited to attend as part of the ANNA processes. As one presenter at the PEI Aboriginal Health Conference said: "Non-Aboriginal refusal to understand is evidenced in practices of pathologizing and assimilation." Some community members discussed cultural barriers with non-Aboriginal workers: "Statements that you can stop drinking if you want are not helpful and may do more harm than good." In Labrador, recognition of Inuit identity and provision of services and programs that are Inuit specific was identifies as an issue. As one participant stated, "I had a client come back and (the assessment) called him First Nations...that is pretty serious for psychiatric assessment. Inuit are not First Nations. There is just not knowledge about Innu or Inuit culture". Lack of cultural knowledge is not safe in health, mental health or addictions.

Chansonneuve (2007), reports that within Canadian history, no other group of people have endured "such a deliberate, comprehensive, and prolonged assault on their human rights as that of Aboriginal people..." therefore "Learning about Aboriginal historical experiences is also crucially important for service providers to work effectively with Aboriginal clients."

As the First Nations and Inuit Mental Wellness Strategic Plan asserts: "there are limitations in what one can expect to teach non-First Nations service providers. The office visit is far from ideal for providing culturally sensitive care when the First Nations way of healing occurs outdoors or in ceremony. *Culturally sensitive care can only be achieved by First Nations people, both in terms of developing services and providing services."*

> **ACTION: Knowledge of respectful cultural approaches to health and wellness is required for cultural safety on the part of all service providers. Cultural safety will mean training, mentoring, and**

supervision of Aboriginal and non-Aboriginal workers, as well as a functional system to adjudicate complaints of unsafe care.

Specific Goals and Objectives to Ensure Cultural Safety, adapted from the *Mental Wellness Strategic Action Plan* (AFN 2006), include:

- ⊕ increase the number of First Nations and Inuit service providers, by providing increased wages, relevant and accessible training as well as increased supports to reduce burnout.
- ⊕ increase the cultural competency of all providers of wellness and addictions services for First Nations and Inuit by identifying and strengthening the linkages and partnerships between First Nations and Inuit communities and training/educational institutions. Cultural Safety can only be achieved by a vigorous examination and revision of current health and addictions education curricula across the country and within the Atlantic Region.

SECTION TWO: THE MENTAL: UNDERSTANDING THE HISTORICAL AND STRUCTURAL CONTEXT

> ***"Indigenous people are starting from a good way back in terms of all the social benchmarks of health, education and economic equity. These are the realities of our post-colonial history. As a nation we must be prepared to recognize these truths and to put into place strategies that aim to bring some equity into the lives of Indigenous people. It will take considerable resources and it will take considerable time, as the gaps are so great. Most importantly, we must be prepared to enter into a genuine dialogue with the Indigenous community to determine the way forward in addressing the challenges that lay before us. Unless the engagement and dialogues between us is premised on the concept of 'the listening heart' then our relationship will remain out of balance and our endeavours will be doomed" (Patrick Dodson in Altman and Hinkson 2007: 29).***

Previous national research work among First Nations and Inuit has attempted to identify the factors that are associated with alcohol and substance abuse. According to the AFN response to the Regional Health Survey (RHS) (2007) obtaining clear data on the prevalence of substance use, abuse and dependence among First Nations and Inuit is limited by problems with existing surveys[13]. They include low levels of participation, lack of cultural sensitivity in the survey tools and interpretation of results, and culturally-biased diagnostic instruments. Part of the cultural limitation is that many studies are based on psychological assessments of individual factors, with inadequate attention to the historical and structural contexts which have shaped thoughts and actions of members of First Nations and Inuit communities. As understanding context is critical to resolving distress, this section will attempt to address this gap in the existing research,

CHAPTER FIVE: SETTING THE FIRST NATIONS AND INUIT ADDICTIONS CONTEXT

According to the AFN (2007) paper, there is no conclusive evidence that First Nations and Inuit are genetically prone to alcohol problems. This suggests that exceptional problem drinking, or harmful use, among First Nations and Inuit relates more to certain environmental factors, including history of abuse, family history of alcoholism, and other structural forms of victimization. First Nations and Inuit who have experienced a history of sexual and physical abuse, for example, have consistently higher levels of alcohol or drug abuse.

A history of alcoholism in the family is linked to future alcohol and substance dependence, and increases the risk of childhood abuse. Other risk factors include: exposure to alcohol and drugs; childhood neglect; depression; attendance at residential/boarding schools; and, being a victim of violence.

> **ACTION: Understanding of these determinants and conditions be mandatory training for all addictions, mental health, health, anti-violence workers, as well as all policy and administrative workers in FNIH.**

Alcohol dependence has been found to be linked with higher rates of abuse of other substances, particularly cocaine and marijuana. The combined use of these substances has also been associated with negative health and behavioural outcomes such as violence, injury and psychiatric conditions: alcohol-related deaths amongst First Nations people were six times higher, and drug induced deaths were more than three times

higher, than those of the general population (AFN 2007). For more quick facts, see; Appendix IX: Quick Fact Sheet on Environmental Factors Impact

Historical and Cultural Context

Colonial history has definitely shaped the use patterns of First Nations and Inuit. First was an increase in the availability of alcohol, which was often used during trade and talks. "The frequent use of alcohol by European authorities has been viewed as representing a type of chemical warfare aimed at creating a European advantage as colonization was initiated" (AFN 2007). The heavy drinking 'frontier lifestyle' modelled by early traders, and the need to engage in the rapid ingestion, or 'gulp drinking', of alcohol in order to avoid authorities when alcohol was made illegal may still be an influence on heavy consumption patterns, like binge drinking.

Over the past hundred years, ongoing assimilation policies, such as the residential school system, further contributed to the disintegration of traditional cultural and family structures. "Federal policies such as the *Act for the gradual enfranchisement of Indians* (1869), the *Indian Act* (1876) and the creation of residential schools (1892) were deliberate attempts by the Government of Canada to wipe out all traces of Aboriginal cultures including languages, beliefs, customs, and spiritual traditions. The actions carried out under these polices continue to profoundly affect all Inuit, Metis, and First Nation people." Chansonneuve (2007) goes on to state that "The roots of addictive behaviours are found in the impacts of this mass psychological trauma and these human rights violations. Unexpressed and unhealed, these impacts have manifested in social disorders. Cultures that had never before seen youth suicide, addictive behaviours, substance abuse, or physical and sexual abuse began a spiral into tragedy."

Clearly, substance abuse has been used as a coping mechanism for the growing loss of identity and culture. A higher degree of cultural connection at both an individual and community level has been found to reduce the risk for substance abuse and suicide. Many of the current factors associated with substance dependence focus around ongoing inequities in "the determinants of health"[14]. Despite improvements, there continue to remain clear differences between the First Nations and Inuit and non-

Aboriginal population in educational attainment, income and employment opportunities.

> **ACTION/TRAINING: Mandatory training of all addictions workers on the methods of the colonial process and the consequences and impacts on First Nations and Inuit.**

Health impacts on First Nations and Inuit in Atlantic Canada

The health and wellbeing of the First Nations and Inuit of Atlantic Canada are impacted upon by tremendous inequalities in social conditions. Assessing the health of Inuit and First Nations in Atlantic Canada is not an easy task as there is a lack of comprehensive and comparable information and data. We have found two studies (one focusing on Mi'kmaq of Nova Scotia region; one focusing on Inuit of Labrador region) that provide a picture of the health status of Inuit and First Nations, however it is incomplete.

Links between health and structural inequality

Critical housing shortages, high rates of unemployment and low levels of educational attainment (NAHO, May 2, 2007), are making First Nations and Inuit more vulnerable to substance misuse and addictions. The Health of the Nova Scotia Mi'kmaw Population Report (AAHRP 2007) found that almost two-thirds of personal incomes are less than $20,000 per year, while half of all household incomes are less than $30,000 per year. More than a third of all homes reported the need for major repairs and more than half report that there has been mold or mildew in the home in the past year. The report states that these conditions help to explain certain health conditions and health behaviours.

According to NAHO (2008), 53 per cent of Inuit live in overcrowded housing; 33 per cent of Inuit households are in need of core housing, almost double the Canadian rate of 18 per cent; five out of six Inuit households were classified as food insecure; the unemployment rate among Inuit is more than three times the Canadian average (Inuit males is 50% and Inuit females is 21%); and environmental concerns, such as contaminants and climate change, are having a disproportionately high impact on Inuit.

On most indicators where there is health data available for Inuit, Inuit fare far worse than not only their non-Aboriginal Canadian counterparts, but their First Nations and Métis counterparts as well.

At the same time, these socio-economic issues drive and restrain the efforts of those attempting to address the needs of those struggling for healthier lives within the Atlantic Region. For example, *The Health of the Nova Scotia Mi'kmaw Population Report* (2007) asked about the degree of progress that has been made on various issues affecting life in the community. Respondents felt that progress had been made on education and training opportunities, control over health, water and sewage facilities, housing, and increasing cultural awareness in schools. However, many also reported that there had been no progress in dealing with alcohol and drug problems. Many also thought that little progress had been made in the areas of police services, recreation and leisure, and some cultural issues (such as traditional healing, the renewal of First Nations spirituality, and establishing a renewed relationship with the land).

This section of the report will specifically address the structural impacts on populations served within the region, including the forms of addictions chosen to cope with the ongoing impacts of colonization on the First Nations and Inuit of these territories.

> **ACTION: As the current health and addictions patterns of First Nations and Inuit are impacted by poverty, housing, employment, and educational attainment these conditions must change in order for levels of addictions to change.**

ANNA LINKS TO STRUCTURAL ISSUES

Participants in the ANNA processes, frequently raised the historical and structural context through naming many interlocked political and social processes, including: Colonialism, Indian Residential School, Indian Act, Health Canada, Band Cards, Poverty, Reserve System, Relocation, and has resulted in social and physical isolation for individuals and communities. The literature identifies and the participants in this needs assessment confirmed that addictions are linked to: Residential school trauma and HTT (Historic Trauma Transmission); Cultural loss; Relocation and Geographic isolation;

Poverty and homelessness; Family well-being; Community conditions; Poor Health of Women; Violence; Corrections.

Residential School Trauma

Approximately 130 residential schools were in operation between 167 year period of 1831 and 1998 with thousands of Aboriginal children, five-generations institutionalized and subjected to "continual, relentless denigration in order to assimilate them into mainstream culture" (Chansonneuve 2007). Reports of abuse described by residential school Survivors include psychological, emotional, physical and sexual abuse. Residential school/boarding school trauma has had a negative impact on individual, family, and community well-being for every First Nations and Inuit community in the Atlantic Region. Impacts result both for the generations who were forced into residential schooling and the later generations who suffered historical trauma transmission (HTT). Participants in our needs assessment reiterated that addictions programs and services should be mindful of the need for intergenerational healing and supports.

Cultural Loss

Clearly, if we accept the notion put forward in the previous section, that First Nations and Inuit culture is healthy, then we also accept that cultural loss is unhealthy. Participants linked addictions and cultural loss. For some it is the fear of continuous loss of culture through people turning to drugs and alcohol and away from traditional life. As one Labrador participant stated, "Culture has to be part of the creation of self".

For others it was a felt reality, cultural loss had occurred through residential schooling, removal from their family or community, or through enforced Christianity. As a participant shared,

> "I recall a story that my husband told me. He was at camp and there were three brothers who were very upset because they could not set up their tent. And I was saddened by it because it struck me as being two connected issues: the loss of culture and that I had taken it for granted that Innu would be able to set up a tent".

Relocation and geographic isolation

Relocation is a main issue and still very current for the Innu and Inuit. Particular issues were identified that were specific to the area due to historical and recent patterns of relocation. In 1999 Davis Inlet (now Natuashish) became a worldwide symbol of the plight of aboriginal people when Survival International, a London-based human-rights group, issued a report comparing the decimation of Labrador's Innu to the systematic oppression of the Tibetans by China. According to the organization, Ottawa had issued the Innu a death sentence by forcing them to abandon their nomadic lives for permanent settlements where their traditional culture disappeared and a cycle of alcoholism, abuse and neglect began. [15]

The relocation of the Innu has been linked to record high rates of suicide. A McLeans report in 2000, concluded that the Innu of Davis Inlet (now Natuashish), had the highest annual suicide rate in the world: 178 per 100,000 people. The depth of the problem was driven home when Innu leader Jean-Pierre Ashini, who had flown from Sheshatshiu to London to take part in the media conference marking the release of the report, received word that his 15-year-old son, Andrew Rich, had swallowed a vial of pills and then killed himself with a gunshot to the head.[16] "Understanding the causes of suicide in the Eastern Arctic isn't rocket science" says Dr. Frank Tester "Culture is sacred and it gives meaning to life. It contributes to physical, mental and spiritual well-being. When you alter that, it affects people, especially young people who are dislocated from previous generations of their family and cultural life" [17]

ANNA participants called for more recognition of the impact of relocation, boarding schools, and intergenerational trauma on addictions and mental health. Seventy-seven percent of workers identified links to colonial history, including relocation, as a priority concern. Colonial impacts of relocation are combined with current realities of First Nations and Inuit communities who experience geographic isolation, including: few if any services and programs for remote communities; inadequacies in provision of care (e.g. assessment, treatment, follow-up, charting); and lack of professional services, including doctors and mental health practitioners.

Poverty, homelessness, poor housing

ANNA participants identified poverty and homelessness as significant challenges facing their communities. In terms of recovery, they pointed out that housing shortages make leaving your community for recovery difficult. As one participant stated, "My son went to Detox and when he got out he was homeless". In some communities, there is a desperate need for affordable housing for everyone including transitional shelters for single men. For some, health and addictions issues create systemic barriers to accessing the shelters that do exist in urban locations.

Inuit communities are hard hit by the lack of housing, with "overcrowded and unsuitable facilities", impacting on peoples' recovery and well-being. As one participant in Labrador stated, "There is nothing on the coast, if they do get out to (the psychiatric hospital), they get back after a short period of time and no one knows what was done. They say they need to be in a safe house but the family is still drinking, there are thirteen people living in the same house. We need to start documenting all these things. It's so serious, and difficult for the staff in the communities, because people are not getting the help they need and others are at risk."

Family wellbeing

As we heard over and over in community meetings, family well-being impacts the health and well-being of everyone. Where families are struggling with addictions, youths face various stressors that have been found to be linked with hospitalization for attempted suicides. For ANNA participants, the topic of family well-being raised the connected issues of child protection, support for children remaining in the home while parents are away to heal, and parental fears of losing their children when they go into a healing facility. To address this difficult issue, participants suggested a more holistic approach that would include child and parent well-being through the provision of family healing programs, and traditional parenting programs.

Community conditions are interrelated with addictions

As the AFN (2006) has documented: "Poverty and social exclusion increase the risks of divorce and separation, disability, illness, addiction and social isolation." ANNA

participants pointed out that addictions and recovery are not simple linear processes. The same factors both contribute to addictions and result from addictions, including: losing one's children; loss of jobs; mental health issues; loss of self esteem; isolation from family; conflict; loss of social status; lack of education; dropping out of school; and lack of exercise.

Eskasoni community members identified a number of urgent, interconnected social issues underlying addictive behaviours: "We have a complicated web of issues we are struggling with—alcohol and drugs, gambling, sexual abuse, family violence and the full spectrum of residential-school survivor issues related to parenting, emotional withdrawal and slow, burning rage" (Lane et al., 2002:36 in Aboriginal Healing Foundation, 2006).

When there is no meaningful means to livelihood, to be able to support oneself and family, no possibilities for a quality of life, hopelessness sets in, which can sustain addictions problems. "Alcohol and drug use is both a response to social breakdown and an important factor in worsening the resulting inequalities in health. People tend to turn to alcohol to numb the pain of harsh economic and social conditions" (AFN 2006).

This report cannot directly address the chronic socioeconomic disparities faced by First Nations and Inuit across the Atlantic region in terms of poverty, unemployment, overcrowding and inadequate housing.

> **ACTION: Much more work will be necessary, both to identify the extent to which lack of basic needs may impact on First Nation health, addictions, suicidal behaviours, and to commit resources to dealing with these issues.** [18]

A Gender Based Analysis [19]

According to NWAC (2007), First Nations and Inuit women are at higher risk for alcohol and substance abuse, mental illness, suicide, diabetes (including gestational diabetes), cervical cancer, as well as more frequently experience poverty, alarmingly high rates of spousal, sexual and other violence, inability to access safe, secure, affordable, non-discriminatory housing for themselves and their families (on- and off-reserve, in rural, remote and urban settings), and barriers and lack of access to higher

education, job training, employment, entrepreneurial loans and investments, and related socioeconomic opportunities.

First Nations and Inuit women are affected differently by structural inequities and therefore by policy and program decisions. Social issues are interactive, they reinforce one another – and shape Indigenous peoples experiences of violence.

> **ACTION/RESEARCH/TRAINING: There is a critical need to take gender into account when analyzing historical and current struggles with addictions and in developing solutions.**

VIOLENCE WITHIN AND AGAINST FIRST NATIONS AND INUIT

Violence against First Nations and Inuit women

First Nations and Inuit women continue to report higher rates of male violence. In 2004, First Nations and Inuit women were more likely than non-First Nations and Inuit women to report the most severe and potentially life-threatening forms of violence, including being beaten or choked, having had a gun or knife used against them, being sexually assaulted (54% of First Nations and Inuit women compared with 37% of non-Aboriginal women), or being murdered or missing. Spousal violence is also severe. First Nations and Inuit women have suffered physical injury, received medical attention, taken time off daily activities as a consequence of the assaults, experienced 10 or more separate episodes of violence from the same perpetrator, feared their lives are in danger, and been murdered by their partners (Stats Canada 2006). These statistics are a result of a combination of gender, cultural and racial discrimination by non-Aboriginal and Aboriginal men, and need to be understood in the overall colonial context of poverty and abuse of both men and women.

Violence against women was raised by participants in terms of sexism or lack of respect for women, the prevalence of violence against girls and women (e.g., sexual assaults, family violence), and the relationship between the violence and addictions. ANNA Participants connected these current perceptions of women, and violence against women, to colonialism and cultural influences. One participant stated, “Where did the

violence start? It really started in 1492 – the violence and the alcohol. Abuse wasn't something that existed it is prevalent now. Abuse is often related to drugs and alcohol."

ANNA participants reported sexual assault is underlying 85% of addictions problems. "Addictions is like a blanket covering over, hiding, a big pile of crap. And that crap is sexual assault". One participant told this story: "We have no program for dealing with sexual assaults. Victims won't go to programs in (the city). Medical services does not transport for these programs, only for medical or dental care. One young lady was sexually assaulted on weekend. She came to talk to (a counsellor). That's a step forward. It was drug and alcohol related. She doesn't want a referral. There will be no charges. We offered referrals but she won't go. She is on methadone and she used because of the assault".

> **ACTION/TRAINING: Given that sexual abuse is often related to drugs and alcohol, both when sexual assault occurs, and as an underlying factor for people who abuse substances, and given that there is currently no Aboriginal-specific program for dealing with sexual assaults, an Aboriginal-specific community-based service be developed and delivered regarding sexual assault, including the training of all addictions workers and in links between colonization, sexual assault, and substance abuse and all sexual assault center workers in cultural safety.**

Violence against self: Adolescents, Addictions and Suicide

Suicide among adolescents was one of the biggest issues raised by ANNA participants. While there is a serious lack of data on Aboriginal suicide issues within the Canadian population, "Over the last 20 years, rates of suicide among Aboriginal people in North America have been consistently higher than the average of the general population and higher still among Aboriginal people in Canada" (Aboriginal Healing Foundation 2008). According to NAHO (2008), for the period of 1999 – 2000 Inuit suicidal rates were more than 11 times higher than the overall Canadian rate. Sixty-two Labrador Inuit committed suicide in the past 13 years (2006). There were a total of nine suicides for the period of 2006 & 2007. The Health of the Nova Scotia Mi'kmaw Population Report (AAHRP 2007) found that among youth, 31 per cent of females and

16 per cent of males reported having thought about suicide. Actual attempts were reported at 11 per cent for females and 5 per cent of males. Almost a quarter of male youth indicated that in the past 12 months, a close friend or family member had committed suicide. In the ANNA questionnaires, around 65% of community members (26+ years), and 30% youth members (15-25 years) reported having thoughts of suicide and 46% community members and 21% youth reported attempting suicide.

Researchers have typically explored suicide as an individual act, often preceded by depression, loneliness, social isolation, confusion about sexual orientation, and frequently combined with substance abuse. Ninety-four percent workers linked youth suicide with addictions. The consumption of alcohol and other intoxicating substances is often a contributing factor to suicide for several reasons. Alcohol (and other central nervous system depressants) can reduce inhibitions, increase impulsivity, and intensify difficult emotions, like sadness, anger, and anxiety. They may also decrease a person's fear of death and reduce the ability to imagine the consequences of their actions. Taken together with other drugs, alcohol can increase the lethality of the over-the-counter and prescription medications or drugs that are often used as instruments of suicide. On occasion, people who have been drinking without serious suicidal intent may impulsively attempt suicide while intoxicated. The frequency and amount of alcohol consumption is also a factor (Aboriginal Healing Foundation, 2008).

One Resource for Youth is: **Honouring Life Network**: suicide prevention for Aboriginal youth[20], sponsored by NAHO. It targets both Aboriginal youth and suicide prevention workers in First Nations, Inuit and Metis communities. The site was developed by Aboriginal youth, and is available in English, French and Inuktitut. It contains positive strategies and resources, a Youth Corner, and a Youth Worker's Forum where youth workers from across the country can connect to discuss and share suicide prevention resources and strategies. The Web site can be accessed at www.honouringlife.ca.

ACTION: Chandler and Lalonde (2008) research shows that suicide, and in particular youth suicide is a social act, clearly related to socio-economic and cultural conditions in communities. As those communities with more progress in reclaiming cultural and political autonomy have less youth suicide, supports and resources towards communities in their work to reclaim cultural and political autonomy are required to resolve this problem, in addition to more resources towards addressing the specific programming needs of youth immediately affected.

Violence turned outward: Corrections

Nationally, Aboriginal people make up about 3 per cent of the overall population, but they make up about 17 per cent of the total prison population. In Newfoundland and New Brunswick, incarceration rates of Aboriginal people are four to six times the provincial average. Over 60% of inmates at the Labrador Correctional Centre are Inuit (NAHO 2008). There is a drastic overrepresentation of Aboriginal people within both the Canadian criminal population and the criminal justice system and Aboriginal people are "more adversely affected by incarceration" because of culturally inappropriate systems and rampant discrimination.[21]

The RCMP in Nain (Labrador) estimate that over 90% of offenses and arrests are alcohol-related (NAHO 2008). ANNA participants identified links between abuse, addictions and legal problems. As one participant stated, "looking at their history it was the addictions that contributed to their crimes. A lot of the people with addictions have sexual abuse, violence, and residential school issues" (Millbrook). The need for a holistic approach to dealing with offenders was stressed: "The way it works currently is that we just deal with the crime, not the addictions. Customary law deals with the whole person". This participant recommended an Addictions Court to meet the needs of the Aboriginal community.

Some ANNA participants shared shocking stories of locking vulnerable youth (on substances) into jail cells. "This cannot make the situation better, but may do more damage." One participant shared this story: "Allowing a child to be locked in a place

with convicted….a drunk tank is a human rights issue. I went in. I was asking for help, there was vomit on the floor, hair on the floor from the person the night before".

In the RAPC Reprofiling Workplan (2005), one priority identified was financing/programming for Clients within the Justice System: "Develop referral and funding protocol framework for the treatment of clients within the judicial system." (28)

> **ACTION/TRAINING: Given the link between addictions, corrections, and colonization, a greater collaboration between addictions and justice workers to develop a more seamless healing program based on an understanding of historical and structural impacts, and the Aboriginal principles of restorative justice be initiated. This could include cross-training opportunities to network and build stronger interrelationships.**

CHAPTER SIX: SPECIFIC ADDICTION AND SUBSTANCE ABUSE CHALLENGES

Multiple addictions

As the AFN (2006) policy paper illustrated, First Nations and Inuit are turning to addictions to soften the blow of the harsh social and economic realities of their daily lives. This has been shown to be true from the simplest to the most complex substance. For example, it is true of tobacco. "Social deprivation – whether measured by poor housing, low income, lone parenthood, unemployment or homelessness – is associated with high rates of smoking and very low rates of quitting"

First Nations and Inuit were and are caught in a complex web of conditions produced through colonial intervention, learned to cope and then became addicted to substances introduced as part of the colonial process (alcohol and illegal drugs), and developed addictions to all substances and even some processes, including gambling, shopping, coffee, sex and food. Most recently, First Nations and Inuit are increasingly challenged to face the multiple addictions resulting from the substances provided by the medical system, given by doctors to heal from pain, grief and traumas.

When participants in the ANNA processes were asked to identify the specific addiction and substance abuse problems that they believed were important to their community, the top priority addiction and substance abuse issues identified were:

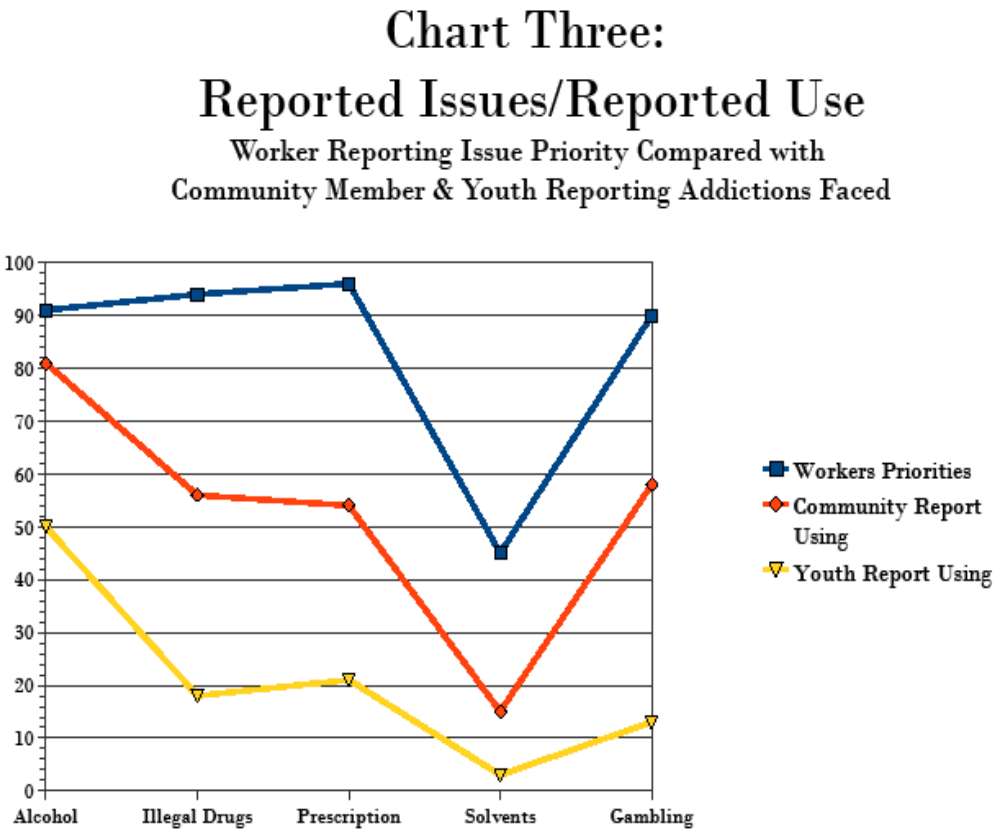
- ⊕ Alcohol misuse/abuse, and in particular in combination with other substances, was the highest addiction and substance abuse problem identified by participants overall (91% of workers mentioned alcohol as a priority, 81% of community members, and 50% of youth reported using alcohol). However it was frequently noted in meetings and interviews that nowadays, alcohol is rarely used in isolation of other substances (Moncton Gathering, Mi'kmaw Healing Lodge, Kingsclear, Rising Sun).

- ⊕ Drugs (whether prescription or illegal) were identified as the second highest priority identified by participants--96% of workers named prescription drugs, 54% of community members and 21% Youth reporting using prescription drugs. Ninety-four percent of workers reported illegal drugs as a priority and 56% of community members and 18% of Youth report using illegal drugs.

See CHART THREE: COMBINED WORKER PRIORITIES/REPORTED USE, page 68 for a combined Worker, Community and Youth report on addictions and substance use. It is clear that the worker stated priorities are aligned with the expressed use patterns of both community members and youth.

As CHART FOUR: PRIORITIES FOR WORKERS, page 70, shows, over 90% of workers identified as the issues of multiple addictions as an important priority, including multiple substance addictions and substance addictions plus other problems such as gambling addictions, along with concurrent mental health issues. Workers are aware of the compounding effects all addictions play with the community atmosphere. As a worker in Nova Scotia

stated when discussing lateral violence, "Add poverty, crowed housing, gambling, smoking,…"



ALCOHOL

As CHART THREE illustrates, alcohol addiction is a high priority for communities; more than 90% of workers considered it a priority. According to the AFN report (2007) on the RHS there are higher rates of abstinence and a lower frequency of alcohol use in First Nations and Inuit populations. They link these differences to a rediscovery of traditional cultural attitudes and values towards alcohol and other substances, as those not consuming alcohol were more likely to have seen a traditional healer over the past year

than those consuming alcohol. There is a need to explore the role of culture as a preventative tool.

Among the Inuit, eighty-one percent (81%) of people report alcohol/drug abuse as an issue in their community, and 33% of people reported they or a family member had a drinking problem (Nunatsiavut Government, 2007). The AAHRP Health Study of Nova Scotia Mi'kmaw found that in terms of the consumption of alcoholic beverages in the previous 12 months – 65 per cent for males and 59 per cent for females; the percentage of binge drinking was found very high. As historical factors may still contribute in part to the pattern of binge drinking seen today, historical and cultural awareness campaigns could also be used in prevention.

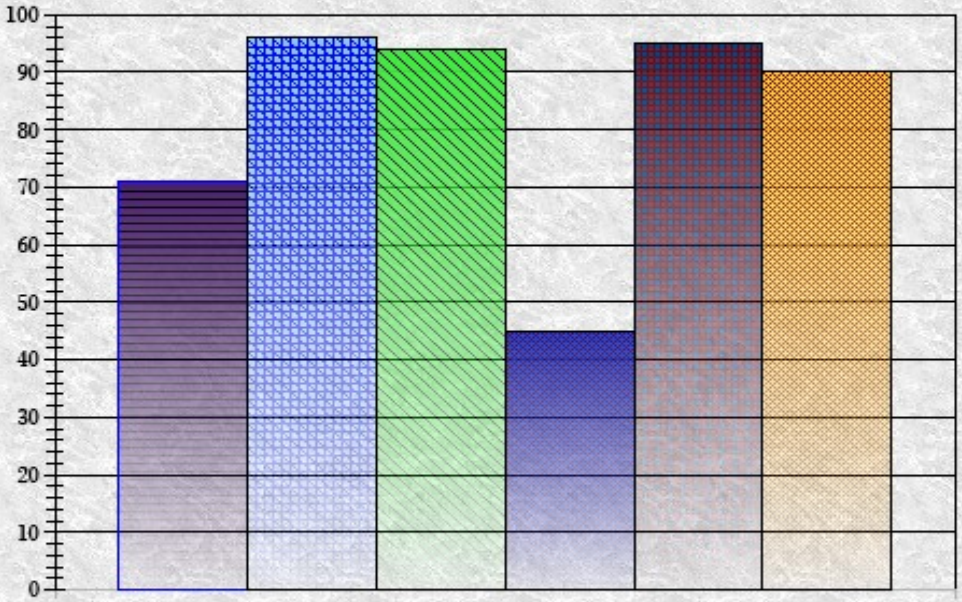
> **ACTION: Prevention material regarding the link between substance use, binge drinking, historical factors and the role of culture as a recovery tool be explored.**

Workers are facing a new pattern of consumption, that of mixing a "cocktail" of alcohol and various other prescription and illegal drugs. The effects of these toxic cocktails on people's attitudes and behaviours are increasingly difficult to predict, presenting challenges to detox, and leading to unintended deaths, particularly in the younger population. Youth participants in ANNA indicated that they found it challenging and frightening that drugs and alcohol are so easily accessible in their communities (Eskasoni, Eel Ground). As one youth participant said: "There really isn't help on the rez." Another said: "It's hard living in [my community]." Some called for an increase in police protection:

> **ACTION/TRAINING: Information and training for workers, Detox staff, community members, and youth, on the effects and potential behaviours from the effects of mixing alcohol and various other prescription and illegal drugs.**

Another key alcohol related issue First Nations and Inuit communities are now facing is the prevalence of intergenerational FASD. Prevention programs are in place in some communities to inform people of the risks of alcohol consumption while pregnant, and some services are provided in school to detect and support children diagnosed with

Chart Four: Addictions



Percent of workers who view as priorities

***Methadone is a combination of 3 Priority values;**
Methadone & long term side effects, Methadone & the NNADAP client, and Methadone & pregnancy.

FASD. Approximately 240 Inuit children were identified as at risk for FASD and 66 have been diagnosed (NAHO 2008). A large gap is now being created in services to young adults who have FASD and are now of drinking/child bearing age. They remain a population at risk with no real mandate in place to designate who is in charge of providing the array of necessary services.

ACTION: Enhanced community services for FASD remain a necessity, including services for FASD young adults who are now of drinking/child bearing age.

Because alcohol has been known as a challenging substance for First Nations and Inuit communities for a few generations some communities have taken action toward the establishment of "dry communities". However, as some participants pointed out "bans" on alcohol purchase may simply drive people out of their communities in order to consume (Natuashish/Kingsclear). We may be able to learn from these earlier experiences with control of alcohol as a substance, as leadership today is faced with the new drugs of choice, and are trying to ban the dealers of them from their communities (Elsipogtog/Eskasoni). The more publicized prevention efforts in First Nations communities have utilized prohibition, but these are dependent on enforcement policies and infrastructure. Prohibition efforts need to be incorporated into broader community prevention strategies. As one youth said: "We need undercover cops so they can bust the drug dealers."

ACTION: Prohibition efforts need to be incorporated into broader community prevention strategies.

DRUG ABUSE/MISUSE: Prescription Drugs

In the conclusions of the Nova Scotia First Nations *Exploring Health Priorities* Report (2008), addictions and substance abuse were referred to in three priorities, one of the three was prescription drug abuse: "The Tripartite Forum and its partners should continue to address the issue of prescription drug abuse in First Nation communities in Nova Scotia".

Abuse of non-prescribed drugs is identified to some extent by the *Mi'kmaq Health Survey* (AAHRP 2007). About 41 per cent of the adult population took mood altering drugs at least once in the previous 12 months, without a prescription. However, further research and training is required as many prescribed drugs are made available through drug trafficking and thus are

not necessarily prescribed to abuser (RAPC 2004). Information on prescription drug abuse was identified nationally as a gap in programming and research (NNAPF 2003).

> **ACTION/RESEARCH/TRAINING: The prescription drug issue becomes especially complex with those dealing with mental health issues, and requires an immediate strategy for both prevention and treatment.**

The ease of availability, the widespread misuse and the combining of prescription drugs with other substances, was a frequently discussed concern amongst participants in the ANNA processes. It is an overwhelming issue for the region in general and more so for certain communities. The OxyContin task force in Atlantic Canada found that a growing number of young people were abusing OxyContin. In a six-month period, about 50 of these young people were admitted to an outpatient mental health counselling service in St. John's, NL. (CCSA 2005). In an article in the community newspaper, York, the RCMP officer, said "oxycontin abuse is the biggest problem afflicting Elsipogtog, where 90 per cent of crime is connected to drugs." [22]

The frustration is expressed in the following statement: "FNIHB pays for all these drugs; they should put a stop to it. It was a big issue 10 years ago, but now it is under the rug. They will pay for all these addictive drugs but will not pay for what people need."

ANNA participants at the Moncton Gathering reported that addiction service workers and communities need information/data on drug use, misuse, and abuse, as well as information on drug prescribing trends in order to target appropriate interventions for First Nations (e.g., programs for youth and Elders). For many communities, there is a basic need to better understand the health risks of anxiety and depression reducing drugs, as well as drug-related harm reduction strategies for First Nations and Inuit. At the Health Conference session on prescription drugs in Moncton, facts on these drugs were relayed by professionals from Health Canada without demonstrating adequate research into the impacts specifically on First Nations and Inuit. Additionally, emphasis was placed on First Nations and Inuit individuals building a good relationship with their physician to be empowered to discuss drugs as an appropriate course of action for treatment in their particular case. Given the lack of access to physicians in Newfoundland and Labrador, and the current and chronic issues of authority and control

invested in "white experts", individual attempts to negotiate a healthier solution with their care providers is an unlikely solution to a wide scale problem.

While we were able to do standard internet research on the various drugs mentioned and found some useful websites, [23] we were unable to gain access to the statistics compiled on prescription drug use by Health Canada for the First Nations and Inuit communities in Atlantic Canada. We understand that some statistics are made available to First Nations and Inuit communities, and that we could have gained access through releases by each of the communities. Due to time constraints, we were unable to facilitate this process, but understand that meaningful and understandable materials on use patterns remains a critical issue of concern. Elsipogtog, through DUPPWG (Drug Utilization Prevention and Promotion Working Group), has gained access to these statistics, and have publicized them in the community based newspapers as a tool of prevention, and are also working with prescribers, pharmacists and clients to reduce use and misuse.

Some NNADAP locations, like the Rising Sun and Eagles' Nest Recovery House saw the rise in prescription drug use and during the Fall of 1996, decided to launch a program to work on prescription drug misuse. Mindfulness was introduced as a key component of the program, and due to its success in treating substance abuse, it remains part of the program at Rising Sun. A summary of the work accomplished, including more details on the Mindfulness Program, is included in Appendix X: Rising Sun/Eagle's Nest Treatment Center Prescription Drug Use Program . Unfortunately, while this program was successful, it was not funded on an ongoing basis.

Now, more than ever, First Nations and Inuit Treatment Centers need resources (e.g., Aboriginal-specific research, accessible and understandable materials, detoxification programs and programs for treatment centres to properly respond to prescription drug abuse issue. Many participants expressed a need to tighten controls on doctors' prescribing behaviours with First Nations. Several communities have instituted programs to restrict double doctoring, and to intervene with physicians serving their communities. Some successes have been seen in Eskasoni, Elsipogotog, Newfoundland, and PEI with these collaborations. Unfortunately controlling access is not restricting demand, as some communities report 30+ dealers, most of

prescription drugs, obtained from either larger centers outside of the Maritimes or off the internet.

> **ACTION: Information on the work of DUPPWG in Elsipogtog, and program developed by Rising Sun/Eagle's Nest be shared with other First Nations and Inuit as examples of innovative strategies to work on prescription drug abuse.**
>
> **ACTION: A collaborative infrastructure between FNIH, doctors, pharmacists, RCMP and Band Councils to lesson double doctoring, combined with public information on the dangers and warning signs of frequently misused drugs, as well as innovative healing strategies will be necessary to address this issue.**

At the Moncton Gathering and at our Advisory meetings, specific concerns were addressed with respect to prescription misuse in relation to Elders. Language barriers and inability of health professionals to provide culturally safe healing environments lead to confusion about prescribed medications, interactions, side effects, and expiry dates. Another significant issue is the safety issues of Elders, and the risk of having medications stolen. With the new security measures on certain prescription, some Elders are having to suffer with their pain as they are unable to get their meds replaced if misplaced or stolen.

> **ACTION/TRAINING: Culturally safe methods of engagement with Older First Nations and Inuit be taught to doctors and pharmacists, and advocates/translators provided, to ensure clarity and safety of prescription drug use, along with a re-examination of policies and practices regarding refilling lost or stolen prescriptions**.

Methadone

The most frequently mentioned and most controversial prescription drug is Methadone. Methadone is currently being promoted as part of a harm reduction approach to opiate-type drugs. In New Brunswick, Circle Works visited the Oromocto Methadone program, delivered by provincial Health Services, and located in the Oromocto First Nation. Since 2006 they have been providing on site assessment and dispensing methadone to people locally and to other First Nations in the area. There are no waiting lists. Staff administering the program state that "users are so busy surviving that counselling is not a high priority. They come in for help when they are in crisis". The Methadone Program is considered a success by the Oromocto Health Centre: "The theory of harm reduction is that things get better for the community and the

individual when they are on methadone. They are getting up in the morning, caring for the kids, etc. They are building resources. Now people are going back to school and they have jobs, parents are getting their kids back, they are back in the system getting health care, getting their teeth fixed, putting weight on and able to parent. When someone is doing opiates the opiates attach to a specific set of receptors in the brain. When they go on methadone, it overrides the street drugs and attaches to those receptors. Methadone replaces street drugs – eventually. They can be on it for a lifetime, even 30 years".

In Nova Scotia, Direction 180 (Halifax) is delivered through Mi'kmaq Native Friendship Centre. It provides methadone to reduce the dangers associated with injection drug use (IDU). Counseling, primary health care, and referral to other community-based services are also offered. Circle Works did not visit Direction 180. [24]

Some of ANNA community participants spoke of the advantages of the methadone program: "At the beginning I used it as a withdrawal program, now it is a maintenance program. Methadone gave me the strength to be the person I am today. As I got stronger, the dose of methadone lessened. As a harm reduction strategy….if people are not injecting that is one harm reduction… So maybe someone on the street is now living in a place. Parts of their life have improved."

It is clear that those involved in these programs, see the positive benefits of Methadone. The inability of some to adhere to an abstinence program, and the high risk of life threatening diseases associated with the opiate drug practices are a main reason to support. Some spoke of seeing lives changed in a positive way as a result of the Methadone program. Other participants spoke about the need for a more comprehensive community program around the use of methadone (methadone prescription, counselling, follow-up). Some spoke about the supports needed and received in order to gradually reduce their dependence on methadone. In general those who supported the Methadone programs agreed that there is a lack of supports for reducing dependence on methadone – as one participant stated, "detox programs are needed (for Methadone) in this area" (Rising Sun).

For most ANNA participants, the cultural appropriateness of Methadone as a form of harm reduction has not been validated amongst the First Nations population. Honouring abstinence

in seen in some communities as the only strategy that has worked. Substitution of one drug for another, creates an immediate conflict between the medical use of a substance, and a traditional drug-free way of life. Eighty-four percent of workers in the ANNA questionnaire responded that exploring other harm reduction strategies was a priority.

Methadone is not widely accepted by the NNADAP/NADACA workers in the communities who are generally opposed to giving a drug to treat drug addiction. CHART FIVE: METHADONE (page 78) shows the concern community workers have for issues surrounding methadone use with clients. It also shows the kinds of healing options that are being offered to clients, with methadone being the least frequent option offered. Keep in mind, the community members that completed the survey are most likely people that have gained some success in their recovery programs.

During the ANNA process, participants discussed the idea of mixing abstinence-based treatment centers and harm reduction models – "the fear is a diluted program and nothing working well." Question 70 asked workers to identify policies and procedures discouraging a treatment path, and lack of facilities to deal with people on methadone maintenance programs was written in several times.

Methadone prescription instead of becoming a solution to drug problems can become a drug problem, particularly with youth "still chasing drugs": "Some are on methadone, my son won't take methadone. He sees his friends that are on it, the first thing in the morning they are rushing to the drug store to get their drugs and they are high. It is the same as chasing the next drug, but they are taking it legally. You are getting your next fix but you don't have to scheme as much for it. But the need is just as bad in the morning as any other drug" (Millbrook).

Some ANNA participants describe methadone as being used as a "quick fix" – in combination with alcohol and other drugs (Tobique). One Elder shared strong words: "methadone is a drug, whether or not articulated to a harm reduction framework, it is still causing harm of individuals, families, and communities".

The fear of not being able to reduce dependency on the drug is a critical issue. Some participants reported difficulties in reducing the amount of methadone and needing extra support: "My max dose was 140 and this was a little too high. I stayed here for 6-8 months.

Then I came down to 110 and stayed there stabilizing. On the third year I came down to 90. It was a slow process to come off. My goal was five years. When I got down to a dosage of 13 I was starting to hurt real bad. I called the doctor and he increased the dosage. It took me five years and eight months to come off."

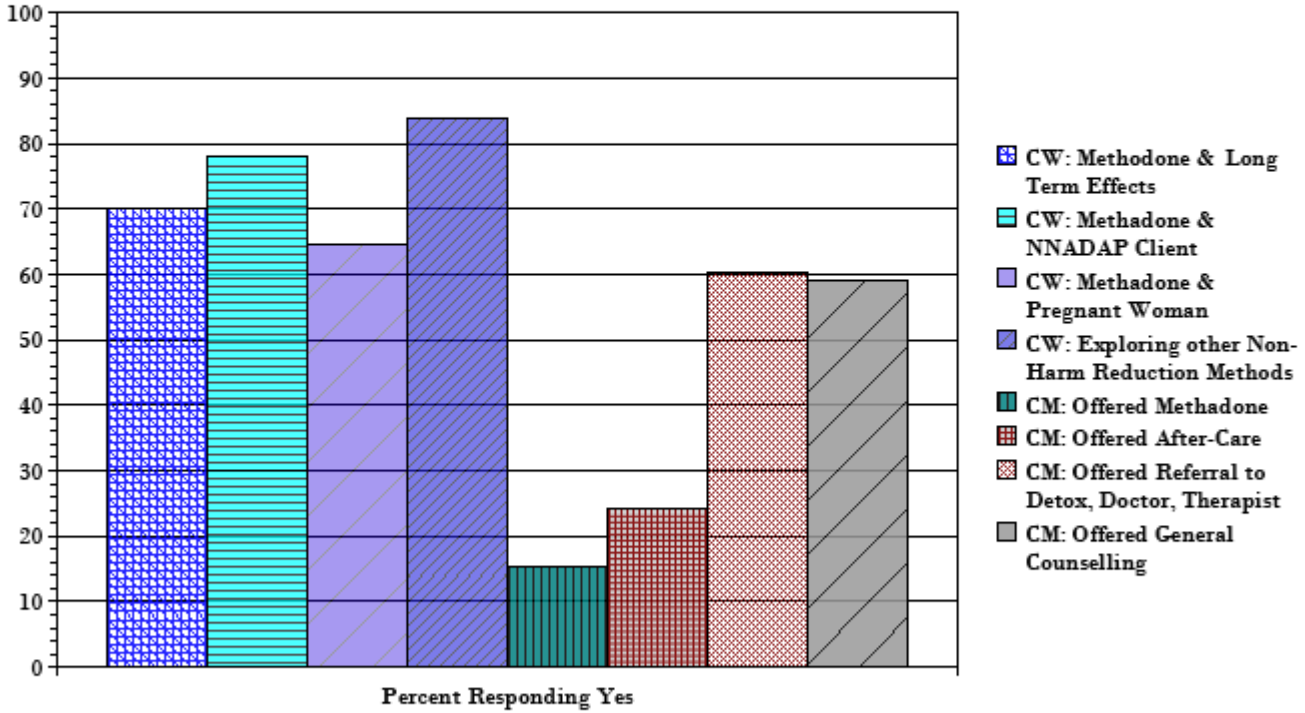
Methadone effects on maternal health, on infants, and on parenting more generally were an often voiced concern and a primary topic at the Moncton Gathering. There is a lack of information on the long term effects of Methadone and a deep concern of the effects of Methadone on both the mothers and the unborn, the next generation: "We want to know what are the risks of methadone use during pregnancy". "We also want know the risk of morphine use on children and on later addictions." In a couple of communities we were asked: "We have FASD now; will there be foetal methadone disorder in future?" As one Elder commented: "The kind of effect it will have on people has not been studied enough. Look at some of the kids. I don't know if it's methadone or what but they have problems. It's almost like an experimental thing."

The high rate of methadone prescriptions in First Nations is alarming to some, as is the amount of dollars of money designated to First Nations and Inuit health being diverted to methadone and transportation to methadone programs. "We have clients on methadone but they have to go a long way to get it. We are not ready for methadone. Don't agree with methadone – replacing one drug with another. Third parties are getting rich off us" (Tobique). For many, a huge problem is that little is known about the risks of methadone use and the effectiveness of methadone in solving the issues of drug abuse. According to a report of the Canadian Centre for Substance Abuse, at present, there is little evidence about the benefits and risks of harm reduction policies and programs as a whole.

> **ACTION/RESEARCH/TRAINING: Communities want to know the long term risks of methadone, and risks regarding use during pregnancy, and there is a need for Aboriginal-specific information, training, services and supports regarding reduction of dependence on Methadone. A knowledge translation process regarding methadone risks be undertaken, and shared publically. Training on risks and reduction of dependence be provided to addictions and health workers who are currently being asked to provide services for people on Methadone.**

Chart Five: Methadone

Community Worker (CW) Priority Issues Compared with Community Member (CM) Offered Treatment Options



ACTION: The cultural appropriateness of Methadone as a form of harm reduction has not been validated amongst the First Nations population. Given the historic link between substances and colonial oppression; honouring abstinence is seen in many communities as the only strategy that has worked. Other non-drug related forms of harm reduction need more exploration. A plan needs to be negotiated with existing addictions service providers and health workers to create infrastructure to provide supports to methadone clients without diluting abstinence based wellness programs.

Illegal Drugs

Illegal drugs were identified by participants as the most concerning issue in some communities in Nova Scotia (Millbrook and Indianbrook) and New Brunswick (Eel Ground, Elsipogtog, Tobique, St. Mary's). Designer drugs, GHB (date rape drugs), Ecstasy, cocaine, crack, and crystal meth were named. Crystalline methamphetamine or Crystal Meth is considered the biggest problem for youth for some communities in New Brunswick (Elsipogotog). The AFN (2006) expressed their concern with the emergence of crystal meth. "The impact that such a drug has goes beyond the individual to include the community at large."

Addictions and substance abuse problems have changed; community participants asked for information and education about the substances that are available in their communities – what they are and their availability. As a participant from Newfoundland stated, "In 1986 it was alcohol and marijuana. Now we have everything. Crack/cocaine right here. You can go on the Internet and find out how to make illegal substances. Things have changed!" Knowledge about the changes being faced in communities as a result of changes in addictions and addictive substances was identified as a gap in service by several participants.

Action: A method of obtaining current information and education about the addictive substances that are available in communities.

Participants discussed the current complexities of addictions and the link to health issues. Some participants called for specific information about the link between opiates, HIV infections, and Hepatitis C (Eel Ground; Oromocto).

Action: Information regarding the link between opiates, HIV infections, and Hepatitis C.

Solvent Abuse

In the Brighter Futures evaluation (2006), solvent abuse was not identified as a significant problem in any of the communities visited, except to the extent that it is one of several substance abuse and addictions issues. This remained mostly true in the Atlantic NNADAP Needs Assessment, however, among Innu who responded to our survey, solvent abuse was identified as being of the highest priority in addictions for workers, youth, and community members.

Solvent abuse prevention and intervention is addressed through specialized solvent abuse prevention program offered by NADACA in Nova Scotia, and the youth treatment program at Charles J. Andrew Youth Treatment Centre located in Sheshatshiu, Labrador. The NADACA program includes education for teachers and students, and activities to promoting healthy lifestyle decisions among young people through "peer-to-peer" programs. Charles J. Andrew Youth Treatment Centre is a program of NNYSA (National Native Youth Solvent Abuse Center). The group is comprised of a network of 10 First Nation Youth Treatment Centres spread throughout Canada. Eight of the centres are solvent abuse specific services while 2 are targeting multi addictions" (YSAC Annual Report 2007). Although reprofiling was discussed as a possibility at the ANNA meeting, Charles J. is currently a solvent specific service. Information is available on the website at: http://www.cjay.org/mission.html.

> **Action: Review of current needs and utilization of Charles J. as a multi-addictions Treatment Center.**

OTHER INTERRELATED ADDICTIONS

Smoking

Research shows that smoking is directly related to alcohol dependence and other addictive behaviour including illicit and prescription drug dependence and problem gambling Tobacco abuse among Aboriginal persons is at alarmingly high rates as compared with the general population. Recent data has approximately 60% of First Nations people smoking as compared to 22% in the general population (National Aboriginal Health Organization - First Nations Centre, 2005). Smoking is responsible for almost one in five adult deaths among First Nations

people. The smoking rate among Aboriginal youth is 2 times higher than non-Aboriginal youths.[25]

To be effective, Aboriginal smoking prevention programs must recognize and acknowledge differences between ceremonial tobacco and commercial tobacco use. "Immediately after taking the puff of smoke, our minds would race, and our whole body would be this smoke since tobacco is a very powerful medicine. It has a specific purpose which must not be abused" says Elder Danny Musqua (WUNSKA, 1997).

ACTION: First Nation smoking prevention programs must recognize and acknowledge differences between ceremonial tobacco and commercial tobacco use.

Gambling and other Addictions

The RAPC noted in their reprofiling priorities that emerging gambling issues is an increasing concern. This was noted in the NNADAP review and covered in detail by the Canadian Public Health Association 2000 Position Paper on *Gambling Expansion in Canada: An Emerging Health Issue* (cited in RAPC 2004). Gambling issues among the Mi'kmaq population in Nova Scotia, the youth in particular, is further supported by a research study summarized in a final report by the Mi'kmaq Health Research Group, *The Health of the Nova Scotia Mi'kmaq Population* (1999).

Gambling was consistently identified as pressing problem. CHART 4: COMBINED WORKER PRIORITIES/REPORTED USE shows gambling as a critical, yet often under serviced issue: 90% of workers express that gambling is a priority, 60% of community members and 13% of youth report gambling. ANNA participants shared how they saw the impacts of gambling on families by the countless hours spent in front of machines and the loss of family income. Some also talked about how entire communities are impacted; everyone is vulnerable, as participants told us, "even the strongest members: the leadership, the addictions counsellors themselves."

We did not initially include any questions on tobacco, marijuana, food, internet, or sex addictions. All of these were mentioned or written in to the questionnaires by either workers or community members, and some became specific questions on the youth questionnaire. Participants were asked what if any other addictions have been faced, they included: (based on

most frequently reported to least):1. marijuana 2. tobacco 3. food addiction 4. Shopping 5. motion sickness pills 6. family members 7. Steroids

During the community visit process, several comments were made regarding the 'socially acceptable' standing of marijuana in communities. As one participant in Labrador said "marijuana use seems to become like it is socially acceptable." At the Maternal Health focus group in Moncton, one participant exclaimed, "How do we de-normalize smoking pot, drinking on the street, taking pills, etc. It is not/should not be seen as NORMAL behaviour!"

ACTION: All addictions are interrelated and should be treated together. This concept has implications for research, training, treatment, and policy changes.

GAPS IN ADDICTIONS SERVICES

As much as colonization has created conditions that produce and sustain addictions, including providing the need for, and the access to, many of the addictive substances and activities, these same processes remain at work in the challenges and gaps faced in delivering services. As one Labrador participant tells it: "Lack of training, barriers and our whole system of doing things is based on a bureaucratic western white system that isn't the best way to work in an Aboriginal community".

In the AFN, Gaps paper (2006a), it was found that generally there was a lack of public health services offered to First Nations and Inuit communities. Specifically, Atlantic participants raised concerns with respect to community services, pointing out a lengthy review of programs that are offered to the provinces but not to First Nations communities. There is reoccurring difficulties in learning how to manage "the system" and where to access the expertise.

Participants in the ANNA processes addressed what they consider are their current needs. It was frequently mentioned that all First Nations and Inuit (including status, non-status, on-reserve, off-reserve) are underserved by the current system, especially obvious are: homeless, at risk of homelessness, women and youth. Smaller and isolated communities are underserved. "Racism within funding structures, and thus in the political will of the federal government toward Aboriginal defined and delivered programs" was cited by participants as a key factor in creating gaps in the process.

Due to a combination of lack of funding and jurisdictional issues, there are no First Nations or Inuit Detox or Family Wellness programs in the Atlantic Region, and the one Youth Treatment facility is geographically isolated and only profiled for solvent abuse. There are long waiting lists for treatment, lack of long-term wellness facilities, limited prevention and aftercare programs. There is a general failure of funders to recognize a holistic perspective that would enable programs to provide services such as transportation to programs and services that are not currently provided for under medical and dental. Resources for family-based and community based activities and for cultural programming are only available through donations of time or short-term grants.

> **ACTION: Review funding structures and decision-making process in terms of defining and delivering programs for youth, women, two-spirited people, residential school survivors and people with mental health issues.**

In general ANNA participants noted the lack of accountability and responsibility on the part of Health Canada to follow through on their promises to invest in culturally appropriate practices delivered by First Nations and Inuit to First Nations and Inuit. "I know when I was working for the First Nation, NNADAP came forward and said they were going to do training. That was two years ago and nothing. So the accountability on the side of Health Canada is poor".

> **ACTION: In general, participants noted the lack of accountability and responsibility on the part of Health Canada to follow through on their promises to invest in culturally appropriate practices delivered by First Nations and Inuit to First Nations and Inuit. Health Canada can move towards the increased funding of much needed services rather than ongoing "evidence-based" needs assessment.[26]**

We will turn in a more detailed manner to these questions, namely the ways in which Health Canada continues to shape and control policies and services, even now that devolution to First Nations and Inuit communities is a process underway.

SECTION THREE: ENGAGING THE WHOLE COMMUNITY IN RECOVERY

> ***"Aboriginal communities are inextricably linked to particular geographical areas, and language and cultural beliefs are unique to these communities. As the invader takes over the lands and replaces the old institutions and languages with its own, many Aboriginal ways will be subsumed within the civic and political life of the invader, and be more likely to disappear. New values are adopted as a survival tool. This is a real issue for…Indigenous peoples, given that our historical nomenclature has all but been destroyed, with geographical regions, including rivers, waters and mountains, being renamed. Important symbols of religion and culture have been removed to museums" (Mansell in Altman and Hinkson 2007: 75).***

"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 behavior, but that its solutions lie in collective action of the communities" (NNADAP Literature Review).

On many occasions in our discussions with directors, workers, youth and community members throughout the ANNA processes, people spoke of the importance of engaging the whole community in recovery; the addictions of one member of the family or community affected and are interconnected with the addictions issues of all members of the community. Ninety-one percent of workers expressed concern regarding the lack of environment supporting sobriety. "Once they get out they don't have that extra support. Some come out of treatment, and they do not have a structured environment, or support to maintain their sobriety at home" (Moncton Gathering). As another participant said "Recovery is forever, you must maintain constant vigilance" (Kingsclear).

The experiences of members are shaped not only by what we have in common, but also by our cultural or tribal language and beliefs, geography, specific family and community history. Our lives and ability to cope with daily experiences are also affected by our gender, age, sexual orientation, and schooling, and in particular residential schooling. We will review some impacts of addictions on different members of the community and the key challenges in service delivery that are resulting from these differences.

In the conclusions of the Nova Scotia First Nations *Exploring Health Priorities* Report (2008), addictions and substance abuse were referred to in three priorities, one of which was initiatives for FN Elders, adults, and youth to address illicit drug use, solvent abuse, and alcohol abuse issues. The far ranging impacts of addictions and substance abuse are discussed, including mental, emotional, social, family, physical and economic.

The following chapter discusses reported impacts and service needs for Youth, Women, Two-spirited, Residential School Survivors, and people with Mental Health issues (Concurrent).

CHAPTER SEVEN: IMPACTS AND SERVICE NEEDS FOR POPULATIONS

Youth

There was widespread concern expressed for children and youth and the desire to protect them from the harms caused by alcohol and drug abuse. According to one Elder "children are hurting and being hurt and nobody is listening". Indeed, many participants in the ANNA processes reported that "many resources should be targeted towards helping children and their families so that they become strong and resilient". Participants raised issues of disconnection of youth from families (Eskasoni); boredom (Rising Sun); and cognitive health issues e.g. learning and attention difficulties (Moncton Gathering).

First Nations and Inuit Communities in Atlantic Canada are very concerned about the impacts of addictions and, in particular, suicide, on their children and youth. CHART SIX: ISSUES WITH YOUTH ADDICTIONS (page 87) reflects the workers placing a high priority on youth issues generally. The chart shows that: 96% considered the lack of youth treatment centres as an important issue; 94% expressed concern about the link between addictions and youth suicide; 94% also

considered the lack of youth detox an important issue in youth addictions; 92% considered the voluntary nature of treatment as important; 91% related to the need for youth role models; and 88% considered the lack of female specific treatment options a concern.

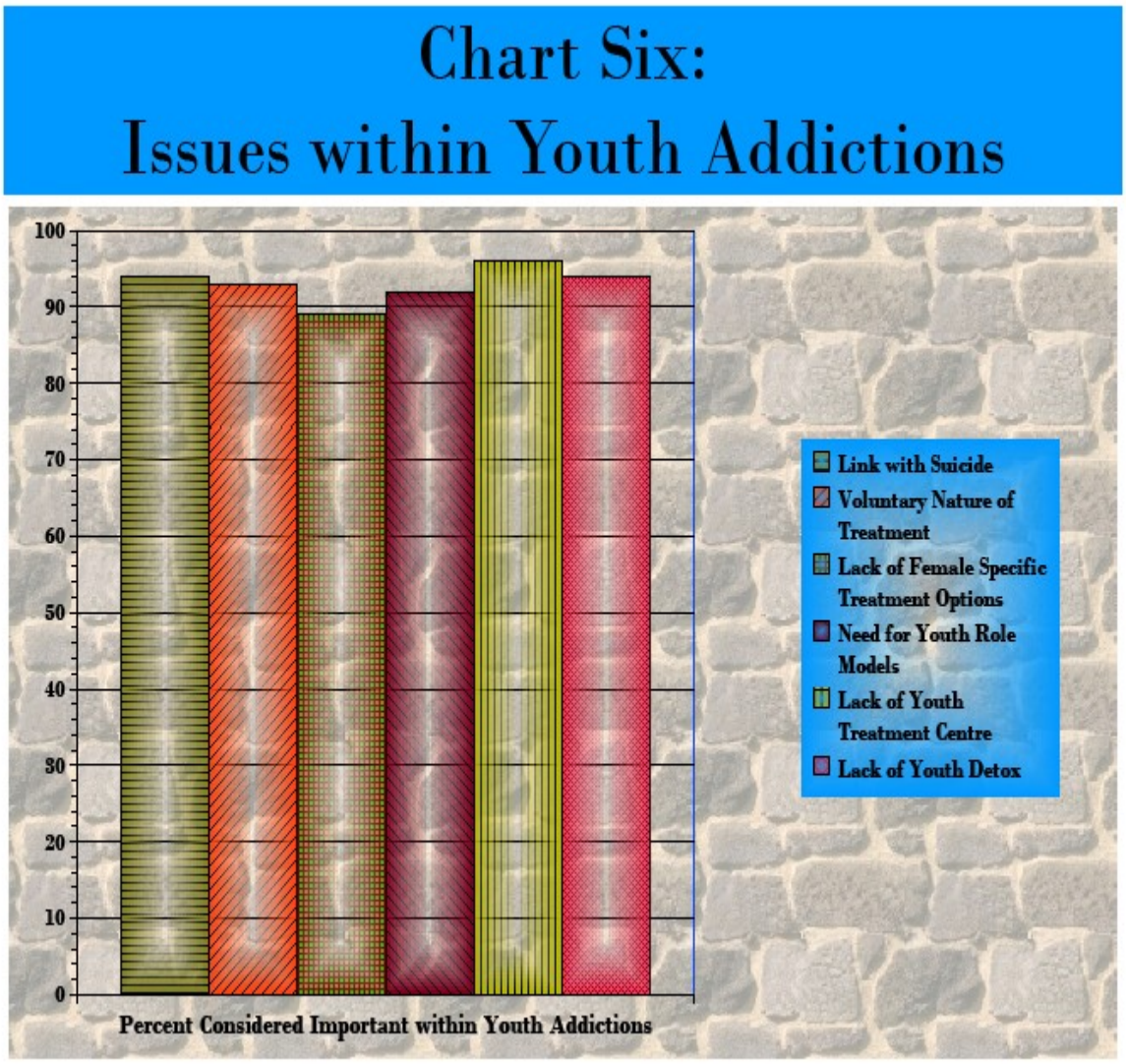
During the time of the ANNA processes, there were a total of five suicides on Atlantic Canada's largest First Nation reserve—Eskasoni, and another five drug- and alcohol-related deaths since early 2008. This life and death reality has made youth services the number one priority in Nova Scotia, and this has been confirmed by every community in Atlantic Canada we have visited. News of the Cape Breton tragedies, and the community events held, can be found in the online version of The Cape Breton Post.[27]

As the CHART SEVEN: SUICIDE (page 89) illustrates, suicide is a huge issue facing communities. According to the chart, 53% of community members and 18% youth members reported having thoughts of suicide, 36% of community members and 22% youth members reported attempting suicide and 94% of community workers reported youth addictions are linked to suicide.

> "Preventing youth suicide, and depression and substance abuse which can lead to suicide, will continue to be an important priority for youth health care. Many of the risk conditions that underlie these problems: poverty, unemployment and economic uncertainty, coupled with rapid social change, resource-deprived institutions and communities, family breakdown and dysfunction - are trends that are likely to influence the lives of children and youth in the Atlantic region for the foreseeable future, putting youth at risk for mental health problems in coming decades" (Exploring Health Priorities 2008).

Participants in the ANNA processes from all communities talked at great length about the impact of addictions on youth, focusing specifically on the relationship between addictions and youth suicide:

⊕ Some interpreted the increasing young age of children and youth struggling with drugs and solvents as "cries for help";
⊕ Some talked about the harmful use of harm reduction because "a young person is being set up as an addict";
⊕ Some spoke about the desperation they see with the youth;
⊕ A group of youth expressed fear of violence from local drug dealers and a need for more police members and action.



Priorities for Youth

Priorities for children and youth were discussed by Nova Scotia First Nations in Exploring Health Priorities: "We need a prevention program to stop children and youth from developing addictions/substance use problems; We need Native youth treatment centers (the closest one is in Newfoundland and Labrador); Youth need their own space; and we need to make the program interesting so kids will come." Priorities coming from ANNA include:

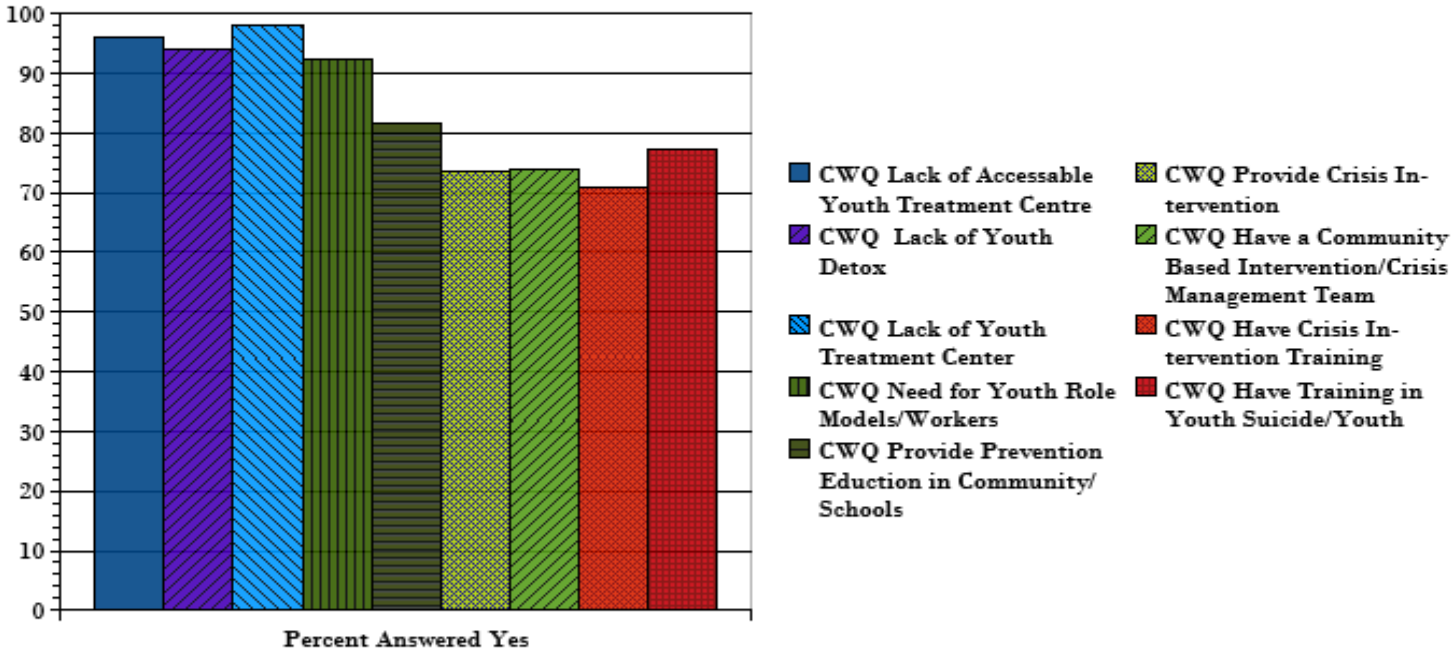
- ⊕ Indentify youth needs, peer issues, relationship issues, concerns, and values;
- ⊕ Identify youth participation in community process and initiatives and their participation/connection to mainstream society;
- ⊕ Provide sexuality education in schools, home, and communities;
- ⊕ Provide more education for youth on HIV/AIDS;
- ⊕ Provide education for youth on street drugs, alcohol, and prescription drugs;
- ⊕ Provide First Nation Healing Centres that serve youth;
- ⊕ Provide accessible healing centers. There are presently no First Nation Healing Centres just for youth, with the exception of the Charles J. Andrew Youth Treatment Centre in Sheshatshiu, Labrador;
- ⊕ Provide youth specific detoxification programs. Provincially, youth occasionally do enter adult Detox programs hospitals. There are no First Nation Detox programs for youth;
- ⊕ Provide community services and programs and professionals for youth aged 10 – 18 years;
- ⊕ Provide more youth-centered community-based programs and activities, e.g., athletic activities, cultural activities, art therapy and theatre activities;
- ⊕ Provide youth with a youth-centered continuum of care that includes detoxification, rehabilitation, and aftercare;
- ⊕ Provide programs to train and support youth role models and youth workers.
- ⊕ Parental involvement.

Parental Involvement

A priority issue related to youth identified as a key concern for Atlantic First Nations and Inuit communities is parental involvement. The CIET Aboriginal Youth Resilience Studies (Andersson and Ledogar 2008) indicate that parental care and support, parental monitoring, parental attitudes, and parental example clearly support the resilient Aboriginal youth. In the *Exploring Health Priorities* Report (2008), they note that Nova Scotia First Nations communities expressed the following concerns: "We need parenting support programs and education so that parents can have healthy lives and show their kids the proper way; We need more help at dances to keep kids involved; and We need to involve parents in the school – get them engaged with the children in the school so they know what's going on. They've never been invited to be part of daily life in the school (e.g., helping in a classroom)".

Chart Seven: Suicide

65% of Community Members & 30% Youth Members Report Having Thoughts of Suicide
46% of Community Members & 21% Youth Members Report Attempting Suicide
94% of Community Workers Report Youth Addictions Linked to Suicide



*** CWQ = Community Worker Questionnaire**
***Blue = Facilities; Green = Community Education/Services; Red = Training**
***Community Members: 26-51+ years old and Youth Members 15-25 years old.**

The impacts of parents with addictions and their involvement in the care of children and youth were often discussed as part of the ANNA processes. One key question explored was: How can we get parents involved in parenting, and in particular, in parenting their youth? (Moncton Gathering, Eskasoni).

A Continuum of Services

Participants in Labrador summed up the need for a continuum of services and service delivery. "I think one way to be successful is to get the youth involved in their own treatment. Prevention and education is an area we have to focus on. The problem we have is getting the youth to come out. Depends what is going on in the community and the times of the year. Hockey, then no one. We need to find innovative ways to get people. We need a lot more resources for outreach. Travelling to the communities, and following up. That is a big issue, how do we follow-up. We need to get agencies together. We are all working in these little pockets."

NADACA has recognized that more focus must be on youth. Vision statements in their Policy Manual reflect this concern:

> "Our treatment setting needs to focus more on young people, but we need to greatly enhance our infrastructure (human and material resources) to make this a reality" (p. 61).
>
> "We will strive to enhance the efforts of our community education programs so as to better meet the needs of…the youth of the community" (p. 59).
>
> "We will place a greater emphasis on the needs of…the youth in designing and delivering treatment programming" (p. 59).

However, due to funding constraints, specific services for youth continue to be lacking, and policies within NADACA do not specifically address the needs of youth.

What is Working Well for Youth?

⊕ **NB.** " After the Thunder: the story of Simon Bishop " is a play about suicide and how to manage stress, done by Eel Ground First Nation Drama Club, from Eel Ground First Nations School in New Brunswick. The drama club won the Kaiser Foundation award in the category of Addictions. In a previous year the focus was on FAS; this year the production was on Prescription Drug Misuse, in partnership with Elsipogtog School[28].

⊕ **PEI. "Perceptions" -** video of play written and performed by participants in "The Young Mom's Program" on barriers faced by young, single Aboriginal mothers.

⊕ **NS. Eskasoni Response to Youth Suicides**:

○ **Eskasoni Youth Rally**: Building Integrity Today, Preventing Crisis Tomorrow…the Sequel. Feb 26 to Mar 1, 2009 with Lorne Cardinal, Adam Beach, Glen Gould, Carla Robinson, Wannek Horn-Miller, Elijah Harper.

○ **Eskasoni Youth Talk Back Radio Show:** The Peer Helpers of Eskasoni have started a Youth Talk Back radio show, where each week the youth will discuss a topic, sharing their personal views on it. (NADACA assisted).

○ **Art of Resilience Video:** The Eskasoni Youth got parents and youth involved in the video creation, called the *Art of Resilience*[29]. It has received national attention, and has over 2000 YouTube views to date.

⊕ **NB. Soaring Eagles Project**. Providing training for volunteers to facilitate year round alcohol and drug free cultural group that can operate in every interested FN regardless of size, across NB. Program for children 5-18, activities grounded in the community's culture and language, grounded in four seasons. Next session April of 2009 in Tobique.

⊕ **NS. "Nemi'simk, Seeing Oneself "** Youth Early Intervention Program Model at Indian Brook First Nation and Eskasoni First Nation, NS. It is based on a holistic model of "personality matched, motive-specific brief interventions" to help teens identify and move away from maladaptive coping strategies that contribute to substance abuse (Chansonneuve 2007). An article has been published on this work by Chris Mushquash, Nancy Comeau, and Sherry Stewart (2007).

⊕ **LAB. The Charles J. Andrew Youth Treatment Centre** Sheshatshiu. A sixteen week live-in program for youth using Nutshimit practices (e.g., camping, fishing, hunting, hiking, canoeing, healing circles, sweat lodges, art programs, local drum dancing presentations, life skills training, multi-cultural youth gathering, and regular school programs). Relapse prevention and aftercare are discussed with family prior to youth leaving the Centre.

⊕ **NS. NADACA Youth Programs** The Education Day Program is an educational pre-treatment program operates in two-week cycles and focuses on informal workshops, discussion groups, films, lectures, and group interaction. The program can be mobilized and moved to any First Nation community in the Province. The Youth Services Coordinator serves as a Provincial resource for the development and delivery of youth programs.

The Atlantic RAPC (2004) identified and argued for more Youth Treatment Programming dollars in their reprofiling submission, which have not yet been provided. This need has increased rather than decreased.

> **ACTION/RESEARCH/TRAINING: "Develop both an interim and long term plan for addressing the absence of youth treatment programming in the Atlantic Region" (26). This would include: prevention programs (i.e. providing programs to train and support youth role models and youth workers); identify youth needs, peer issues, relationship issues, concerns, and values; identify youth participation in community process and initiatives and their participation/connection to mainstream society; provide accessible healing centers, youth-specific detoxification programs, and more youth-centered community-based programs and activities; provide youth with a youth-centered continuum of care that includes detoxification, rehabilitation, and aftercare; and, find create ways to encourage parental involvement.**

Gender

When exploring a Gender Based Analysis (GBA) in terms of addictions in Atlantic Canada, we uncover the particular needs of girls and women around maternal health care and parenting, as well as the health and mental health impacts of high levels of physical and sexual violence historically and today. Women, and in particular the epidemic of sexual violence against women and children was frequently raised in relation to HTT (Historical Trauma Transmission), as one legacy of Residential Schooling. While the intergenerational impacts of sexual violence on both women and men are feeding the need for addictions for numbing, as a survival strategy, few programs specifically address this.

A GBA also helps us become conscious of the limited availability of gender-specific addiction programs for either girls or women in the Atlantic Region. The link between violence against women and children, and in particular sexual violence and addictions has been identified as a serious problem in several communities. NADACA has also recognized that more focus must be paid to women in their vision statements noted in the NADACA Policy Manual.

> "We will strive to enhance the efforts of our community education programs so as to better meet the needs of Native women…of the community" (p. 59).
>
> "We will place a greater emphasis on the needs of Native women...in designing and delivering treatment programming" (p. 59).

While there are specific intakes for women at the Rising Sun and for girls at the Charles J., the programming is not gender-specific, and the staff remains a mix of males and females. There are no specific policy initiatives within NADACA or the Atlantic Region that address the particular needs of girls and women with respect to their roles as mothers, their experiences of violence, or their need for female counsellors or Elders. It is unclear what process is in place to mediate a complaint, should a female client or worker experience unwanted sexual advances. There is no designated advocate for women to hear and mediate these reports.

As CHART EIGHT: WOMEN IN TREATMENT (page 95) illustrates, the specific needs of women in treatment were identified by workers and communities as a priority issue. For example, women who are struggling with addictions are also facing issues such as domestic and sexual violence. However, as the chart also illustrates, while recognized as high priority, few programs and services are delivered to this population. Needs reported by ANNA participants include:

- ⊕ Addiction treatment services specific to the needs of women;
- ⊕ Shelters for First Nations and Inuit women who are experiencing violence;
- ⊕ Access to shelters for young First Nations and Inuit women
- ⊕ Community programs for women and their children;
- ⊕ Community prevention programs with the aim of stopping violence against women in all its forms;
- ⊕ Programs for victims of sexual assault

Maternal health

First Nations and Inuit women who are pregnant and are struggling to address their problematic issues with substances need appropriate supports during their childbearing years. Some Aboriginal women are able to find harm reduction programs within the mainstream society and in some First Nations (Oromocto). ANNA participants talked about the lack of maternal health supports in general (PEI) and the impacts of addictions on maternal health (Moncton Gathering). There remains a lack of knowledge about the effects of various addictions on maternal health and the health of children, and in particular mothers who are being given Methadone as a form of harm reduction.

What is needed is a more holistic maternal health program. For example, the Sheway[30] program for Aboriginal women who are pregnant: draws on a harm reduction approach to

provide education, referral and support to women to help them reduce risk behaviours and in particular to reduce or stop the use of alcohol and other drugs during pregnancy, while providing a safe, encouraging and supportive environment where women can learn problem-solving skills, gain valuable experience in interpersonal relationships, and enjoy role modelling and learning from other women.

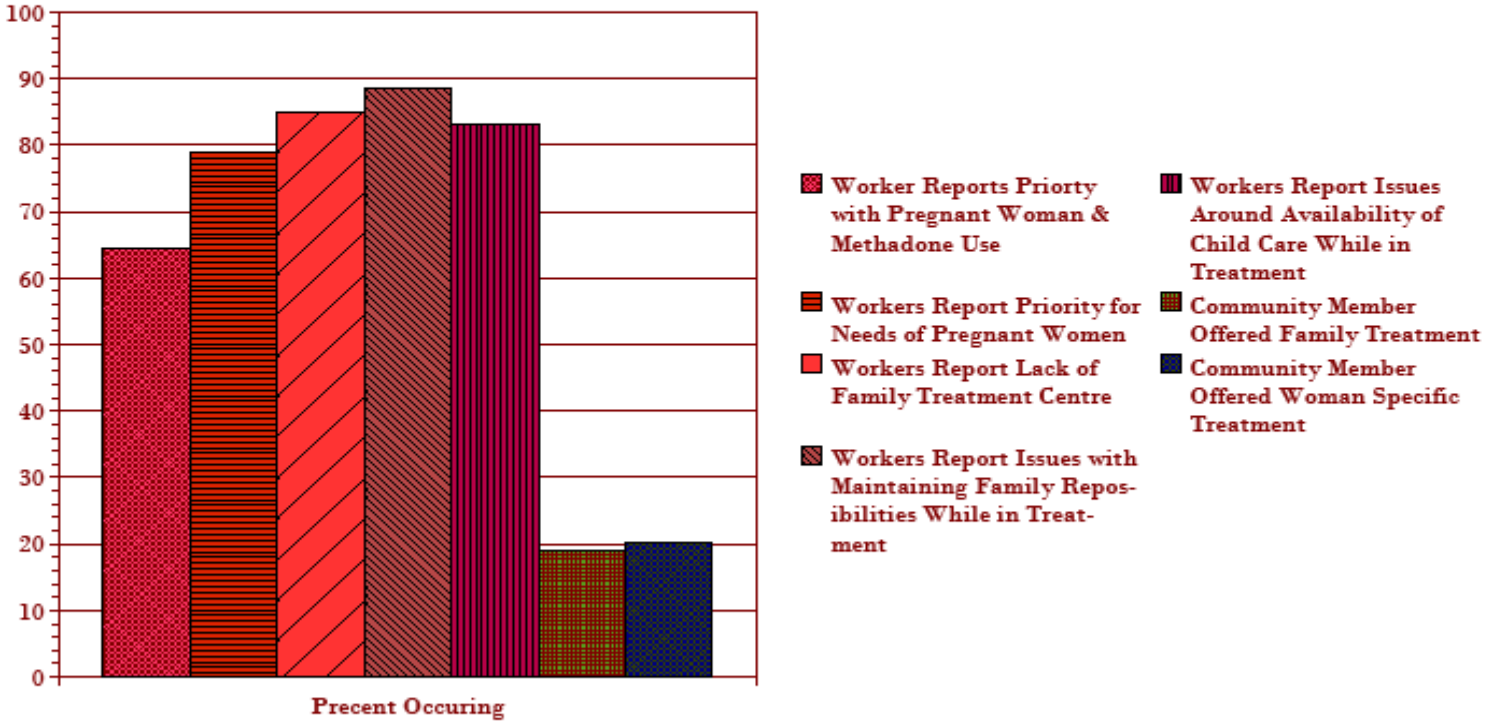
At the Moncton Gathering several key points were raised with respect to services for women as mothers: there needs to be family planning so mothers have choices or options, including pre-natal services; ongoing parenting support for those who are struggling with addictions; more knowledge about methadone effects on pregnancy; and prevention education about addictions and the effects on pregnancy. A concern was also expressed that fathers, and in particular single parent fathers also need acknowledgement and support.

Needs and services to young mothers was also a key topic at the Moncton Gathering. Participants shared concerns that teens who do not know they are pregnant may continue using. Not knowing the risk involved with drug and alcohol use they risk miscarriage and complications both during pregnancy and during child's lifetime. There is a lack of educational and other transitional supports and resources (on topics, e.g. FASD/ADD, addictions), and follow-up care for teen parents. Parenting programs for teens are seen as crucial in breaking the intergeneration cycle of addictions and abuse, as are drug and alcohol free community-based family activities.

For women, community-based healing programs are a priority. As one participant informed us "Treatment programs need to be in the communities to meet the needs of women, who want to be near their kids" (Indianbrook). Another said, "What about programs that let women bring their children, we need one of those". Many strides have been made in incorporating adult treatment programming in the Atlantic region, but there are currently no addictions-focused family wellness programs in the Atlantic Region.

> **ACTION: A more holistic maternal health program can help address the interconnected health needs of mothers and their families, including the positive cultural affirmation of the role and value of traditional Aboriginal reproductive, pregnancy and birthing knowledge.**

Chart Eight: Women in Treatment
Prevalent Issues



FAMILY WELLNESS:

Most prevention and intervention services in the Atlantic Region do include family counseling and support groups, often through networking with other agencies. But, much of the programming is on an ad hoc basis and specific healing plans are lacking. Most family wellness programming currently offered is developed in response to spousal and child abuse, with less focus on addictions or substance abuse. One exception is the youth treatment center, *Charles J. Andrew Centre* in Labrador, which includes family involvement.

Family Wellness will require development and integration into current programming. The lack of family-based programs is a priority issue for 85% of workers across the region. While half of the workers report they offer family programs, only 18% of participants said they were offered family programs; 53% said they were not offered programs and 29% said they did not know whether or not family treatment programs existed.

Throughout the ANNA processes, family based treatment was discussed by several participants. In working with Residential School Survivors, one participant noted: "Our survivors are really calling for family healing." (Nova Scotia). Some saw family as an essential aspect of a holistic approach: "Until we take a holistic approach, a family approach, it won't work". At the Moncton Gathering, there was a call for family treatment: "After-treatment the family environment has not changed, this is a call for family treatment." Another said: "the family must be treated". See CHART NINE: FAMILY WELLNESS (page 97).

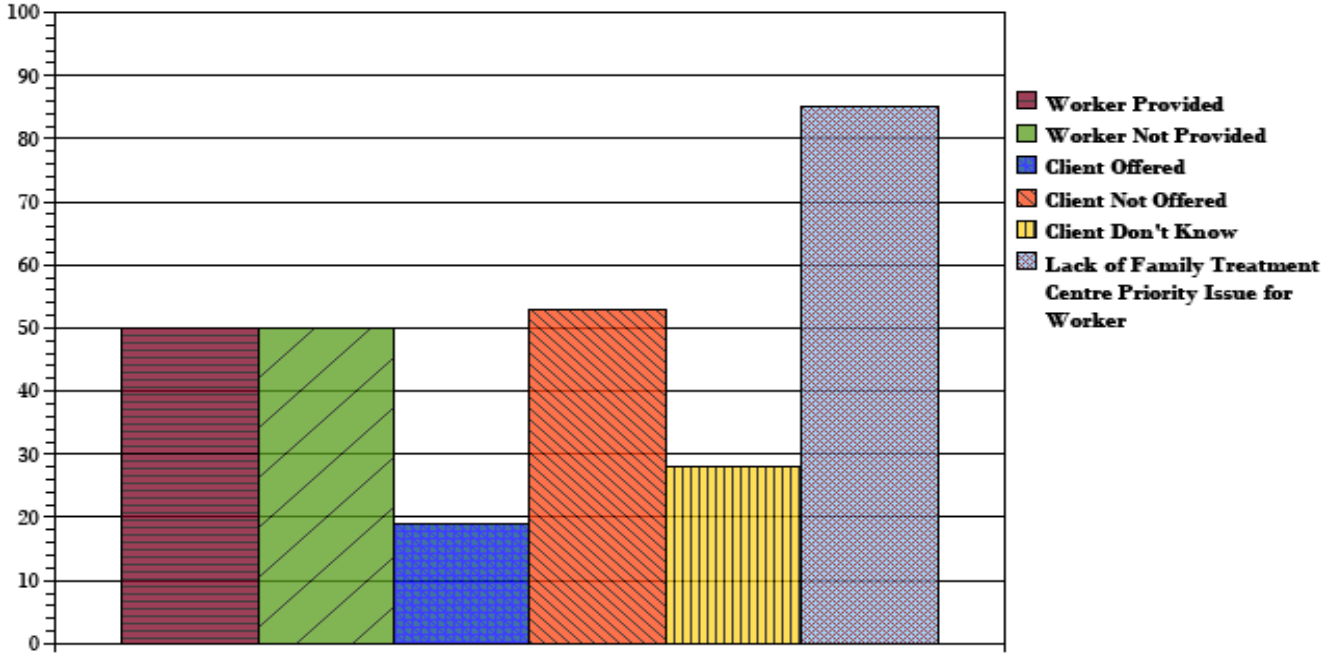
> **ACTION: As addictions are understood to affect all members of the family, including children and youth, and women's access to healing is at times affected by being primary parent, a family wellness center, with a dual focus on addictions and violence be established in Atlantic Canada.**

Addictions and Violence Against Women

The link between addictions and violence against women, and in particular sexual violence has been identified as a serious problem in several First Nations and Inuit communities. The connection between violence against women and substance abuse was raised across the Atlantic Region. The need to look at the root of the problem, namely contact with the non-Aboriginal society was raised. Others talked more specifically about the lack of services and

Chart Nine: Family Wellness Services

Percent Worker Reported Providing Family Treatment
As Compared to Client Reported Being Offered Family Treatment
Also Shown; Worker Reporting Lack of Family Treatment as a General Issue within Addictions Services



programs for First Nations and Inuit women, saying "When our women want help they need it now. If they have to wait, forget it. It's not going to work".

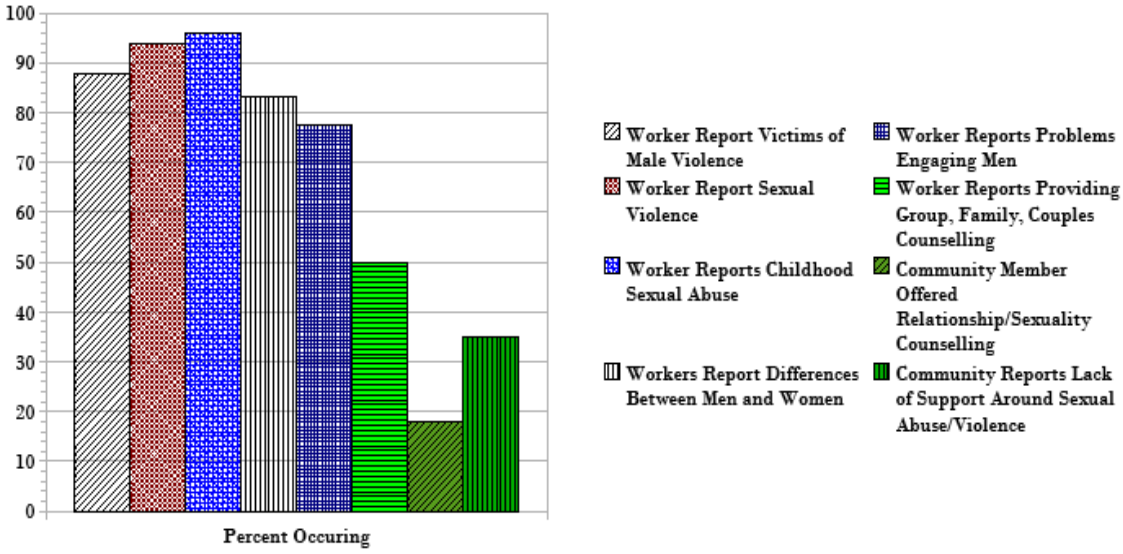
There are specific programs in Atlantic Canada for First Nations and Inuit women experiencing violence, these include the Gignoo House in Fredericton, Chief Mary Bernard Memorial Women's Shelter in Lennox Island, We'koqma'q Family Healing Centre in Whycocomagh, Cape Breton; the Millbrook Family Treatment Centre in Truro, NS**;** Libra House in Happy Valley-Goose Bay, NL; Nain Safe House in Nain, NL, and Selma Onalik Safe House in Hopedale, NL. We were able to speak with some of these service providers about the levels of collaboration with NNADAP and the key issues that still need to be addressed.

Within the shelters for First Nations and Inuit women in the Atlantic Region, Gignoo does not admit women who are struggling with addictions because of funding criteria and because they are not equipped to deal with addictions including methadone treatment. The We'koqma'q Family Healing Centre on Cape Breton Island has worked with women struggling with addictions while collaborating with NADACA and the RCMP. The Chief Mary Bernard Memorial Women's Shelter in Lennox Island is part of a collaboration team regarding the Health Transition project that is focusing on addictions. We are not aware of the policies of others or the levels of collaboration.

> "It's a challenge to get access to services …there are no innovations (in New Brunswick) except an Aboriginal women's provincial advisory committee to end violence against Aboriginal women" (Gignoo).

Males, Females in Relation

As Chart Ten: Males, Females in Relation (page 99) illustrates, community workers reported high rates of violence against women: specifically male violence, sexual assault, and childhood sexual abuse. At the same time, workers reported difficulties engaging men in healing. While 50% of community workers reported providing group, family, and couples counseling, less than 20% of community members reported being offered relationship/sexuality counseling, and 34% of community respondents reported a lack of support relating to sexual abuse and violence.



Addressing sexual abuse

In Atlantic Canada, there are no programs for addressing sexual abuse in First Nations and Inuit communities. Programs like Avalon Center in Halifax offer some counselling services to individual women, but they face funding constraints and expressed a need for ongoing cultural safety training. [31] "Sexual abuse is not being dealt with and this impacts people's desires for their own sobriety" (Millbrook). "It is a reported fact that 87% of our community members have experienced sexual abuse. This is what is underlying addictions, and nobody wants to talk about it" (Elsipogotog).

Priority recommendations related to Health, Safety and Wellness, overwhelmingly supported by the Aboriginal women of NAWS I (The National Aboriginal Women's Summit I) [32], relevant to the ANNA participants include:

1. More national financial and policy support for enhanced programming regarding family violence and abuse.
2. Make violence against Aboriginal women and girls a priority in all areas, including addictions.
3. Ensure that resources be available to address all issues that negatively impact on Aboriginal women's well-being.
4. Ensure economic opportunities strategies consider all the socio-economic conditions that are required to create the right environment for Aboriginal women to participate in the economy.
5. Recognize and understand: the role and value of traditional Aboriginal reproductive, pregnancy and birthing knowledge.
6. Aboriginal women must be engaged fully within environmental stewardship issues, including water, land, food, air quality, medicines.

What is working: Women-specific programs

Women-specific programs were frequently expressed as a priority. Most programs are mixed, including both men and women. The Rising Sun has a women only intake, and Charles J. also has gender-specific intakes. In the Atlantic Region there are no other programs specific to women other than transition houses/shelters, and shelter workers are not specifically trained to work with women who are struggling with addictions (Gignoo). Although some Transition House workers, particularly in Cape Breton, have received addictions training as past NADACA workers, this is the exception rather than an expectation.

> **ACTION/TRAINING: Transition House and sexual assault workers receive training in addictions and cultural safety, and addictions workers receive training in violence, and in particular sexual assault prevalence and intervention to provide a more seamless service for women.**

Programs for young women were also a stated priority at the Moncton Gathering. Young women face yet another barrier in seeking shelter when experiencing violence: the age of admission. These young women are falling between the cracks – no longer considered children and considered to be in need of care and not yet old enough to have obtained legal status of adulthood.

> **ACTION: More family violence and sexual assault workers are also needed in all communities, for education and to support families to become safe environments for all members.**

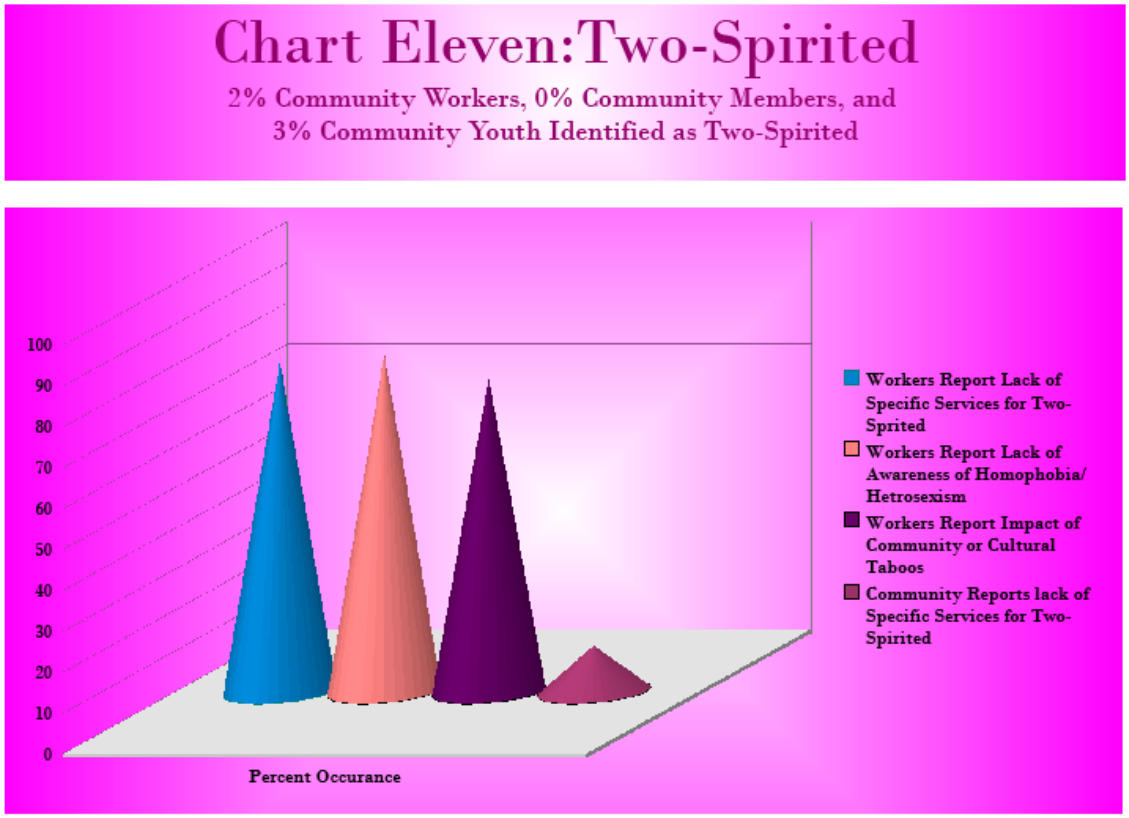
Two-Spirited

As CHART ELEVEN: TWO SPIRITED (page 102), illustrates, 70% of workers in the ANNA's processes reported a lack of specific services and programs for two-spirited people and also a lack of awareness of homophobia and heterosexism. Only a few community members reported a lack of specific services for two-spirited people, perhaps reflecting, in part, community taboos on the topic Generally, at least 10 percent of the population is two-spirited, and community taboos can have the effect of invisibility for two-spirited people within that environment, sometimes resulting in suicide. "In many Aboriginal communities, homosexuality remains a taboo topic and is highly stigmatized" (Aboriginal Healing Foundation 2007).

Programs for Two-Spirited

Two-spirited at this time are a non-served and underreported gap in service; there are no programs specific for two-spirited people with addictions in the Atlantic Region. For those participants who did share, we can report that there is little success in keeping two-spirited people in programs if they do enter. Two-spirited family members have to leave the Region to receive services and support. As one participant shared: "More counsellors are needed to address specific needs of Two Spiritedness – women to work with women and men to work with men." A participant at the Moncton Gathering noted "More support is needed for Two Spiritedness. We need to revitalize traditional ways of viewing Two Spiritedness . Two Spirited People are closer to the Creator and a gift to the community." An informative website is The North American Aboriginal Two Spirit Information:
Page http://www.ucalgary.ca/~ptrembla/index.htm

In the United States, a national survey of almost 12,000 adolescents, with questions about both sexual orientation and suicide, confirmed that homosexual adolescents are more than twice as likely as their same-sex peers to attempt suicide. (Aboriginal Healing Foundation 2007).



Are the high rates of youth suicide linked to addictions, and the lack of programs focused on or working for two-spirited youth or adults in Atlantic Canada connected?

What is working for Two-Spirited: Healing Our Spirit[33]

Healing Our Spirit is an Aboriginal HIV/AIDS service organization in BC working to provide holistic and culturally appropriate HIV/AIDS prevention workshops to health professionals, students, communities, youth, incarcerated people, Elders, families and Chiefs and Council. We include it to illustrate a gap in service to two-spirited, in particular youth.

They have found that very few resources were available to youth who were questioning their sexual identity. Youth identified conferences and school counselors as resources but expressed that resources as a whole were extremely limited or non-existent. Youth had to rely on each other or on themselves, and if one person in the community was trained to deal with

issues of sexual identity, they were over-burdened with responsibility. A youth shared an experience of another youth in their community committing suicide due to isolation and fear around his questioning of his sexual identity. The situation in an urban setting was seen as more positive, with more resources and support available.

Similarly, few services were available for Aboriginal two-spirited youth, especially for those living in a rural or on reserve setting. Youth commented about their experience that "there's nothing there for us to go to." Concerns about confidentially abounded amongst the youth, who observed that two-spirit youth are scared to approach health professionals or other youth providing services because "everyone would find out." Some youth suggested that Elders may be a source of knowledge and support.

Youth had little more access to services geared towards two-spiritedness in urban centers, with one youth living in Surrey noting that no services were available for Aboriginal two-spirited youth. In greater Vancouver, youth cited UNYA, The Centre, Healing Our Spirit and Directions as organizations that address the unique sensibilities of Aboriginal youth and positive sexual identity.

> **ACTION/RESEARCH: There is a critical need to address the gaps in the provision of health and healing programs and services to address the needs of two-spirited individuals, and in particular the link between isolation and invisibility of two-spirited youth and suicide.**

Steps that could reduce invisibility and create some supports for two-spirited people within NNADAP programming would include:

- ⊕ revitalize traditional ways of viewing Two Spiritedness – e.g., Two Spirited People are closer to the Creator and a gift to the community;
- ⊕ provide more counsellors are needed to address specific needs of Two Spiritedness – women to work with women and men to work with men.
- ⊕ acknowledge the potential link between social isolation, two-spiritedness, addictions and suicide, in particular for youth programming.

4. Residential School Survivors

There has been much focus on the impacts of Residential Schools in Canada with the Truth and Reconciliation processes, including the public apology by Federal leaders.[34] Atlantic Canada

was shook up with the tragic addictions-related murder of Nora Bernard, Residential School Survivor and well known activist in 2008. Her death left many community members, and many other Residential School Survivors and Elders feeling fear and uncertainty.[35]

While some Residential School Survivors have been on a healing journey, others are finally being acknowledged and provided opportunities to engage in healing. Some learned to cope, and are continuing to cope, through multiple addictions, including alcohol, prescription drugs, food and gambling. For some, there is a lot of anger and frustration built up from so many years of struggling with the hidden and denied abuses, and sometimes these pains have found their ways onto the next generation, leaving a residue of guilt, shame and regrets. As one participant in the Moncton Gathering told us: "Our parents did the best they could, which was not a lot. They were not shown love. My mom brought up 6 of us, working 2 jobs, but we all have our issues. She did the best job, she was my teacher."

Residential School Survivors were a focus of concern for ANNA participants, with many reporting the links between residential school trauma and addictions. Issues raised included the lack of resources for specific addiction and mental health services to address the many needs arising from the legacy of HTT (Historical Trauma Transmission) and the levels of sexual violence against women and children frequently raised in relation to HTT, and the intergenerational impacts of this feeding the need for addictions. See CHART TWELVE: RESIDENTIAL SCHOOL EFFECTS (PAGE 106).

Many Residential School Survivors are now Elder-aged; some have not had opportunities to engage in learning or practicing the traditional knowledge of their peoples, so it is difficult when they are called on the be cultural or spiritual "Elders". Regardless, many ANNA participants speak of the needs of Elders and Residential School Survivors simultaneously. "Our Elders can help us to bring back our traditional teachings."

Some ways that participants indicated that addictions issues interface with needs of Residential School Survivors/Elders include:

- ⊕ Residential schools stole the knowledge of parenting (Indianbrook);
- ⊕ Grandparents are taking care of babies (Moncton Gathering);
- ⊕ Lack of support and respect for our Elders (PEI);

⊕ "We need more security for Elders living alone, to prevent intimidation, abuse, stealing and break-in to take their meds" (Indianbrook);
⊕ They do not feel they are taken seriously; they do not feel they are heard; they have health issues, including depression and suicide; some misuse prescription drugs/medications; financial issues; isolation; sexual abuse; feeling unwanted (Moncton Gathering);
⊕ "Our Elders have a lot of unresolved health issues such as diabetes, and addictions, and the stress caused by the addictions" (Natuashish).

Many participants understand that Residential School trauma is intergenerational, and so healing programs should also be. As one participant shared: "When we are addressing the impacts, we are not able to take the survivors away from their families. Family and community healing must all go together. We want to be able to extend that invitation out to the family. I have heard survivors say 'if you can't bring my wife, my family, and my grandkids that have been putting up with me....' Our survivors are really calling for family healing. 'Bring my family to these healing places. If you are to bring anyone I would rather my grandkids because they are the ones with the problem today'".

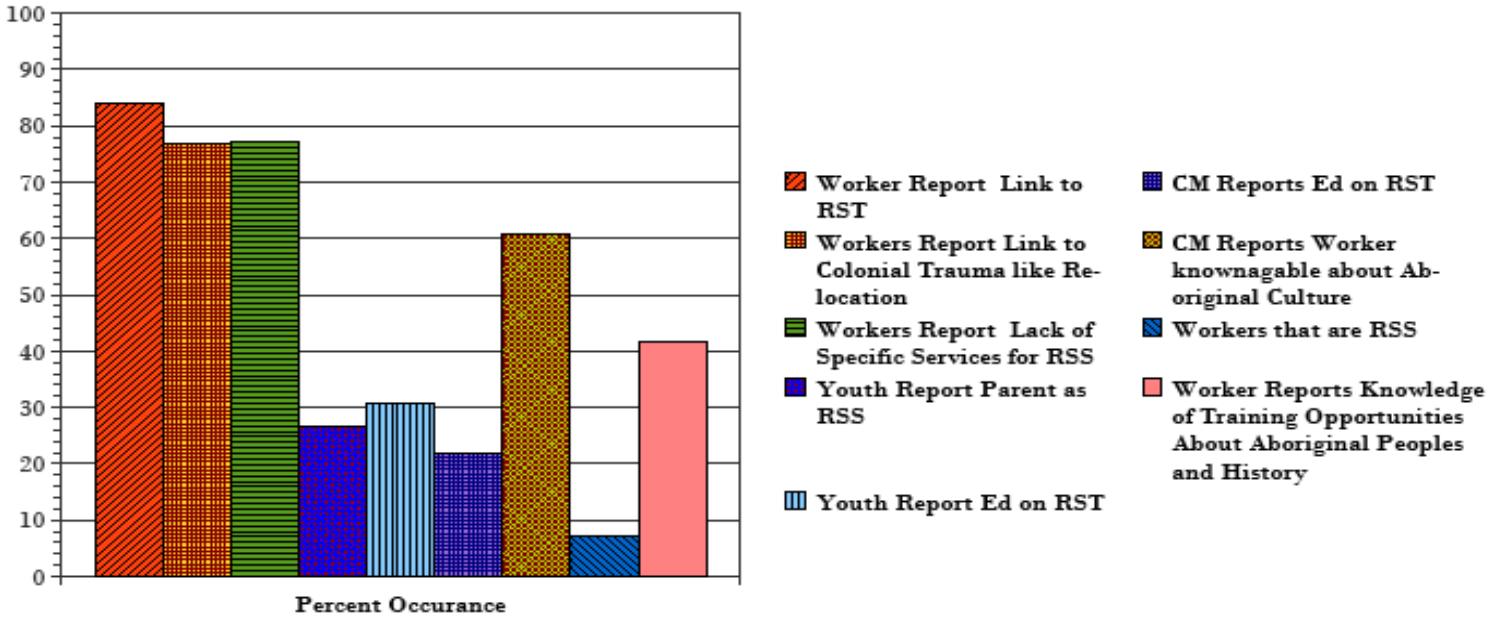
ANNA respondents reported gaps in services for Residential School Survivors. These included:

⊕ Lack of transportation to all needed programs and services;
⊕ Lack of resources and inclusion of family members in Residential School Survivor healing.
⊕ Lack of intergenerational work. Not just education about drugs and alcohol, but going to the roots of addiction;
⊕ A safe environment to begin a journey with supportive people around survivors so they can begin to trust;
⊕ Lack of services in Mi'kmaq language.

Many needs were expressed regarding serving older adults in our communities. More community-based, and in-home programs need to be developed. As one participant said: "Older people do not like to travel to strange places to tell their stories to stranger people". This would include programs for residential school survivors who continue to suffer, and include their family members in the healing process. Working with families together within the community will break the isolation of Elders and allow Elders greater involvement in delivery of

Chart Twelve: Residential School Effects

While workers report residential school trauma as linked with addictions, knowledge of training opportunities, specific services for, education regarding RST for clients and worker knowledge about Aboriginal culture are reported as lacking.



*RSS = Residential School Survivor

* Ed = Education

*RST = Residential School Trauma

* CM = Community Member

programs and services. “We need healing for our parents, not blame,” an ANNA participant said.

As the chart Residential School Effects illustrates, while workers reported the need to address the link between residential school effects and addictions, they identified gaps in the ability of communities to deliver services. Some of these gaps include knowledge of training opportunities regarding RST impacts; lack of specific services for RST clients; lack of education regarding RST for clients; and lack of worker knowledge about Aboriginal culture.

Elders and Residential School Survivors who participated in the ANNA processes focused on their role in the community. As one participant said: “There needs to be more programs for Elders to increase their social connection to the community and break the isolation that some are living. This would include an Elders Advocate to work with Elders on their behalf”

At the Moncton Gathering, it was identified that enhanced roles for Residential School Survivors/Elders in the Community could come through these Holistic services: powwows; Elders lodge; ceremonies; Sweats; Church; Traditional healers; Youth and Elder meetings; social gatherings; physical fitness activities; bingo; Talking Circles; caregiver support; meals on wheels; storytelling; weekly or monthly elders’ meetings; Elders lodges; supportive care for elders (emotional, health, addiction); self-esteem class and self love programs; bringing Elders together from different communities.

What is working for Residential School Survivors?

NADACA offers the Journey of Healing Program

The Journey of Healing project which began in March of 2002, with funding to March of 2007, still provides many programs and services to residential school survivors. The project is staffed by two clinical therapists, one at the main NADACA office in Eskasoni, and the other at the NADACA sub-office in Indian Brook. The project also employs two program assistants who provide direct assistance to the clinical therapists. The program hosted “Spirit of Hope” Gathering, July 19, 20 & 21, 2004 at Millbrook Community Hall; a Residential School Survivor Gathering: Hope and Humor, September 14 & 15, 2007 in Sydney, NS; and the Journey of Healing: Strengthening Our Spirit Conference, November 8,9,10, 2008 in Membertou.

ACTION: Long-term funding for service providers and programs specifically for Residential School Survivors need to be provided throughout the Atlantic Region. Specifically resources be provided for an Elders' advocate program to hear and act upon the needs of Elders and Residential School Communities.

ACTION/TRAINING: Training for workers on: knowledge of RST impacts; awareness of specific services for RST clients; awareness educational programming regarding RST for clients; and increase all workers knowledge about Aboriginal culture and Aboriginal safety.

5. Concurrent Issues

Ninety-eight percent of workers priorized the link between mental health issues and addictions. Community members with ADD, FASD, and mental health issues (like autism, schizophrenia, bi-polar, depression) face additional obstacles when it comes to receiving treatment. In these situations in particular, the jurisdictional issues are creating gaps in services. As one participant commented "It is difficult to assess children who may be struggling with addictions and substance issues unless they have FASD." A Newfoundland participant shared: "Once you get a diagnosis then what? We don't have anybody to refer to."

For others, there is a "need to identify and address underlying problems relating to addiction". ANNA participants raised concurrent issues of mental health and addictions in relation to Elders and Residential School Survivors, including the issues of self esteem, identity and culture loss, and trauma resulting from the abuse inflicted on individuals at IRS, all of which lead to addictions and mental health issues. "If we do not address what is causing the pain, how are we ever going to stop numbing or killing ourselves?" one Elder asked.

For adolescents, the link between addictions, suicide and the mental health of youth means it is critical that workers assess quickly and appropriately (Rising Sun). In Labrador, holistic supports are lacking, including crisis intervention, safe shelters, counseling, and family involvement, especially at times of high vulnerability – at times when a youth may attempt suicide. As some participants mentioned "A suicidal person may be turned away because [name of service] is does not deal with mental health issues." Youth suicide is one example where services need to be able to deal with concurrent issues of mental health and addictions.

Mental Health issues affect every part of the community, and addictions workers need to be more aware of the interconnection between addictions and mental health concerns. Like issues such as post-partum depression. As one participant stated, "I am trained for addictions. Is post-partum long term or short term? We need to know this". Labrador participants spoke about needing more awareness of the relationship between addictions, family violence, and mental health issues.

Participants talked about the need for more dedicated mental health resources; more mental health workers to deal with mental health issues; culturally safe clinical therapists; more interagency networking so that addictions workers will know what is available to support their work in addictions; and more community partnerships across sectors to meet the needs of clients with mental health concerns. Some felt that educational materials that normalize the need to seek help for depression, alcohol or substance abuse, and family problems may help to reduce suicide attempts. (Millbrook, Moncton Gathering, Elsipogtog, Eskasoni, PEI, Charles J., Labrador, Newfoundland).

The widespread use of prescription drugs as a primary form of healing for grief, depression and anxiety has lead to a whole other area of addictions. Participants in the ANNA processes expressed serious concerns about the increasing misuse of prescription drugs (including methadone, cancer medications and mood-altering drugs) and the combining of prescription drugs with street drugs and alcohol.

> **ACTION/RESEARCH/TRAINING: Research and education for and with addiction, health and mental health workers on the specific affects and interactions of prescription drugs for First Nations and Inuit is desperately needed. Inappropriate prescribing patterns and the need for stronger monitoring of doctors as well as blocking other access routes (known dealers/internet) for these substances, and widespread prevention programming about the risks of these drugs is called for.**

An Integrated Community-Based Recovery Model

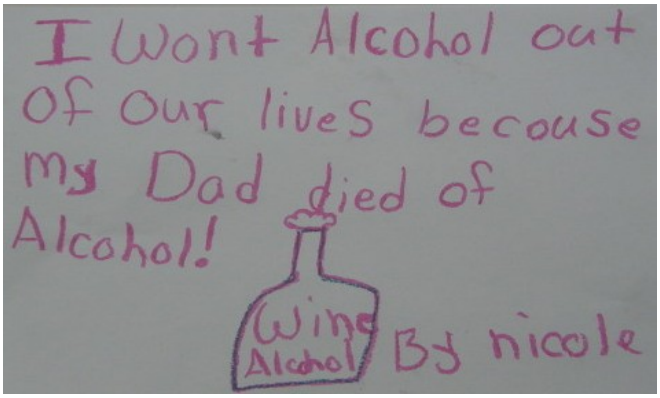
We support the integrated path in addictions treatment suggested by Nunatsiavut (2008), as one that employs a broader range of healing models and intervention strategies, builds upon First Nations and Inuit traditional healing practices, values and culture and is more responsive to the complex issues facing many Indigenous peoples in the Atlantic Region. Emphasis should be put on strengthening community-based counseling, self-help and after-care support services as services closer to home are more easily accessible, and can be more cost-effective.

First Nations and Inuit cultures place importance on family and community and all interventions need to reflect this value. Individuals and families must be respected and empowered to set wellness goals in partnership with addictions workers, honouring the First Nations and Inuit tradition of self-determination within a supportive community. An integrated practice requires workers who are specifically dedicated to addictions, who are knowledgeable of relevant First Nations and Inuit cultural philosophies, languages and practices, who recognize the relationship between trauma, loss and problematic substance abuse, and who have access to standardized training and skill development opportunities as needed.

This approach is supported in the Best Practices Report on Concurrent Mental Health and Substance Use Disorders (Health Canada, 2002). It recommends an integrated approach to the healing of Post Traumatic Stress Disorder and substance abuse. In reality, Healing Centers would continue to evolve into centers that specialize in providing programs to those who have concurrent issues, given that all substance abuse issues are in reality based in multiple distresses, including mental ones.

> **ACTION: The Nunatsiavut plan could be explored as a template for the Atlantic Region. Healing/Treatment Centres' mandates could also include providing clinical consultation and support in the areas of trauma, loss and violence to First Nations and Inuit communities and workers.**

CHAPTER EIGHT: A FULL CONTINUUM OF SERVICES



As one ANNA participant stated, "It seems like we just do crisis intervention. The long term is lacking, a holistic approach is missing, we don't have post treatment". The community approach of the National Native Addictions Partnership Foundation outlines a continuum of service delivery[36].

PREVENTION

The NADACA manual supports prevention and development of community supports as a priority: "We will place more emphasis on diversionary programs and activities so that we do not merely send clients back into the same environment from which they came. We also need to provide more employment and educational counseling to ensure that clients become solid community citizens and family providers" (p. 61).

Participants in the ANNA processes clearly recognized the fundamental need for prevention. They shared the kind of initiatives that their versions of prevention include such as turning the front office of the treatment centre into a community room; and providing daycare, Headstart programs, and school education. Participants across the Atlantic Region all support and see the need for more prevention work. Some fear too much attention is paid to treatment in the funding parameters established by the Canadian government at the expense of long-term prevention work. While well-established Treatment Centers like Rising Sun and Mi'kmaw Lodge have developed ways and means to incorporate prevention programming into their facilities, in other locations such as Wolastoqewiyik Healing Lodge, concerns regarding access to and use of the facilities for after-hours prevention initiatives were raised.

As CHART THIRTEEN: COMMUNITY EDUCATION (page 113) illustrates, close to 90% of community workers reported offering prevention services in the form of community education and workshops. Pertinent topics include: FASD, grief and loss, family violence, residential school effects, and relationship issues. Respondents at the Moncton Gathering emphasized the need to continue to deliver messages to communities in a holistic manner, emphasizing the maintenance of overall good health.

ACTION: Support and resources are needed to deliver messages to communities in a holistic manner, emphasizing the maintenance of overall good health.

DETOXIFICATION PROGRAMMING

For many service providers across the Atlantic Region, an Aboriginal detox is a number one priority. On the questionnaires, 98% of Workers indicated Lack of an Aboriginal Detox as a primary issue.

⊕ "People feel real worried about detox. How do you go to treatment without detox for 2 weeks? People are isolated going to detox, they feel alone so they don't want to go. So then they don't go to treatment. We need our own detox" (Indianbrook).

⊕ "Addiction becomes Number One for people using…Getting that person sober is the first priority" (Moncton Gathering).

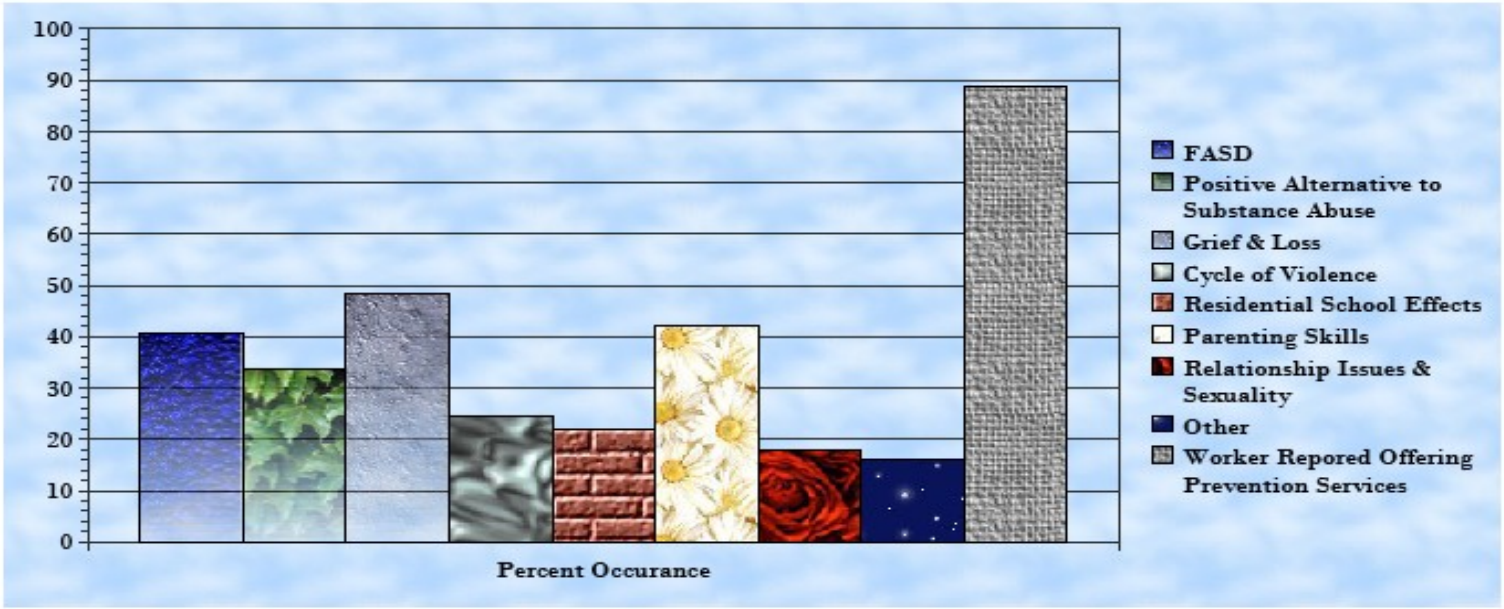
⊕ "We lose people to alcohol & drugs because they don't get support in a timely manner. That is one of the major things in this province (Nova Scotia). We need to have a Native detox. There are other priorities that we have but that is the first step, to get into treatment. We are losing more people, our children" (Eskasoni).

⊕ "Treatment center policies and other policies are a stumbling block. We have no detox. They have to wait for treatment and they end up relapsing. I see the same clients on a regular basis. We could have a nurse or doctor visit weekly to help clients wean off. I'm stuck. That's why the methadone is here. It is helping reduce harm. It is a drug but it is reducing crime and drug abuse. We need more help in other ways. Number one is a detox centre" (Rising Sun).

⊕ "We need a detox in the community. We need a safe house. There are well educated people here. They could watch our community members 24/7. We lose so many people in the transition period, getting them to detox is an issue. We lose people during the 2-3 week lag period. When they get home they have no support. It makes our job a lot harder" (Tobique).

Chart Thirteen: Community Education

Prevention is part of the solution. Prevention comes in the form of Education and Workshops.



*** Other includes: maternity class, suicide prevention workshop, entrepreneurship, family violence, follow-up, & career training.**

***As reported offered to clients by community members survey participants.**

Provincial Detox Programming

Different geographic areas are all struggling in their own ways to deal with the known problems with the provincial detox: "Detox needs to learn to deal with Aboriginals". "The treatment in detox is racist". "They cannot get support when they are in detox. They have to say (the worker) is family for her to get access". Given the range and depth of concerns regarding the provincial detox programs, a questionnaire was formatted particularly to attempt to gain more information about the detox programs across the Atlantic Region: How many Aboriginal clients do they serve? How many Aboriginal workers do they employ? What cultural safety training do they have for workers? Over a month long process, many phone calls were made to get contact names and to follow up to request the information. At the time of writing the report we have received no responses to the questionnaire, which is included as Appendix VI: Detox Survey. This particular issue needs immediate follow-up.

> **ACTION/TRAINING: There needs to be dedicated First Nations and Inuit beds and cultural safety training and supervision for provincial detox staff.**

Hiring First Nation and Inuit Workers in Detox

> "We are trying to get district health authority to provide support for different things. One thing we are working on is the isolation at the detox center. The district health authority is trying to hire an Aboriginal person. Because no one wants to work for the district health authority because of the taxes….so we are trying to work out where we can hire the person and they work at Detox. So we are trying to push and establish that relationship".

Taxes are not the only issue in securing Aboriginal staff at the existing Detox Centers: "We have (names 3 successive employees) but it was fighting the union and racism. The (Aboriginal) workers were positive. But that is the reality. Detox is a terrible place to work. There is a high turn over."

> **ACTION: An employment equity policy needs to be put into place and monitored to ensure that First Nation and Inuit are hired, mentored and supported to work in the provincial Detoxification systems.**

Detox and Prescription Drugs

There are limited services for detoxing from prescription drugs. Detox admissions policies restrict admission of clients on prescription drugs: "I had a client that was taking so many pills

detox would not take him. So we had to work with the doctor to lessen what they were on. Then detox would take them." As a medical informant said: "When going off anti-depressants it is best to do it with the doctor. Gradually lower the dose. There is a lot of fear. Patients are afraid to feel like they did before. Remember you have adjusted the brain chemistry. You don't want it to be quick. It will adjust itself gradually."

> **ACTION/RESEARCH/TRAINING: Accurate and current materials on detoxification from various drugs and combinations of drugs be gathered and training provided to Detox staff as well as NNADAP/NADACA workers.**

Detox and Youth

Detox for youth is also a big issue: As the Director of Charles J. said, "We have youth come in, travelling for long distances. Sometimes they are not fully detoxed, and we are not equipped to deal with the Detox." Some ANNA participants mentioned the need for youth Detox as a safety issue. Is it really having youth part of the adult population with everyone being that early in their recovery process? For others it was part of a long wish list for youth programming.

> **ACTION/TRAINING: An Aboriginal youth Detox program be developed, and in the interim, adequate training and resources be provided to Charles J. to deal with the Detoxification issues that arise with youth admitted to the program.**

Detox and Women

> **ACTION: Given the need for other women specific services, a gender based analysis should be considered when exploring the need for First Nations and Inuit Detoxification Programming.**

First Nation and Inuit Detox Center(s)

A necessary part of the *RAPC Reprofiling Workplan* (2004) is the creation of Aboriginal Detox Center(s). They conclude: **detoxification for some of our clients is a matter of life or death.**" (24)

> **ACTION: Establish a First Nation and Inuit driven and medical and non-medical detoxification program that is culturally relevant for both adults and youth.**

The existing NNADAP Policy noted in the Atlantic Region Manual stands in the way of successfully meeting this need: NNADAP is only responsible for "non-medical treatment

services: Includes post-detoxification, primary care and counseling, focused on social and cultural rehabilitation" (p. 12).

As one Director says: "I know of no Native detoxification program across the country. I think the federal government sees it as a pre-treatment phase so there is no need to be sensitive to culture…..The thing about culture not being relevant with detoxification is false. If there is Aboriginal employee, or culture they are more likely to stay longer..."

COMMUNITY-BASED WELLNESS STRATEGIES

As CHART FOURTEEN: STRATEGIES OFFERED TO CLIENTS (PAGE 118) illustrates, community members reported the most frequent strategies offered to themselves or their families are**:** 1. referral to Detox programs, doctors or therapists (61%); 2. general counselling (58%); 3. AA (53%) and 4. Sharing Circle (50%). Family and community based strategies were also discussed in ANNA processes as working well. In Labrador, mother-daughter activities and father- son and activities for the whole family are offered in land-based camps. Participants at the Moncton Gathering mentioned family resource centers as working well "even though they do not specifically address addictions, they do help families". Traditional games and activities for more interaction between families and traditional culture were also mentioned favourably by participants (Moncton Gathering, Labrador, Newfoundland, Mi'kmaw Lodge).

Across the region, community members and workers were asked to described what they think is working well to address substance abuse. The list included a combination of many types community based strategies:

- "Having an addictions/NADACA worker *in the community* helps people, and can get them into a treatment facility if they want help;
- "Support groups/self-help groups (e.g., Alcoholics Anonymous; Narcotics Anonymous) draw on *community strengths*";
- "Approaches that use traditional models help build upon *community resilience*";
- "Available medical drivers *within the community* for people to get to a detoxification facility or treatment facility"; and
- "Collaborations among service and programs *delivered within the community*";
- "As people are more mobile, *networking across* different First Nations *communities* helps address addictions/substance abuse".

Other community based strategies were offered that were at more of a tribal or organizational level. One Elder offered "Healing comes from recognition that Aboriginal people are more than band members, numbers, card carriers; we are humans." Recognition of Mi'kmaq as a Nation was mentioned by Chiefs at the NADACA meeting. Positive and committed leadership was mentioned as very important for success in addictions work in Newfoundland, New Brunswick and Nova Scotian communities, especially in terms of appointing of "appropriate people in appropriate positions." Collaboration and support for positive interventions by leadership is always appreciated (UNBI).

A community-based healing model was experienced by the Circle Works team in at the Mi'kmaw Lodge (Eskasoni) and at the Rising Sun (Eel Ground).

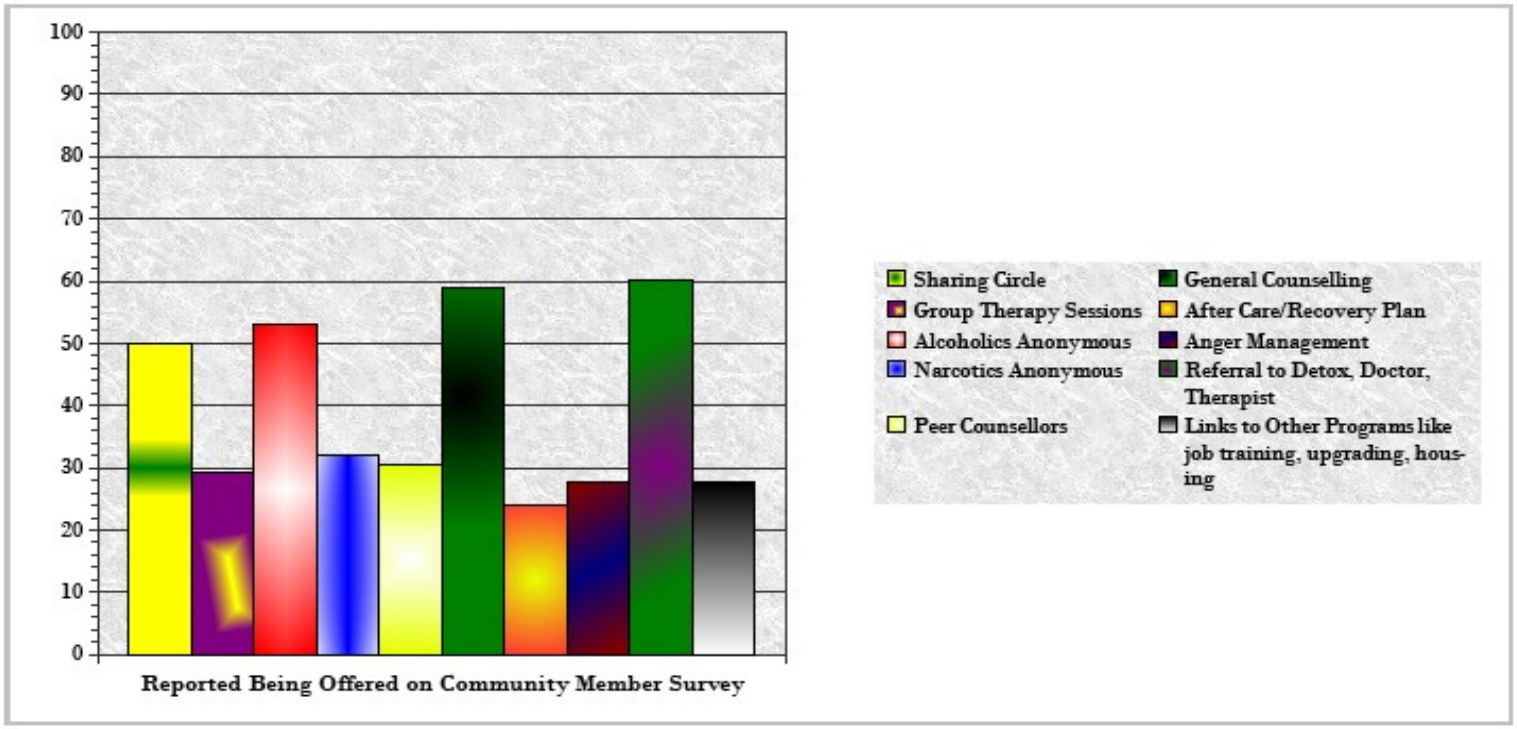
Eskasoni and Mi'kmaw Lodge

Eskasoni's story[37] is about meeting the challenges of addictions in a community with a very large population spread out over an extensive geographical area. Members of this community have generated a remarkable array of innovative prevention and intervention program partnerships within and outside of the First Nation. The following are examples of a range of addiction prevention strategies for children and youth involving numerous partners and stakeholders:

- *Moose Camp*[38] was Canada's first program of its type bridging Elders, youth, and RCMP together for positively-centered activities. In the context of a moose hunt, the youth learned cultural skills such as how to harvest traditional foods for the good of the community. This program was nominated for an RCMP award in 2004.
- *The Sunflower Project* helps youth better understand their personal life experiences by planting, growing, and harvesting sunflowers. This project was developed in partnership with Cape Breton University.
- *PATHS/Empathy Program* targets school children aged 5–11 who engage in bullying, violence, and lack of interest in school. This program was developed through the Eskasoni School Board.

Chart Fourteen: Offered Strategies

With Sharing Circle, AA, General Counselling & Referral to Detox, Doctor or Therapist being the most frequent as reported.



Eskasoni was the first Aboriginal community in the Atlantic Region carrying out multidisciplinary case management through an interagency committee. Service providers and schools are proactive in programming opportunities on behalf of children and youth, including:

- *The Ballerinas & Judo Warrior's of Eskasoni* is an initiative of the Mi'kmaw Lodge to create an environment that is friendly to youth members of the community. It has seen a turn around on how the community views the Treatment Center. As a participant at the Lodge stated "Even this building 25 years ago, it was a Treatment Center with prevention. But now it is seen as a Healing Center. It used to be called Alcatraz. 10 years ago we started reaching out to youth ….using it for Dance, Judo, Swimming program. All those things tell the kids that NADACA is a safe place you can come to and you don't have to be a drunk."

"Rising Sun Treatment Center is a place of healing" says the Miramichi Leader.[39]

"The Rising Sun Treatment Center is a good place; it has the right stuff to help people in need of help. If it wasn't for the help at treatment, my life wouldn't be the same. Now, I know it works when you make up your mind and open your eyes to see what is out there besides booze. It is a good life now, and I am happy to be sober," Dean Brooks said. Brooks, a former resident at The Rising Sun, has attained 20 years of sobriety.

"Through the years, Paul has observed numerous success stories. "We have people at different stages, but you know every person even if they have one day or one month seeking that new direction in life, that's amazing," she said. "One of the people on the poster is from the original six, the very first group, and he has 20 years of sobriety. Everyone on the poster has been successful, some are at 10, some are at 16, 17. That's not all the people. Those are not all the people by any means."

"So when we say the medicine wheel teaching," Joyce Paul explained, "It's mental, physical, spiritual, emotional and cultural. We try to touch on all that. Because the medicine wheel is a mirror of yourself… For First Nations people it seems to be reclaiming of self that has really proven successful in finding their way of life, their new alcohol and drug free life. Whatever is their way is respected. If a person wants to see a minister, priest, whatever. That's all right. Whatever makes you see the goodness in yourself."

For their 20 year anniversary, the Rising Sun profiled testimonials from several clients in recovery. Please see Appendix XI: Rising Sun Anniversary Testimonials. When visiting the Rising

Sun the warmth and dedication of the workers and the returning clients was inspiring to witness at both the youth community event and the Healing Circle.

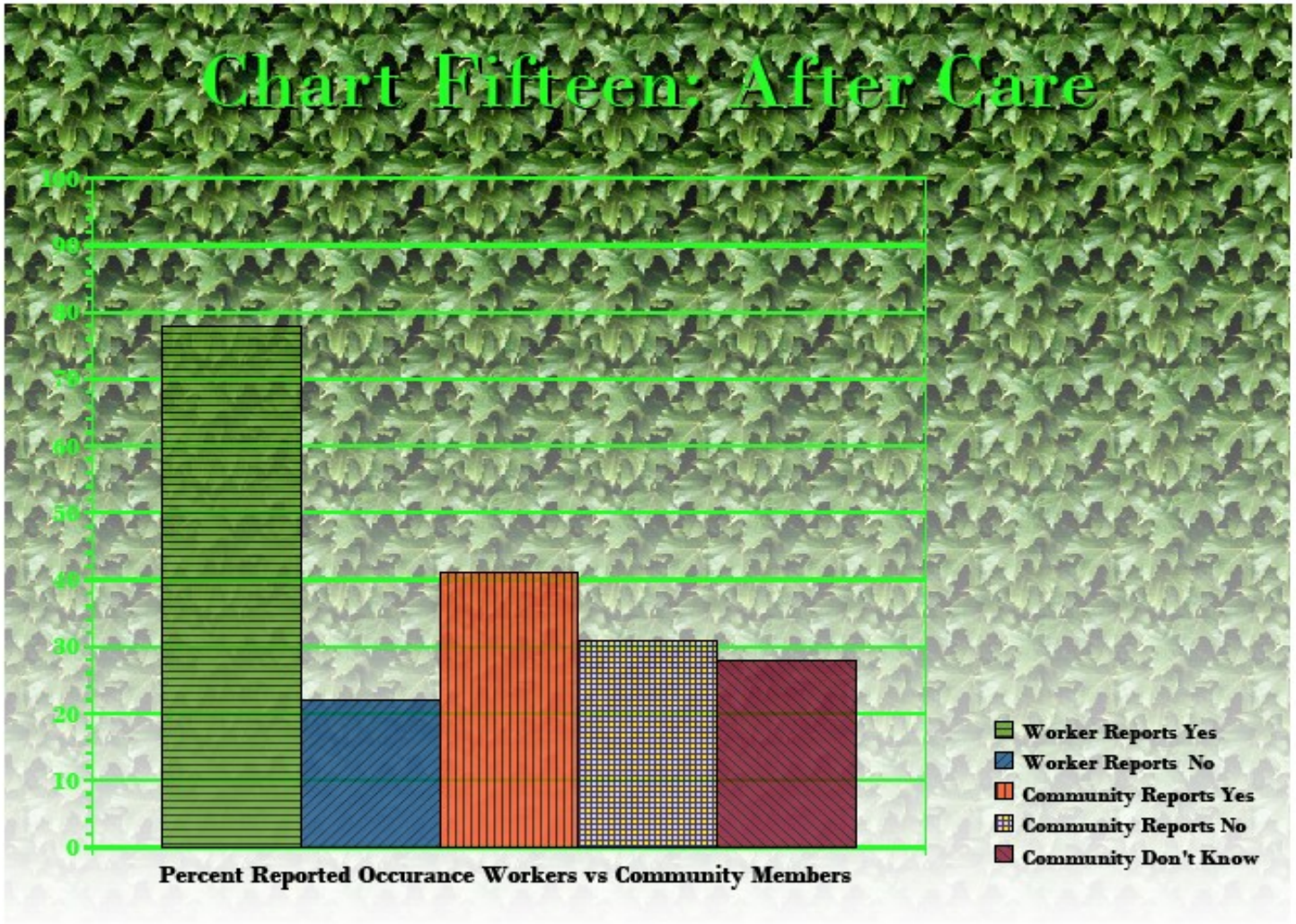
AFTERCARE

Aftercare is not just a few weeks after getting out of the Treatment Center, it is access to lifelong learning and healing aimed at maximize quality of life. As one participant stated: "Long term treatment needs long term funding". Due to lack of resources, aftercare is limited in the Atlantic Region, particularly for smaller and more isolated communities. More time and effort into aftercare is a stated priority for NADACA. "We will put more time and effort into follow-up and aftercare services so that the client is given every opportunity to stay clean" (p. 61 NADACA manual).

As CHART FIFTEEN: AFTER-CARE (PAGE 121), illustrates, while near 80% of the workers report they are providing follow-up services, nearly 60% of the community members who responded to our survey reported they follow-up was either not provided or they did not know if follow-up was provided. Issues related to after care and long term treatment were raised in all communities visited, including: long-term support especially for people who do not have the family or community support in order to maintain their sobriety; day programs for people interested in follow-up services; and the need for resource buildings so people, especially young people, can gradually re-enter home and community.

Although aftercare planning is a requirement of admission to treatment facilities according to the Atlantic NNADAP Manual, it is a large gap in service generally in the Atlantic Region. During the meeting at Rising Sun, participants commented that they were offered an aftercare program, using the Rising Sun Aftercare form[40]. Participants said that one really good model of delivery of this program was in the Eel River Bar area, "they have very few relapses", we were told.

ACTION: Further exploration of Eel River Bar aftercare as an innovative practice is recommended.



CHAPTER NINE: COLLABORATION

In the AFN (Gaps, 2006a), the lack of a coordinated approach resulting in communities not feeling well connected with each other was identified by an Atlantic participant. They stressed that more communication and collaboration needs to occur amongst communities. Health Canada has recommended the collaboration of First Nations community leaders, health professionals, government and law enforcement agencies in the development of prevention frameworks. There is a need to address the broad determinants of health, such as poverty, in order to have an impact on substance issues. The RHS data (AFN 2007) also indicate that a higher proportion of those seeking treatment had a medical condition, which suggests that a continuum of services is needed, including links with health providers within the treatment setting.

As CHART SIXTEEN: COLLABORATION (PAGE 124) illustrates, the majority of ANNA workers frequently collaborated with: child welfare (91%); corrections (89%); Community Health Workers (89%); Health Centers (84%); Doctors (81%); NADACA/NNADAP workers (80%); RCMP (80%; and Detox (80%). Most indicated a positive relationship with the various collaborators.

INTERAGENCY COLLABORATION

Working together for change within our communities is not only a traditional practice, it is the only way that healing will happen. Participants in the ANNA processes addressed specific issues that an inter-agency collaboration could help address:

Common Clients

⊕ Shared responsibility for supporting people who are seeking help can help address client issues in a holistic way. As a doctor at the Moncton Health Conference reminded us: “We are not experts in everything”.

⊕ A team approach helps to facilitate referral process and ease the transition from one service to another.

Case-specific issues

Collaboration between helpers within the community can provide people in need with more supports, including:

⊕ Counselling for people who have not quite admitted that they have a problem;
⊕ Social workers and elders and youth working together;
⊕ Bridging the gap for obtaining all of the services a particular client might need

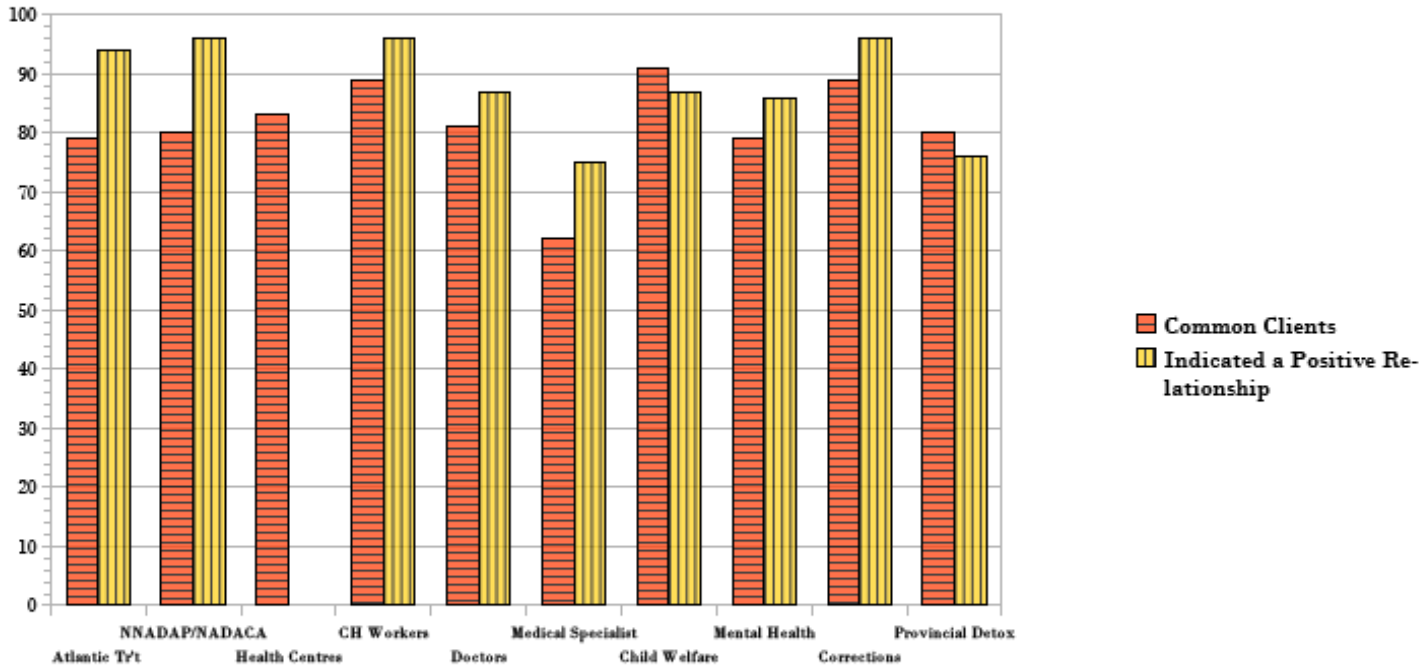
Interagency teams

ANNA participants spoke highly about interagency teams. "there is a need for regional agency meetings to assess what we have, what we need and what we can do". Other benefits include:

⊕ Community and inter-agency collaboration for events, intramurals, after school activities, contests around drugs and alcohol, e.g., making movies on addictions as was witnessed in Eskasoni, Eel Ground, and Elsipogotog;
⊕ Information systems are being used in some communities, like Elsipogtog and Eel Ground, and NADACA to connect communities and agencies e.g., databases/services/resource websites, with dedicated support so they can be constantly updated;
⊕ In Labrador and Newfoundland particular issues were identified that were specific to the area due to geographic isolation, including more recognition of extra resources needed to pursue working relationships with other communities and regional agencies.
⊕ Interagency collaboration would be required to operate a culturally-appropriate Atlantic-wide crisis line via telephone and Internet, including interagency collaboration for referrals, ie. training young people to respond to crisis calls (telephone and Internet).

ACTION: That the feasibility of a culturally-appropriate Atlantic-wide crisis line be explored.

Chart Sixteen: Worker Collaboration (In Percent)



Service-management can be supported by collaboration:

⊕ Collaboration across sectors can help with service management issues for groups of underserved clients. Several participants stated that they would like to see more of this, particularly with the use of methadone harm reduction programs (Rising Sun, UNBI).

⊕ Collaboration can help to resolved some of the structural issues impacting on community members. One example is in the case of physicians' misdiagnosis of client problem and over prescribing. As a doctor at the Moncton Health Conference stated, "I know in the First Nations communities that benzos are a serious problem. There is no excuse for that behaviour. If you can bring that to the health director or physician's attention then that is great".

⊕ Conne River, MCPEI, Elsipogtog Health Center, and Natuashish Healing Lodge provide a team approach of services and program in one building, including mental health and addictions workers; a justice program, regular relationship with the provincial health care system and the RCMP.

> **ACTION: Each of these four locations could be further explored as models of innovation regarding positive collaboration.**

Some find that collaboration can support more **Community-based Events:**

⊕ Social gatherings can help people heal relationships in the community (Mi'kmaw Lodge);

⊕ There is a need to strengthen connections between parent and child by providing parents with strong supports from the community (Moncton Gathering);

⊕ Working together workers can plan more social interactions in the community e.g., more powwows and family-oriented events. As one participant stated, "We need to bring back old ways, more interaction with elders, community events – enhance the social aspect" (Moncton Gathering);

⊕ More community-based resources and independent services to be effective and provide help to people in their own communities and therefore help the community (Tobique, Labrador);

Creating Partnerships is another form of collaboration mentioned by ANNA participants:

⊕ School Counselors were listed as positive partners, and responsibility for community knowledge and initiatives can be shared with mainstream systems such as provincial schools (Rising Sun, Eskasoni, Elsipogtog).

⊕ Support for community initiatives can also come from agencies such as the police. RCMP can host and participate in community addictions events, as well as in control of substances (Labrador, Burnt Church, Elsipogtog, Mi'kmaw Lodge, Kingsclear).

⊕ Transition Houses partner with Child and Family Services in First Nations to offer programs to women who have been abused by their partners (Gignoo House), and with

Lennox Island health and employment services (Chief Mary Bernard Memorial Women's Shelter)

⊕ Partnerships can happen between community and university, like: the Family Good Decision Making Project in Labrador; and the AAHRP with Dalhousie, NADACA and RAPC for Atlantic-wide training events.

⊕ Many of the recently funding Transition projects in Atlantic Canada, including the SONG project, are partnerships.

⊕ Partnerships with local pharmacists, particularly FNIH pharmacists was listed as a positive illustration of collaboration.

⊕ People working on Residential School Projects are seen as positive partners with addictions programs (Indianbrook, Eskasoni).

⊕ Provincial Mental Health and Regional Hospitals were cited as positive illustrations of collaboration (Cape Breton, PEI).

⊕ Crisis Intervention Teams are seen as positive outcomes of collaborations in Indianbrook and Elsipogtog.

⊕ Other collaborators identified by ANNA participants included: traditional caregivers, Addiction Services Boards of Directors, First Nation Chiefs, NNAPF, Mi'kmaq Confederacy, youth programs, church ministers, and crisis centers.

NADACA: Native Alcohol & Drug Abuse Counselling Association of Nova Scotia

NADACA is the only provincial addictions treatment and counseling agency in the Atlantic Region, and more importantly the only one in Canada. According to some ANNA participants, every province in the Atlantic Region should have a similar "agency-community-type partnership". According some National participants, every province in Canada should have one.

Administered by an Executive Director, NADACA is overseen by a Council of all Chiefs of the 11 Nova Scotia First Nations served. NADACA creates policy, oversees practice and administers funds for two treatment centers: Mi'kmaw Lodge (Eskasoni) and Eagle's Nest (Indianbrook), and has counsellors located in each of the communities it serves:

The NADACA Manual provides a statement of purpose: "Fighting substance abuse is an uphill battle that the communities cannot win alone, and they have banded together to form the Native Alcohol & Drug Abuse Counselling Association of Nova Scotia. So, instead of the individual First Nation communities trying to solve substance abuse issues, the leaders have come together to develop policies and programs to attack substance abuse problems on both a Provincial and community level. These leaders have mandated NADACA to deliver these programs to the communities".

According to NADACA materials, "Currently, the resources of the NADACA are stretched to the limit, and these counsellors must deal with a myriad of substance abuse problems. Our counselors often face overwhelming obstacles, from the community, from the client, and from the client's family. Work in the field is hard, often frustrating and disappointing, but more often than not, very satisfying."

In addition, the organization administers the RAPC (Regional Addictions Partnership Committee); collaborates to host Atlantic wide training initiatives; offers an off-reserve counselor in down-town Halifax; hosts a solvent abuse prevention program, a program for Residential School Survivors, a Youth Program, and many Prevention services.

NADACA received rave reviews for the "sensitive and supportive partnership between NADACA (which brings its expertise and support to the communities) and community-delivered programs." The NADACA family has been a home and training ground for many new workers from all over the Atlantic Region, and thanks to NADACA (and lack of wage parity) many child welfare, women's transition and justice workers have solid training in addictions. NADACA has also experienced divisions due to financial restraints and particular treatment center policies. Once 13 communities, NADACA now represents 11.

Information on NADACA is interspersed throughout this report, and is available in their comprehensive Policy and Procedure Manual. The NADACA web site, www.nadaca.ca as well as ones for the two treatment centers, www.mikmawlodge.ca and www.eaglesnestrecovery.ca are informative.

> **ACTION: That the NADACA model, that provincial wide organizations to support, advocate, and train First Nations and Inuit workers, as well as collaborate on best use of available funds be explored for the Atlantic Region overall.**

OTHER EXAMPLES OF COLLABORATION

Critical Incident Stress Management Team: Indian Brook First Nation

The program provides debriefing or stress management 24 hours after the incident. It uses a comprehensive approach to the reduction and control of harmful aspects of stress in emergency services. Team Members included Wellness Coordinator, Social Work Coordinator;

Justice Coordinator, and 12 community members trained in the model. Team Support: The group provides individuals with the opportunity to discuss their thoughts and emotions about a distressing event in a controlled, structured, and rational manner. The program provides community members with the opportunity to see that they are not alone with their reactions.

Health and Wellness Center. Elsipogtog Health and Wellness Centre believes in the promotion and provision of holistic health and wellness services. List of services provided includes: community health services/wellness; home and community care program; public health protection; mental health and addictions; Aboriginal justice; crisis management; and FASD—prevention, diagnosis and intervention programs. Includes the Elsipogotog Crisis Center, established in 1992, provides crisis intervention, stabilization, referral, support and after care services, 24 hours a day, seven days a week. In *Elsipogtogeoei Community Newspaper:*

> *"Health programs and services are carefully organized so that staff members can work as teams to achieve common goals. As well there is a lot of communication and team building between groups—this helps to provide a full range of care for community members who have health needs in multiple areas. A good example of this is the link between teams that deal with addictions and their efforts."* August 2008.

Telemental Health and Teleaddictions Partnership Project*: Mawi Wolakomiksultine: Together, Let's have Good, Healthy Minds.* This project uses tele-health technologies to deliver Mental Health and Addictions services. It represents a first step in the development of an integrated telemental health and teleaddictions service delivery models among River Valley Health (RVH) facilities, five First Nation communities in Health Region 3, and all Community Mental Health Centres in Health Region 3. The project will position RVH and its project partners for interregional, interprovincial and national linkages Telehealth was adopted to improve mental health and addiction service delivery.

Elsipogtog takes a stand against the drug trade[41] is an example of one community's collaborative work between the Chief, Band Council, Elders and Police to halt drug abuse. They want to banish a non-native man from Elsipogtog on the grounds that he has been dealing drugs to its young people. Many residents are in support, including many elders and the band

council, as part of a larger campaign to send a message of zero tolerance toward drug trafficking and abuse. The commander of the Elsipogtog RCMP detachment, Sgt. Craig York, said Wednesday's drug raid was the fourteenth conducted since last April. The work of a wellness committee, which brings together police, band council, and service providers, and community members, is being credited with providing new hope. "People are really sick of it. Now we are hearing the voices because they know we are behind it," said Chief Simon

According to ANNA participants, similar collaborations resulting in crack downs on drug dealers are currently underway in Eskasoni and Burnt Church.

Cross-Jurisdictional collaboration is probably the most difficult.

Addiction Services offices are located throughout the Atlantic Region. Some First Nations and Inuit communities will refer to provincial services because of lack of availability of First Nations and Inuit-based treatment locally and the proximity of non-Aboriginal services (Labrador, Newfoundland, PEI). Some First Nations and Inuit communities refer to provincial youth facilities for the same reason; they are closer in proximity than Charles J. in Labrador. Two provincial youth facilities exist in the Atlantic Region, Portage Atlantic in New Brunswick, and IWK Choices in Nova Scotia. ANNA participants described them being very limited in terms of First Nations and Inuit programming or staffing for the First Nations and Inuit youth clients they serve. Due to time and resources, we did not visit either facility.

STRUGGLES IN COLLABORATION

Participants in the ANNA processes provided insight into the struggles of interagency collaboration. Some of these include: busy schedules; inter-agency meetings are almost impossible; there is a lack of information and lack of funding for collaboration: “Sometimes it is a question of who will coordinate inter-agency meetings? People burn-out if there are not enough resources, and the same few constantly have to make the meetings happen” (Eskasoni).

Other critical issues about collaboration were raised by ANNA participants:

- ⊕ Some participants spoke about the need to find a positive and supportive way to do pass on knowledge within and between agencies (Indianbrook, Moncton Gathering)
- ⊕ Jurisdictional battles about who owns “the problem” needs to be addressed and this will facilitate supporting community-based initiatives (Eskasoni)

⊕ Confidentiality issues were addressed by some participants. Some make use of filing systems with client information in one binder, secured in a locked filing cabinet. Some are concerned about security clearance required for viewing by different professionals (Labrador, Charles J.)

Some expressed problems with jurisdictional issues and agency rules: "We have asked addictions workers to come to sentencing circles and they are not allowed. No collaboration with addictions….it does not seem to be the workers, but the rules". Some expressed concerns in trying to collaborate with Child Welfare authorities: "We are not doing enough for the kids. The kids can be helped if they are caught early enough. Once a child is in care, I don't know why they are not taking more effort to diagnose."

A few ANNA participants recorded struggles in trying to collaborate with NNADAP services. These included: waiting times; rehab is only offered at certain times of the year or month; "it is hard to reach the client." Several participants mentioned the lack of services for people with methadone addictions. Issues specific to NNADAP will be discussed in more detail in the next Section.

Collaborations with non-Aboriginal providers and services produce even more struggles. Racism was raised by a number of participants as an obstacle when moving towards a collaborative model between First Nations and Inuit and non-Aboriginal service providers. Participants frequently discussed off reserve treatment isolation: "When we have a client that goes to off reserve treatment, it seems like they don't succeed because they are lonely, isolated, not understood, and racism. …When we have a client that goes to non Aboriginal treatment centres they seem to drop out." Some expressed this as "a lack of sensitivity to Aboriginal clients," and "a lack of communication". Question 70 asked workers to identify policies and procedures that discouraged a treatment path, and the lack of connection between Detox and Treatment programs was written in several times. Lack of working partnerships between detoxification programs and rehabilitation programs was also identified in several ANNA meetings, by addictions workers, community workers and by community members. These reports reinforce the need for cultural safety training for all providers, including provincial Detox and addictions workers.

ACTION/TRAINING: That cultural safety training be mandatory for all service providers, and in particular, provincial Detox and addictions programs.

SECTION FOUR: CHANGE: CHALLENGING POLICIES AND PROCEDURES

"It should be recognized that investing in the reconstruction of Indigenous society through traditionally based governance structures, customary land ownership and internal reconciliation and healing are critical to ensuring social cohesion through the interconnected obligations and responsibilities on which Indigenous societies are based. The recognition, respect and resourcing of Indigenous authority by the dominant society is fundamental to dealing with the scourge of grog and drugs that have caused such incomprehensible damage to Indigenous communities" (Dodson in Altman and Hickson 200:. 23-24).

CHAPTER TEN: JURISDICTION, FUNDING AND AUTONOMY

Jurisdiction: Federal. Provincial. Regional. Tribal.

As the Atlantic RAPC (2004) has noted, "The infrastructures of federalism often leave Indigenous populations in a vacuum between National and Provincial approaches to financing governance and the delivery of services and programs". A recommendation related to jurisdictional responsibilities emerged as a high priority in *Exploring Health Priorities* (2008):

> *"While many First Nations communities may not identify jurisdictional difficulties as one of the main health priorities, many of the unresolved issues associated with funding and responsibility are preventing progress in other much needed areas such as health promotion and protection, access to primary health care services and chronic disease management."* (Health System Web Survey Participant).

One addictions priority for many participants in ANNA processes that is obviously hindered by jurisdictional boundaries, is the lack of First Nations and Inuit Detox. Many participants ask

the question: "Why can't we get a detox?" Some know the answer: "I think the federal government has been resistant to this; it is easy to say it is a provincial jurisdiction."

> **ACTION. National: A process to resolve issues of jurisdictional responsibilities at the provincial, First Nations and federal levels.**
>
> **ACTION. Regional and/or TC: At least one First Nations and Inuit specific Detox Center in the Atlantic Region, or alternatively some detox beds assigned to each Treatment Center, with resources to staff them.**

Funding is Federal, or is it?

According to the AFN report on public health (2006), it is problematic that a considerable portion of funding for First Nations and Inuit health and addictions promotion/prevention efforts is provided through "targeted funds". They conclude: "a public health system is a long term agenda, it does not compete on a yearly basis for new funds". ANNA participants noted that in order to get funding, communities are required to do way too much for way too little. As one ANNA participant stated "long term programs require long term funding."

All stakeholders in the NNADAP Environmental Scan (2005) cited funding as the greatest limitation faced regarding staff training, staff certification and meeting the service delivery needs of clients. In the conclusions of the *Exploring Health Priorities* Report (2008), stable funding for addictions and substance abuse workers and programming was listed as a priority:

> **ACTION: Stable funding and resources should be in place to support the important role that NADACA workers are playing to address addictions/substance abuse issues in First Nation communities in Nova Scotia. This request for stable funding needs to be extended to NNADAP in the Atlantic Region.**

In the Atlantic Region in particular, funding is a constraining factor in the organizational success of the program. Due to lack of resources, prevention, Detox, treatment and aftercare are all limited in the Atlantic Region. As one participant at the Moncton Gathering stated: "Everything is based on funding… it is hard to plan for something when there are not enough resources."

ACTION: MORE MONEY, MORE LONG-TERM MONEY

Lack of adequate funding for addictions programs is in part due to not being able to access information about available funding sources, in part because of the funding arrangements, and in part due to federal fiscal reduction, as NNADAP has had no incremental increases for several years. Most government funding policies are geared toward transfer, if not self government arrangements, so funding formulas have to be sensitive to the diversity of developmental stages within the region. According to the RAPC Workplan (2004), "A prime example of this is the *translation services and transportation restrictions* experienced in Labrador and the requirement of greater treatment services for the Maliseet First Nation (p. 14)."

ACTION: A review of the funding formula based on the geographical logistics and cultural landscape of four provinces within the Atlantic Region is essential.

AUTONOMY REQUIRES CAPACITY BUILDING

Capacity building is recognized as a key issue for NNADAP in Atlantic Canada by all parties, including Health Canada; the National Native Addictions Partnership Foundation (NNAPF); the Atlantic Partnership Group, NADACA, as well as workers and community members. According to the Assembly of First Nations (2006), "Wage disparities, lack of training, little support to communities and the overall social and economic disadvantages faced by First Nations have contributed to the lack of capacity".

ACTION/TRAINING: Capacity building address issues of wage disparity, training, community support, and the social and economic disadvantages faced by First Nations and Inuit.

A coordinated approach

In the AFN gaps paper (2006a), lack of a coordinated approach in service delivery was identified as a national issue. One Atlantic participant in the AFN process noted that communities do not feel well connected with each other. More communication and collaboration needs to occur amongst Atlantic communities.

One recommendation in the RAPC Workplan (2004) was to establish a common set of working policies for NNADAP services in the Atlantic Region, and this has been done. This policy manual has been reviewed and some analysis of that will be provided. Further, in Nova Scotia specifically, the NADACA organization also has a policy and practices manual, and these policies

have also been reviewed. Although a policy manual now exists for NNADAP-Atlantic region and for NADACA, ANNA participants talked about the need to implement fair and equitable policies to address issues such as hiring, training, remuneration, worker benefits, and recruitment. Participants in several communities felt that personnel policies should be developed for consistency across the Atlantic Region, and to help new staff.

ACTION: RAPC continue to be consulted with and provided resources as a coordinating body for renewal and reprofiling initiatives in the Atlantic Region.

Organizational Structure: RAPC/NADACA

One major capacity building issue in the 2004 plan was to stabilize the Atlantic Partnership Group and to have it administered by one of the Atlantic Partners rather than FNIH: "the Atlantic Group is critical in fulfilling the roles and responsibilities of the renewal and reprofiling process in order to effectively assist in the healing and strengthening of our communities as we reclaim our journey to successful self determinations" (p. 10). Funding has been provided for NADACA to take over the RAPC as requested, and work is ongoing to continue to ensure that the priorities are driven by the working group and not by FNIH. Goals related to the RAPC are: "to formalize and develop a communication and networking strategy between treatment centers, prevention and treatment, and between stakeholders including assessment, referral and reporting mechanisms" (p. 21) and "to organize and secure funding for annual conferences in efforts to support training and research, best practices, and communication/networking initiatives" (p. 22). NADACA also contributes significantly to a coordinated Atlantic approach to addictions, and identifies current networking priorities as provincial and regional in their Manual.

According to the Atlantic Region NNADAP Policy Manual the Atlantic Regional Addictions Partnership Committee is made up of 4 members from New Brunswick, 2 members from Nova Scotia, 1 from NFLD, 2 members from Labrador (one Inuit and one Innu) and 1 member FNIH (the Regional Consultant). ANNA participants expressed concern over the lack of members from PEI, and this issue was rectified in April of 2009 by adding a PEI member to the RAPC.

As NADACA is the organization empowered to administer the RAPC, as well as to deliver NNADAP services and the Journey of Healing Program for Nova Scotia, it is a primary force for

policy development and implementation in the Atlantic Region. Given the current structure of reporting authority, the Executive Director of NADACA is perceived by ANNA participants as wielding significant amount of power.

For example in Appendix 5 of the NADACA Policy and Procedures Manual, "The Executive Director shall have the sole authority to initiate dismissal actions against employees. Any employee who feels he/she has been unjustly treated shall have the right to file a grievance with that policy" (p. 8). The Grievance Procedure states that any employee, who feel he/she has been unjustly treated shall have the right to file a grievance with the Executive Director of the Association…and then with the Executive Board of the Association. The decision of the Executive Board shall be considered final. This same process is in place regarding Dispute Resolution and Appeal Guidelines. While on the surface these policies appear in line with policies of other organizations, in reality this is a fairly small group of interrelated people, so it is difficult for those who find themselves in conflict with the governing body to feel that there is an impartial venue to have their concerns heard.

The statement in the Atlantic NNADAP Code of Ethics for workers "8. Respect institutional policies and procedures and cooperate in any agency management with which I may be associated" (p. 17) may contribute to some participants feelings that expression of differences of opinion on policies and procedures are not necessarily welcomed.

NADACA Advisory Board:

While other specialized programs, associated with NADACA, like the Journey of Healing, do retain an advisory board, NADACA, as an Agency, does not utilize an advisory board because the Board of Directors (Chiefs), serve in that capacity. Advisory boards are often made up of a general cross section of persons from the First Nations and Inuit community, including elders, youth, and women, as well as others from the community. In addition, community-based Advisory Groups have the advantage of being somewhat arms length from both the service delivery systems and the political systems.

There were some concerns expressed in the communities served by NADACA that there is nowhere to turn with grievances against the organization by either staff or regarding client

treatment, especially if directors or political authorities are implicated. Perceived conflict of interest regarding councils and boards were raised in communities in both New Brunswick and Nova Scotia.

> **ACTION: An independent community-based or Atlantic association, ombudsperson or grievance officer position, be created to mediate concerns by staff, clients and community members involved with NNADAP/NADACA services.**

ACCREDITATION AND CERTIFICATION: Accounting to Who, for What?

The NNADAP Renewal document states: "The transfer and self-government development process raises the issue of which organization and which process is used to implement standards, information systems, and program evaluation." Accountability for a professional field of practice will generally rest with a governing body familiar with the practice, rather than a political body. Can the ways and means of insuring program integrity and sustainability for all program elements, i.e. for training, promotion, prevention, treatment, and rehabilitation be transferred to First Nation and Inuit governments, and if so, how and when? If responsibilities are to be transferred to the Nations, then where is the mounting pressure for accreditation and certification arising from? One Elder challenged: "Accreditation needs to be on the grounds of what we know as Aboriginal people…Do we measure our success from Western eyes or through Aboriginal eyes?"

> **ACTION/TRAINING: That a training institute built on the knowledge and practice of key members of the Atlantic addictions networks be developed and used as a springboard for certification and accreditation based on criteria relevant to practice within First Nations and Inuit communities in the Atlantic Region**

Accreditation

One AFN (Gaps, 2006a) identified gap in adequate funding formulas is the need for support to communities wishing to become accredited for health service delivery. In the 2005 Environmental Scan of NNADAP Affiliated Treatment Centers, ongoing pressure towards accreditation without commitment of resources was a major issue expressed. "With regards to accreditation, incentives must be provided for achieving accreditation…the region is working with CCHSA to have centres accredited due to the fact that it is a requirement tied to funding

and the treatment centres are concerned about the loss of funding should they fail to meet this requirement." This was affirmed at the March meeting of the Partnership Committee.

Accreditation Canada, in their introduction to their Program for Aboriginal Health Services, state: "Our Aboriginal health services standards for Addiction Services and Community Health Services are culturally relevant, having been developed by Aboriginal representatives for Aboriginal communities." A quick scan of the required organizational practices reveals that all materials and categories are set up exclusively on a Western medical approach to health. There is no inclusion of anything specific to First Nations and Inuit philosophies or practices. We particularly note the column named "Culture" has nothing to say about cultural inclusivity, language or beliefs, but rather focuses exclusively on the "culture" of client safety.

The benefits of accreditation, listed on their brochure, include: "promotes a culture of client safety; encourages the transfer of knowledge; provides consistency in evidence-based practice; enhances the use of indicators". On the surface, these ideals can appear universal. How will culture knowledge be suppressed to meet the requirement of "a culture of client safety", and who's knowledge will be transferred in the process. Consistency in evidence-based practice currently does not create space for leading practices outside of the scientific model. An AFN (2006) identified funding formula gap that appears relevant in this case is the use of performance indicators that are irrelevant to First Nations community planning.

In addition to cultural questions, the established process is lengthy—three years, and then has to be continuously renewed. RAPC members at the March meeting expressed a concern that this will require ongoing staff commitment of time and resources, when most Centers are understaffed and overworked. As long as the cultural and financial contradictions outweigh the perceived benefits, accreditation will be continue to be a process driven by FNIH. Another relevant gap identified by AFN is the lack of efficient and transparent mechanisms for dispute resolution.

> **ACTION (Accreditation): Require organizational practices with Accreditation Canada be rewritten to eliminate exclusively Western medical approach to health, and include materials, practices and categories specific to Aboriginal philosophies and practices. All pressures towards accreditation by Health Canada should cease until this is completed.**

Staff Certification

Staff Certification and Standardization was also identified as a pressing Atlantic issue in the 2005 Environmental Scan, noting that nationally, in some regions, close to eighty percent of staff have been certified, while in others, none of the staff is currently certified. Certification requires a specific amount of training. Each of the certification organizations (Canadian Council of Professional Certification-CCPC and Canadian Addictions Counselors Certification Federation-CACCF) have accredited relatively few courses towards certification, and accredited training courses are often concentrated in urban areas and are not readily available across regions. "For example, the CCPC works with three training institutions and all of these are in the Alberta region" (p. 12).

In part due to the lack of training institutes, the certification process is moving forward slowly in the Atlantic region. The 2005 Scan reported: "All centres in the Atlantic region are governed by Contribution Agreements and there is nothing these agreements that states that the band councils have to hire certified staff…The biggest problem is attracting and retaining certified staff. There is no funding for salary increases and there are no salary guidelines for the centres. Only two Regional NNADAP funded centres, affiliated with the Native Addictions and Drug Association (NADACA), maintain standardized staffing standards (i.e. job descriptions and certification requirements) and salaries."

A total of 29 workers have been certified to date. CACCF has awarded the designation of (ICADC) Internationally Certified Alcohol & Drug Counselors to eleven (11) NADACA staff, one from Natuashish (now back in Nova Scotia). According to the NADACA Policy manual, "the vast majority of our prevention and treatment staff have profession certification; some have BSW degrees" (p. 46). Seventeen workers have been certified through the Canadian Council of Professional Certification (CCPC), thirteen in New Brunswick and 4 in Nova Scotia.

A major question we identified when reviewing the certification requirements, is the lack of inclusion of First Nations and Inuit culturally specific counseling courses or materials in the programs. Currently, people can become certified to provide services as an addictions counselor in a First Nations and Inuit Treatment facility or prevention program with no material

or background on First Nations and Inuit history, philosophies or counseling strategies. Likewise, First Nations and Inuit counselors receive no credit for experience or training in First Nations and Inuit methods. This gap in the certification process does not support the vision of addictions programming that would incorporate First Nations and Inuit healing methods, or promote cultural safety.

In the Canadian Drug Strategy: Work Plan Recommendations (2005) for the Atlantic Region it is noted that "there is a wealth of applied knowledge already in use in many NNADAP affiliated centers that can be shared internally" (p. 40). Given the longstanding practice experience of the majority of RAPC members, and other identified role models, the potential for them to function as key members in a knowledge network is great, but remains virtually untapped.

ACTION (Certification): Certification requirements require review as there is a lack of inclusion of Aboriginal culturally specific counseling courses or materials in the programs. That a Certification body for Aboriginal counselors independent of existing bodies be actively pursued.

CHAPTER ELEVEN: ATLANTIC ADDICTIONS WORKFORCE PRIORITIES

An issue that arose during the Atlantic focus group on public health hosted by AFN (2006) was the lack of health human resources. The Nunatsiavut addictions review report discusses the creation of a sustainable workforce "that understands the nuances of rural, remote communities while respecting their culture" as a pressing need. That sustainable workforce must be knowledgeable and skilled in providing a comprehensive range of addictions services

that are culturally appropriate" (Mayo Consulting 2008). Most ANNA participants agreed that there needs to be more dedicated health resources, confirming what was earlier pointed out in an environmental scan conducted by NNADAP in 2005.

Staff shortages

The number one workforce priority for many ANNA participants was the need for more staff – more staff to operate the current programs – many are currently working at the "burnout" level and more staff are needed to deliver much needed programs. Overwork was mentioned by many participants. As one participant stated: "This tells us that more human resources are needed – resources that come from within the community. Not from outside experts." Program Directors all agree: "More funding is required programs and for staff, especially First Nations and Inuit staff who are properly trained."

In Nova Scotia, NADACA continues to experience staffing shortages. "Staffing levels at the two treatment centers are barely adequate to fill minimum needs in most cases. Treatment is a 24-hour-a-day operation and, while our, daytime programming is second to none, after hours programs are limited by staff shortages and scheduling problems. In order to overcome some of these problems we turn to part-time staff to assist. These staff, however, are not well trained and must work under the guidance of a trained counsellor. NADACA has lived with this problem for many years and will, no doubt, continue to do so because of the limited funding" (NADACA policy manual). As one participant confirmed: "On night shift, ideally you should have two people, but we don't have those luxuries."

> **ACTION/TRAINING: More staff are required to operate the current programs. Accessible and culturally relevant training opportunities are urgently needed to increase the number of qualified First Nations and Inuit addictions counselors. Recruitment policies are needed for Northern remote communities.**

Attraction and Retention of Staff

In the NNADAP National Training and Staffing Status Report (2005), attraction and retention of qualified workers for First Nations and Inuit addictions programs was identified as a priority for the NNADAP. High turnover of staff are coupled with the challenges of recruitment and retention directly related to low salary levels and highly demanding work. As indicated in the NNADAP review summary, "many perceive that the NNADAP program serves simply as a

training ground or stepping stone for other opportunities." Due to lack of accessible and culturally relevant training opportunities, there remains an insufficient number of qualified First Nations and Inuit addictions counselors. Labrador participants stressed that recruitment policies are needed for Northern remote communities. As the evaluations of the LICHS noted "Not enough has been done to train Innu in the field of social work, addictions and mental health, the evaluators say, yet these skills are necessary since it's difficult to attract qualified outsiders to these communities" (as reported in the The Toronto Star (2006). [42]

Rather than hiring non-First Nations and Inuit professionals from outside the community or nation, sometimes First Nations and Inuit are hired because of their knowledge of local cultural practices and kinship systems, fluency in their own language and a commitment to alcohol and drug work (often gained through personal history as alcohol and drug clients in the past). Like other regions across Canada, "employers are in a predicament whereby they need to get the 'best possible' worker/counselor and then rely on further in-house training and coaching to get employees "up to speed" (p. 19). Labrador expressed their version of this dilemma: "A good model if the community hires a non-Aboriginal they sign a contract, the community then works to find someone who is Aboriginal to take their place and train them."

While organizations like NADACA and the RAPC have done excellent work in creating an infrastructure to support the capacity building of workers, understaffing, wage parity, lack of training institutes remain chronic sore spots that have been addressed in many previous meetings and submissions. Addictions workers in particular are underpaid, under-resourced, and under-supported for the difficult work that they are undertaking. They are regularly expected to provide service and after-hours prevention and crisis management, well beyond what is humanly possible, with few opportunities to debrief or engage in ongoing self-care.

These issues are linked to funding cuts and lack of service providers in other related areas, including mental health and crisis intervention. In some communities, crisis management has become a second full time unpaid job. A one Cape Breton workers states: "We are on call all the time ...weekends and evenings. If we get called we respond and there is no pay for this extra work: it is volunteer work". A worker from New Brunswick agrees: "We do more than we are mandated for. We don't say no. There have to be detox trips, suicide attempts".

ACTION: Personnel policies developed for consistency across the Atlantic Region, and to help new staff. Policies should be reviewed for a gender-based analysis and to be in keeping with aboriginal views of egalitarian decision making and self-determination.

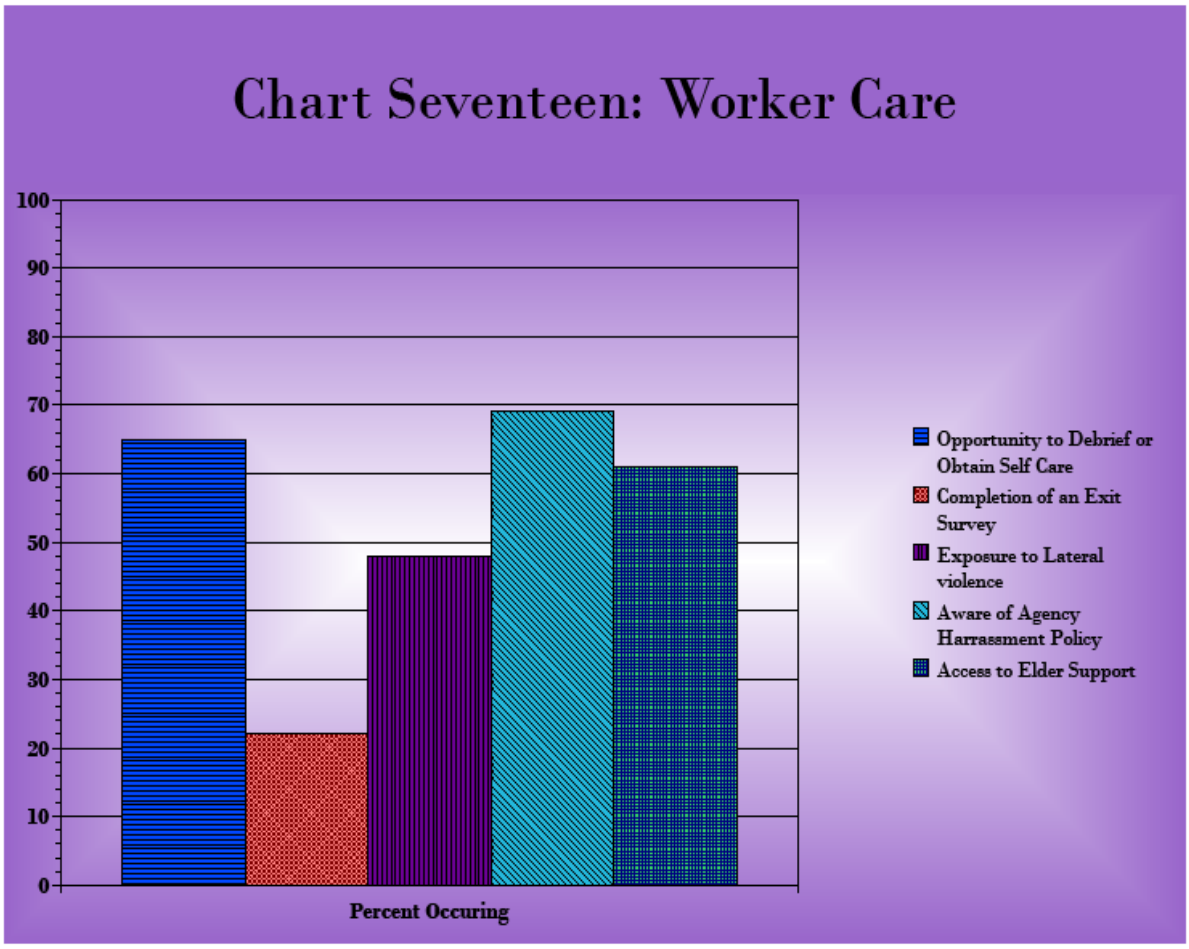
CARE FOR THE CAREGIVER

As aptly noted in Nunatsiavut's report (2008), processes are needed to support employees. "Such processes may assist in keeping employees healthy by reducing incidences of burnout, addressing the potential for experiencing vicarious trauma, and supporting positive coping skill development. It may result in increased employee retention and positive working environments".

Throughout the ANNA processes, Treatment Directors and workers expressed a common voice--self care for workers is a necessity: Burnout is a problem in communities; front-line workers need self-care for workers, debriefing, spaces to vent their frustrations; some workers may have had addictions and there are times when they may need support; the positions are high stress and addictions workers need to be careful with their own health. See Chart Seventeen: Worker Care (page 144)

As one ANNA participant stated, "We need to look after our workers. They are not here for the money. If you look provincially, there are two people hired to do the same amount of work as me. ...I think we need to be healthy before we can provide services to the clients. If I am on the phone all night with someone, and I am late or out the next day, then don't mark me sick".

The NNADAP Atlantic Manual has a section on the issue of worker self-care: "It is recommended that workers have a self-care plan. Take advantage if your organization has an Employee Assistance Plan or any community resources available… It should be emphasized that Self-Care plans are also an important tool for preventing relapse and burnout. Many Prevention counselors so not acknowledge their own needs. These needs are important in terms of their well being and their ability to perform their jobs" (p. 22).



There is a specified EAP policy in the NADACA Manual:

⊕ "The Employee Assistance Program (EAP) is established to assist those workers who experience personal and job related problems that affect their work or health. When such problems become so serious that job performance suffers, or general physical and mental well being is at stake, the Employee Assistance Program is here to assist" (p. 30/31).

⊕ "Treatment may involve in-house counseling by qualified EAP professionals, alcohol and/or drug testing, referral to outside agencies, or a combination thereof. Once in the plan, the employee must follow the prescribed treatment/rehabilitation plan…Up to five days per year EAP leave may be approved by the ED for this purpose" (referral to outside agencies for testing, counseling or treatment) (p. 32).

Some NADACA staff expressed concerns that due to the limited options for referral much of the service available is provided by members of the Management Team. The rurality and smallness of most First Nations and Inuit communities in Atlantic Canada pose program issues of privacy and confidentiality. For female staff there is a lack of options for referral to female counsellors. The overall emphasis on "self-care" policies can place the burden of responsibility on individual workers. As one ANNA participant told: "How long will we continue going in circles and through revolving doors? We had a murder, and everyone was in Post Traumatic Stress and (the Health Director) said: we don't need mental health here, everyone is fine."

According to ANNA questionnaire results, only 66% of community workers reported having the opportunities to debrief or obtain self care. What about the other 34%? Forty-eight percent of workers reported experiencing workplace relationship problems, and 68% reported being aware of an agency harassment policy. Only 60% of workers reported having Elder support available to them, compared to 83% of clients reporting having access to Elder support. Many workers spoke about the reasons for having Elders and Medicine People available for staff. As one ANNA participant stated, "I help people but where do I go when I need help?"

Caring for the caregivers is essential to be able to continue to care for others: "That's the thing none of us can say, that our families are not sick. If you got your own addictions back away and get out of it, and let someone else do the job. When I was having problems with ____, I had to quit, I couldn't focus. I had to choose, it was between a dollar and my family and I had to choose my family. For the betterment of all. We have too many sick people working in this field!"

Working in any helping role can make us "sick". Post traumatic stress is a common reaction for workers given the level of crisis and distress in communities, combined with the intimacy of providing service for your own relatives and community members, and the lack of available staff supports and resources.

> **ACTION: Care for Caregiver programs be developed and made available on a regular basis, individually on a bi-weekly and staffing groups on a monthly basis, funded for all addictions and wellness workers to have the support they need to care for themselves.**

After Hours Service

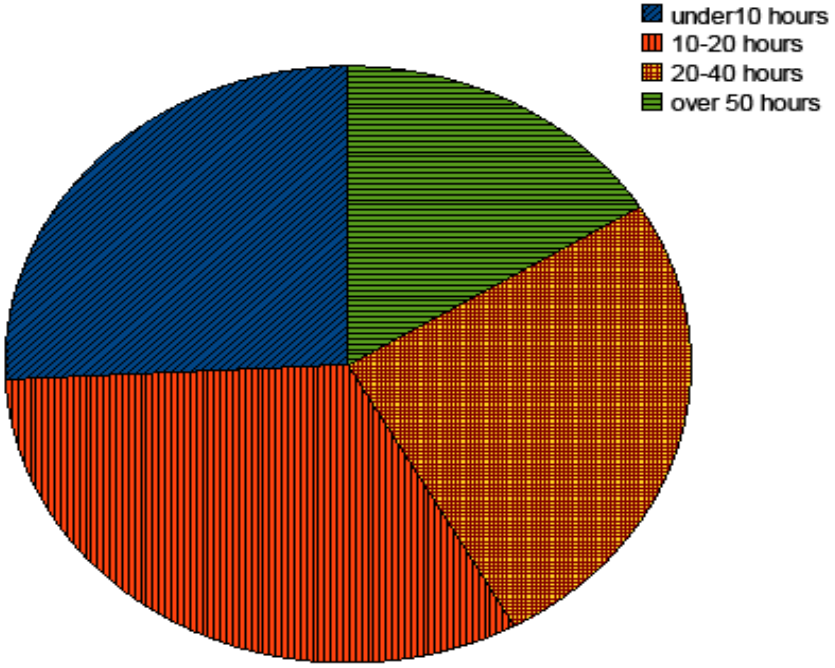
As Chart Eighteen: After Hours service in a month (Page 147) illustrates, 58% percent of workers are involved in after hours service, 73% are attending to crisis intervention or critical incident management. For those workers doing afterhours service, the average amount of service is 21 hours a month. Sixteen percent of workers are providing over 50 hours a month. The hours and service provided by the worker are generally undocumented and unrecognized service. This greatly contributes to the 'burn-out' factor of addictions workers. As one participant stated, "In our community if someone is going through a hard time and the police are called in, they will call in our workers. Our workers are expected to wear multiple hats. Where is the support for them? There is a huge need for others collaborating". The health clinics in Nain and Hopedale (Labrador) report most of the afterhours calls are alcohol-related (NAHO 2008).

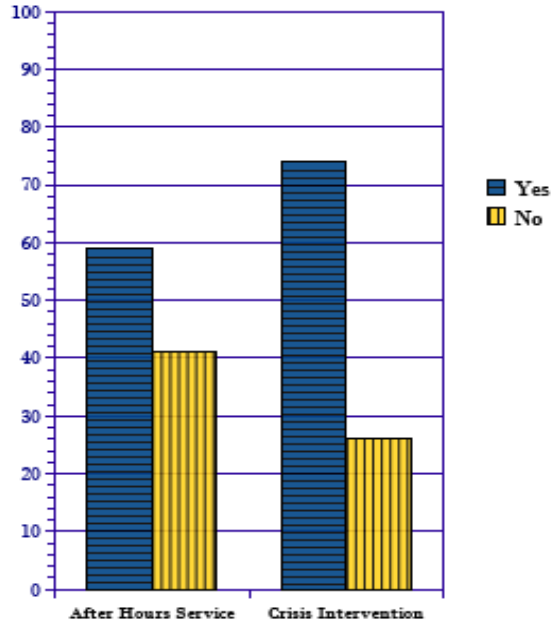
Emergency Response Program

The lack of an adequate emergency response program is documented in the Brighter Futures Evaluation (2006) as a pressing challenge. When asked whether they agreed that their community had the right programs in place to "intervene to reduce the number of suicide attempts and other violent crisis situations" or to "provide crisis intervention, aftercare and training for caregivers and communities to deal with crisis" the respondents tended to disagree." A few larger communities, like Elsipogtog, Indianbrook and now Eskasoni, have a crisis team. As the Chart Nineteen: Crisis Intervention (page 149) illustrates: 74% of workers responded that they are providing crisis intervention; 74% have a crisis intervention team in place; and 48% are members of the crisis team. Seventy-seven percent of workers have youth suicide intervention training and 71% have crisis intervention training. Sixty-two prevent of workers are aware of crisis intervention policies, but only 22% maintain a critical incident file.

According to the RAPC workplan (2004), "every community is unique and program strategies to fit the needs for small and the more isolated communities is necessary especially where other key agencies are limited or non-existent that would ordinarily served as a

Chart Eighteen:
After-Hours Service in a Month
Workers Report





community team in response to emergencies in the large communities" (26). The RAPC proposed to establish an Emergency Response Program for the Atlantic Region.

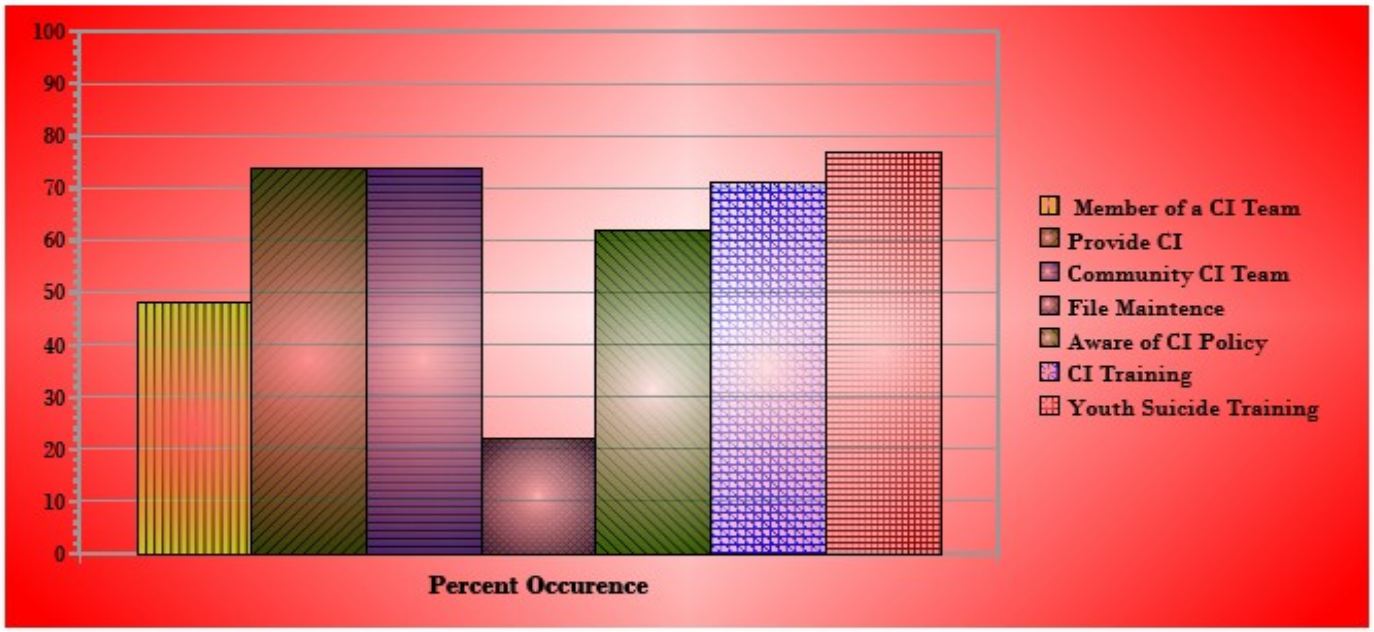
> **Action: "Develop an emergency response program and training program in coordination with NNAPF that is sensitive to geographic and cultural landscape of the Atlantic Region" (27). This could also include a 24 hour crisis line for the Atlantic Region.**

WAGE PARITY

The critical issue of wage parity, appears bolded and in caps in the 2004 Work Plan: **"IT IS ALSO VERY IMPORTANT TO NOTE THAT THE ISSUE OF WAGE PARITY IS OF GREAT CONCERN TO THE ATLANTIC WORKING GROUP. GIVEN THE UNCERTAINTY OF THE FUNDING AND SUSTAINABILITY OF THE RENEWAL PROCESS, WAGE PARITY WILL REMAIN A MAJOR PRIORITY FOR THE GROUP..."** (pp. 2-3) Wage Parity has not been addressed, and remains a frequently voiced concern.

The lack of wage parity was a workforce priority raised across the Atlantic region as a barrier to finding and keeping professional staff. The issues are summed up well by the Directors: "Unless wage parity is taken care of, people are more likely to find work elsewhere. It's a license and you can work outside this facility. We need to protect our investment by paying them a proper salary. Without wage parity efforts to certify people are meaningless" (Nova Scotia). A New Brunswick Director agrees: "We train people but we cannot keep them; no wage parity". Workers also support the call for wage parity. As one worker says, "I think that wage parity needs to be addressed. They need incentive to stay with the job. You cannot support children on loving your job" (Nova Scotia). Another worker stated: "Give wage parity so Aboriginal people can afford to work in and for their communities" (New Brunswick). A Labrador participant stated, "There are some treatment centers that pay a good wage. And some cannot do that, so it is very difficult to get someone to come in and join the team."

Chart Nineteen: Crisis Management



A larger percentage of workers are involved in crisis intervention(CI).

The hours and service provided by the worker are generally undocumented service.

NADACA Salary Review

"We need to achieve wage parity with the public service (Nova Scotia) to ensure our counseling (treatment and prevention) and administrative staff do not feel the need to take second job, or have their wages supplemented by their First Nation community" (NADACA manual p. 61).

These concerns are reinforced by a look at a comparison of the Salary Scales for NNADAP (Appendix 3, NADACA Strategic Management Plan) 2006 version with the NNAPF materials (2004). NNAPF cites comparative salaries for four Treatment Center positions Executive Director, Program Director, Treatment Counselor, Entry and Senior Level. In this case the mid-range salary data for Community based Aboriginal Addictions Programs with less than 15 beds (CTF), and comparable data for non-Aboriginal facilities (NATF) will be used.

Table 5: Wage Parity Table

	NADACA	-- CTF	A= Diff	-- NAFT	B=Diff
Exec Director PR 18	53, 904	53, 231	673	65,320	11416
Treatment Director 1 PR 13 (Eagle)	40, 280	40, 583	303	45,046	4766
Treatment Director 2 PR 15 (Mi'kmaw)	45, 259	45, 503	244	52,202	6943
Treatment Counsellor 1	22, 050	29, 211	7161	36,859	14809
Treatment Counsellor 2	23, 153	34, 282	11129	41,284	18131

A= CTF minus NADACA; B= NAFT minus NADACA

At a glance it is easy to see why Treatment Directors and workers are calling for wage parity with those who are providing this service in the mainstream fields of service provision.

ACTION: Achieve wage parity with the public sector to ensure the retention of staff and the delivery of effective programs and services.

TRAINING

The overall issue of lack of accessible training is well documented in the in the NNADAP National Training and Staffing Status Report (2005). Generally, each community is responsible for meeting the training needs of their NNADAP worker. "Currently, all bands receiving NNADAP funding resources to cover costs for any required training they consider necessary for each NNADAP staff member". One of the biggest issues pertaining to access to training is the

proximity of training to communities, and treatment centres. Related financial concerns for bands are costs of travel to courses, covering for workers while they are on training, and salary increases once training is completed. For some bands, these costs make individual negotiations for ongoing training more difficult. NADACA and the Partnership group have taken on some responsibilities with respect to securing training for workers. In the last five years, three major NADACA Staff Development events have been held. Two Training Symposiums in Partnership with Health Canada, Dalhousie University and the Atlantic Region Treatment Centers, and one Staff Development and Healing Conference . This year, NNADAP workers were funded by FNIH to attend the Atlantic First Nations Health Conference.

The NADACA policy and procedure manual discusses training needs specific to the Atlantic region. Current Training Priorities include: "Personal Communications; Report Writing and Record Keeping; Research Methodology; Program Planning, Management, and Evaluation; Ethics in the Workplace; Nutrition & Health; Public Speaking and Community Presentations; Cross Cultural Awareness; and Detoxification Services" (p. 47). Other future training needs identified include: Suicide Prevention/Intervention; Dealing with Grief and Loss; Prescription Drug Effects and Interactions; Parenting Skills; Human Sexuality; Promoting Self-Esteem; Relationship Issues; Family Counselling; Dealing with Anger and Resentment; Dealing with Family Abuse; Living with AIDS; Health & Hygiene" (p. 62). Critical training needs identified as priorities throughout the ANNA process are itemized in Chapter Thirteen.

Professional development

Professional development was identified by ANNA participants as an important workforce priority. Topics mentioned included:

⊕ New perspectives such as connection between addictions and mental health (Nova Scotia, New Brunswick, PEI)
⊕ New models e.g., harm reduction and what this means for First Nations and Inuit people (Nova Scotia, Moncton Gathering)
⊕ How to talk about sexuality and issues such as "safe sex"(Nova Scotia)
⊕ Holistic models of service and program delivery (Moncton Gathering)
⊕ More education about drugs, e.g., what is out there and what are the effects (Newfoundland)
⊕ How to provide counselling to those who are using methadone (New Brunswick)
⊕ Effects of prescription drugs: (New Brunswick)

⊕ The link between domestic violence and addictions (New Brunswick, PEI)

As CHART TWENTY: STAFF DEVELOPMENT (PAGE 154) illustrates, 91 percent of community workers reported having some training. Sixty percent are not aware of any kind of training opportunities. This could mean that some workers are either poorly informed, or the training opportunities are not accessible to them. Ninety-eight percent of workers stated that it would benefit them to take more training, indicating an awareness of insufficient training in certain subjects and a willingness to engage in ongoing training. A little over 70% keep a portfolio of their training, which will be an issue if PLAR (Prior Learning Assessment and Recognition) is implemented. Seventy percent of workers reported receiving crisis intervention training, and 76% received training on youth suicide (76%). These figures are relatively low compared to the stated needs of communities.

In the Atlantic Region, due to the lack of post-secondary institutions offering addictions counsellor training, many Addictions Counsellors acquire competence through experience, supervision and short training courses offered on-site and NADACA does offer workshops that require little or no funding to attend. Funding is a significant constraining factor to accessing training. Since no local colleges or universities offer an addictions training program, costs incur for outside training such as transportation/travel and accommodations costs. As the National Training and Staffing Status Report (2005) notes, "The lack of academic opportunities for First Nations and Inuit counselors and prevention professionals is due, in part, to the failure of colleges and universities to provide programs designed specifically for a First Nations and Inuit workforce…Organizations and institutions that provide education and training need support to build the capacity, interest, knowledge, and skills required to expand the addictions workforce" (p. 18-19). A summary of the historical efforts and current gaps in training in the Atlantic Region is provided in the RAPC reprofiling workplan (2004).[43]

According to the Canadian Drug Strategy: Work Plan Recommendations 2005-2008: Atlantic Region, "Currently, a partnership is being negotiated with the Nova Scotia Community College (NSCC) to provide basic addictions diploma / certificate for NNADAP workers. Further, the Atlantic region would like to work more with NADACA for training staff in a fashion similar to Alberta region and Nechi Institute." In 2007-08 NSCCA offered a mainstream on-line addictions

diploma. The student retention rate was dismal. A huge gap remains in the availability of Aboriginal-specific training for addictions workers in Atlantic Canada, which is heightened by the ongoing demand to have workers certified and centers accredited.

> **ACTION/TRAINING: Ensure ongoing and up-to-date training and professional development to meet the changing needs of clients and thus staff to confidently address these needs.**

In recognition of disparities for access to training for workers in and across the Region, and the need for ongoing training for new and experienced workers, a critical capacity building initiative in the RAPC Workplan document (2004), was to establish an Atlantic Aboriginal Substance Abuse Training and Research Institute:

> "Again, given the evolution and complexity of substance and other abuses such as gambling and prescription drugs, the region desperately requires a consistent training and research program. Though there is an incredible amount of research in the addictions field, there is little that speaks to the Atlantic experience. Most research is based in western Canada or the United States. The exception to this is the Atlantic Aboriginal Health Research Program (AARHP) launched with Dalhousie University in 2002" (pp. 15-16).

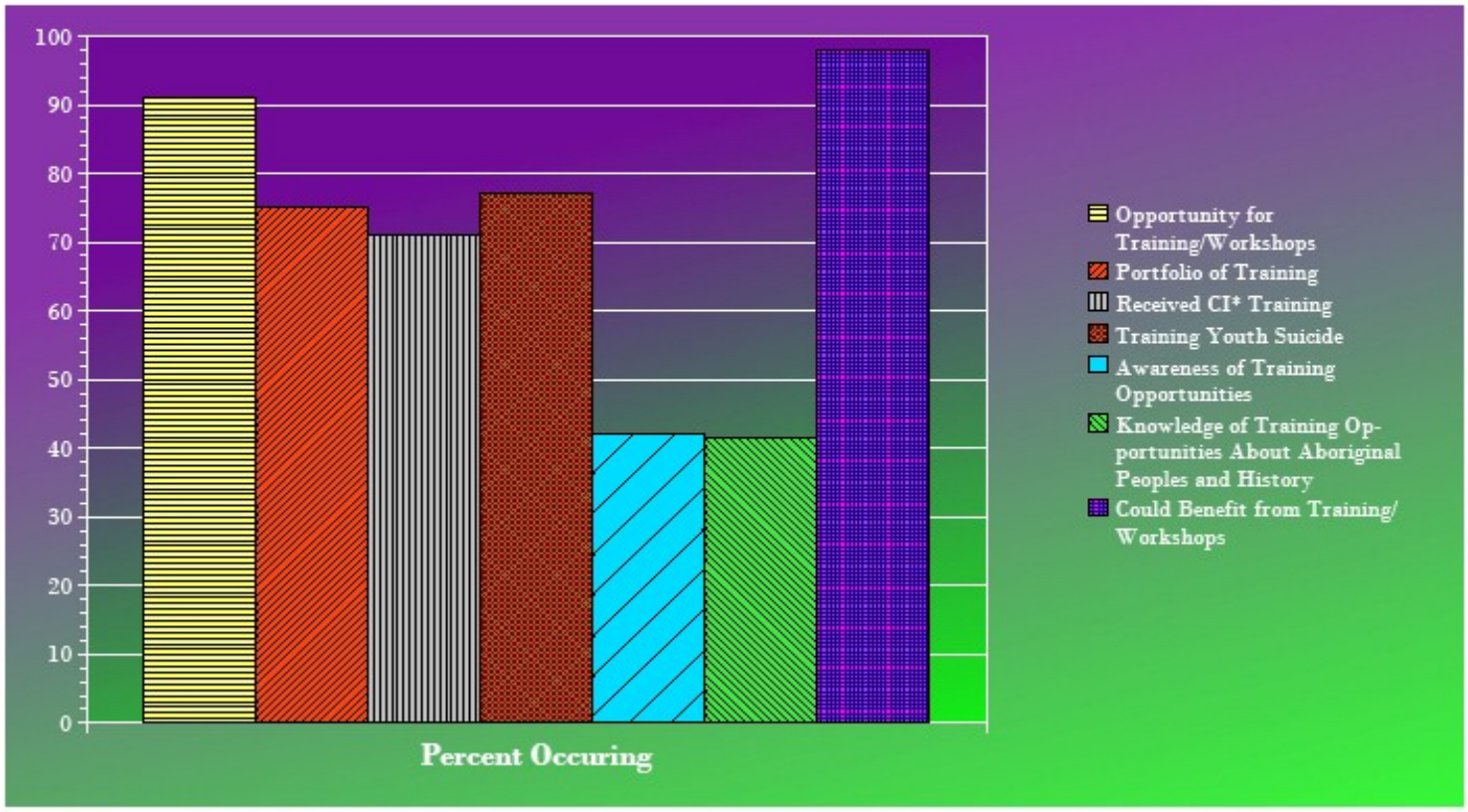
Atlantic Aboriginal Health Research Program (AARHP)

While the AARHP was launched in 2002, there is still very little published research specific to Atlantic First Nations and Inuit Addictions. Most material collected is to meet reporting requirements for governmental financial accountability, especially for transferred programming, rather than based on a regionally driven process for research or program development as a whole.

During February of 2009, the first Addictions Research Workshop was hosted by the AARHP at the Glooscap Heritage Center, Truro NS. Discussions were held and two priorities for research were established, one on cultural strategies at a National level, and one focused on youth services at an Atlantic level.

Chart Twenty:Chart Staff Development

Community Workers Report...



*Crisis Intervention

RESEARCH GAPS exist in all health research, and are particularly acute in the Aboriginal addictions field. For example, there are significant gaps in the research about addictions as they relate to First Nations and Inuit about the benefits and risks of harm reduction policies and programs to adolescent populations as a whole. According to Canadian Center on Substance Abuse (CCSA) 2006 the large number of under-aged youth potentially affected by a shift in drug policy and programming — from having an explicit goal of abstinence to having one of harm reduction — makes this the single most important policy decision as regards harm reduction targeting youth. While it is important to focus on the effectiveness and safety of various models of harm reduction drug education addressing alcohol, tobacco and cannabis use among youth, there is also a crucial gap in the literature about the use of methadone as a harm reduction strategy. Because of what CCSA heard from participants about the increasing use of this particular harm reduction strategy, their report strongly urges that this topic be giving priority as it affects increasing numbers of and perhaps disproportionately Aboriginal young people. The particular research gaps identified by ANNA participants are included throughout the document, and summarized in the concluding chapter.

> **ACTION/RESEARCH: Hire a consultant to work with RAPC, to move forward with the plan to establish a First Nations and Inuit-specific Addictions research and training institute for the Atlantic Region. This would include an exploration of all options of potential links with existing post-secondary institutes, especially tribally controlled institutions, including the UNBI in Fredericton. Given the range and number of previous training initiatives undertaken, implementation of a PLAR (Prior Learning Assessment and Recognition) process in assessing and assigning post-secondary credit would be beneficial to workers in the Atlantic Region.**

CHAPTER TWELVE: ADDICTIONS SERVICES POLICIES

RAPC and NADACA policies highlighted are those that link directly to comments made by ANNA participants in communities served.

Zero Tolerance for Addictions

> *"We will not tolerate any forms of addiction, and that includes addiction to gambling and cigarettes, as it is inconsistent with our goals and objectives and is counterproductive to our efforts" (p. 58).*

Policies exist and are enforced to be consistent with this vision for both staff and clients within Treatment facilities. No mood altering drugs are allowed within the Treatment Centers. Those found to be using drugs are dismissed from Treatment. The NNADAP Atlantic Region Code of Ethics states that workers will: "Refrain from any activities, including the abuse of alcohol, drugs or other mood altering chemicals where my personal conduct might admonish my personal capabilities, denigrate my profession's status, or constitute a violation of law" (10).

Staff in Nova Scotia, are further made aware of these policy through the NADACA Handbook: *"Substance abuse is a danger to the health and safety of NADACA employees, and goes against the very fibre of our existence. The purpose of the policy is to ensure that substance abuse is not tolerated within the Association".*

As part of the ANNA processes, workers were asked to respond to a question on living cultural values: walking the Red Road, i.e., drug and alcohol free. 86% responded

that they are adhering to the Red Road rule of sobriety. Only half of the worker respondents indicated they were addictions workers, the other half were collaborators.

Many participants talked about the importance of additions staff living their culture values including: sobriety, speaking truth, and embracing cultural traditions for self healing. As one youth participant stated, "Walking the red road is walking that traditional path. For me it is walking with my drum, singing, giving the teachings to who wants them".

For some workers walking the Red Road builds trust with clients (PEI); embracing cultural values can help staff deal with their own addictions (Nova Scotia); healthy people create healthy programs (Newfoundland) and Traditional practices can help staff deal with isolation (New Brunswick).

According to the NADACA Handbook, substance abuse issues are dealt with through EAP.

> *"NADACA will take appropriate steps to accommodate employees with substance abuse problems through our Employee Assistance Program. If you require accommodation and assistance from NADACA, you are responsible to communicate this need in sufficient detail and to co-operate with NADACA to facilitate an appropriate course of action. If you refuse treatment or accommodation you may be subject to progressive discipline, up to and including termination."*

While personal responsibility for seeking help must be balanced with safety for clients and co-workers, ANNA participants' perceptions of lack of available help in the EAP process also impact on this issue.

Another identified gap in the Zero Tolerance policy is a lack of a similar policy with respect to the leadership, the Chiefs, who form the decision making body that oversees NADACA, and who in the rest of the Atlantic Region make important decisions regarding the hiring of NNADAP staff and funding of programs and training for workers. "We have all the directors of all these helping agencies, are the Chiefs, sitting on the boards, you can only go so far. Our Chiefs are sick and they are the ones that dictate to us what we can do or not do." One participant expressed concerns that the Zero Tolerance policy also did not extend to staff of Accreditation Canada.

ACTION: Eliminate gap in the Zero Tolerance policy regarding lack of similar policy with respect to the leadership.

"rigid intake guidelines"

According to the NADACA Manual, "rigid intake guidelines" are enforced to ensure "the client is ready and open to treatment" (p. 40). Normally, clients are referred by field counselors, so usually they have received some counseling, perhaps detoxification, and are deemed ready to undergo treatment. Question 70 asked workers to identify policies and procedures that discourage a treatment path**:** expectation of the necessity of detox before treatment or to be two weeks clean was written in on several surveys. While some workers and community members feel the intake policies are too rigid, NADACA feels that "the Treatment Centers need to be more stringent in accepting referrals from outside the Association. It makes no sense to waste a bed and the services of all treatment staff for persons whose only ambition is to ride the tide to graduation" (p. 40).

Process is too long, wait lists

Existing assessment standards include the requirement that the full pre-assessment process must be complete: including pre-assessment form, 5-one hour visits, and relapse prevention plan. While these referral processes have gradually evolved to work towards greater success of clients once in treatment, "NNADAP entrance to treatment policies deter some people from seeking help" (ANNA participant in New Brunswick). Participants in PEI, Nova Scotia and New Brunswick indicated that length of waiting lists for treatment are too long. The idea of rotating intakes across the Atlantic region as a strategy to address lengthy waiting lists was suggested in communities in both New Brunswick and Nova Scotia.

ACTION: Rotating intakes across the Atlantic region be explored as a strategy to address lengthy waiting lists.

Policy Impacts for specific groups

While registered First Nations have priority, and the status number is required on the pre-assessment form, several Treatment Centers did address the need to offer

service to non-status family members within their communities. In total 22% of Atlantic Treatment Center clients were non-status, compared to 8% in Canada.[44] While accommodating non-status was agreed upon to be ethically important in the provision of services, if programs provide services to non-status Aboriginal-identified clients they may not receive remuneration. Some programs also provide services to non-Aboriginal family members.

The policy that Treatment Centers require a doctor to complete medicals results in geographic discrimination for Newfoundland, Labrador and other more remote and smaller communities, as most do not have a medical doctor stationed in the community.

Existing policies that specify that all medical, dental, optical, financial, sports, religious, parole and probation commitments must be attended to prior to admission by some ANNA participants as discouraging a treatment path for those clients with a criminal record history. One participant said "When I was working in the capacity (as NNADAP worker), I would lie on some of the forms, about court, get that adjourned later." Clients with mental health needs are also impacted. As one participant noted: "Some get refused, because they couldn't get off all the meds."

Admission questions

Questions Circle Works staff had regarding the types of information collected include: Why ask religion of mother and father? What are the impacts if you do have family members working at the Treatment facility? What is done with the information regarding the views of authority (especially when the policies and practices around dismissal and authority are noted)? Or the mental health questions, (particularly given the recent policy and procedure changes concerning client safety and suicide attempts)? How are the answers to these questions weighed in the decision to admit a person or not?

No Gender Balanced Analysis of Policies

There are no referral policies noted in the Atlantic NNADAP Manual regarding pregnant women, access to or provision of child care for women or men responsible for children, no policies regarding special considerations for victims of violence or sexual

violence, and no identification of issues around sexual orientation. There are no questions in the pre-assessment process that review these matters, or indications that supports would be in place, like access to healing services with only female staff, to address these gender specific issues.

Participants in a couple of locations mentioned the need for a Code of Ethics for addictions workers and Elders in Treatment facilities to protect female clients. While there is a stated policy in the House Rules prohibiting sexual relations between clients, and in the Code of Ethics stating that sex between workers and clients was disallowed, there were concerns reported regarding the vulnerability of women clients in treatment facilities with male workers and Elders, and the lack of a workable process in place to report and intervene in incidences when sexual relationships were initiated with female clients while in treatment.

> **ACTION: That a position and a process be established to provide a gender based analysis (GBA) of policies and practices affecting women workers and clients in addictions services in the Atlantic Region, with special attention to hearing and mediating claims of sexual harassment/abuse.**

Transportation

Given the geographic distances within the Atlantic Region, and in particular the geographic isolation of some communities, policies regarding transportation are a concern for many participants. According to one ANNA participant “the number one issue in Labrador is transportation”. The second issue, also related to transportation and geographic isolation is lack of access to professional services.

The lack of public transportation in rural and remote communities and the lack of transportation to self-help groups and education were seen by ANNA participants as obstacles to recovery. FNIH does not cover these expenses and programs often do not have the resources to assist.

Within the extensive pre-admission process, we noted in particular how the pre-admission form must be complete for pre-authorized travel. It may take at least 10 days to process travel requests, and FNIH pre-authorization must be obtained. “All travel

must be approved by Consultant (28)". Some ANNA participants indicated that the issue of pre-approval on travel does lengthen the process, creating an obstacle for recovery.

Linked to Transportation issues, is the FNIH policy to refer to Atlantic Centers first (NNADAP Atlantic Policy Manual, p. 28). Several participants spoke at length about the need for flexibility regarding referrals of First Nations peoples to other First Nations communities. There are many reasons to want to refer outside of your own community and outside of the Atlantic Region, including: shorter waiting lists; other centres may be better trained to deal with a particular need; client may be looking for a particular program; and the client may need solitude away from family and community.

The smallness of most First Nations and Inuit and the interrelatedness between people in the Atlantic Region can pose issues of privacy and confidentiality. It was noted by many ANNA participants that the FNIH policy directive regarding transportation costs being paid to the nearest Treatment facility can be counterproductive to positive healing outcomes. As one participant noted "There have to be policies to support people who have issues of confidentiality and need treatment elsewhere" (Nova Scotia).

Another transportation dilemma raised by several participants was: If Dismissal occurs, there no transport home. If the person does not complete, there is no transport home" (30). Although there is a policy to allow bereavement leave, it is unclear what the transportation policy associated with this leave is. The existing policies regarding transportation may deter workers and bands from making referrals to treatment facilities as they do not want to see community members "stuck" without transportation home. One Treatment Center Director noted that now they are asking Inuit communities to guarantee members transportation to and from healing facilities, so that those who are dismissed or do not complete are not "stuck" far away from home.

One of the key factors of a successful First Nations and Inuit program is that "Participants move at their own pace in learning how to become accountable in the context of their relationships to self, family, and community" (Chansonneuve 2007).

ACTION: Changes in the guidelines for the provision of transportation though Medical Services are necessary to acknowledge geographic disparities, to fund transportation to preventive and aftercare services, to encourage access to healing services in a timely manner and to give more flexibility in healing options. Recovery is a long-term process and may take many attempts before being successful. Transportation policies need to account for this.

House Rules

House rules are reinforced and clients can be dismissed: *"When clients continuously break rules, it shows that they are unwilling to dwell in an orderly setting for the benefit of all clients, and this has a negative impact on all clients"* (p. 42).

As previously mentioned, some generic rules exist regarding prohibition of use and abuse of substances, including prescription drugs, nicotine and gambling. No smoking policies were identified as discouraging people on the healing path by several ANNA participants. While some Centers have found ways around this, it was expressed by some community participants that "it is just too much to expect people to come off everything all at once."

The Eagle's Nest was discussed by some ANNA participants as having frequent dismissal of clients. It is listed in the Atlantic Regional Client Status Report (ARCSR) as having the highest non-completion rate in Atlantic Canada in 2006-2007. According to the NADACA Manual, clients are dismissed immediately for physical violence, for failing the random drug test, or for having or using intoxicating substances. Based on the recent shift in policy from a halfway house to an active recovery treatment, clients can also be dismissed at Eagle's Nest for non-participation in program activities. *"Repeated violation of rules or non participation in program activities indicates that a resident is not prepared to make changes in his/her lifestyle and it therefore unreceptive to treatment and will be discharged from treatment."*

Another rule that gave rise to some expressed concerns at the Eagle's Nest, was "Residents are not permitted to enter the Prevention Counsellors Offices or the Journey of Healing offices without prior approval." It was felt that this rule unnecessarily regulates residents with respect to access to the counsellor of choice.

First Nations and Inuit community healing programs are deemed successful for many reasons, one of which is that "Participants are not labelled or blamed, but treated as worthy of respect even though they may have temporarily become unbalanced" (Chansonneuve 2007). As Joe Denny says in the NADACA Booklet: "We care very deeply for the people we serve. We open our doors and our hearts, and we never treat clients as anything other than equal, not matter how far they have fallen. If clients must go through the treatment cycle two, three, or even four times, then so be it. We'll stick with them. My staff and I are confident that one day the clients will make it, and we'll be there by their side when they do". William Nevin says: "It is about offering choices to sobriety, the person chooses".

ACTION: Explore best practice and policy options for NADACA/NNADAP based on traditional philosophies of self determination.

Mental Health Issues: Suicide and Prescription Drugs

NADACA has recently enhanced their case management efforts to monitor and protect clients who may be dealing with various mental health issues, to identify who may be in danger to themselves and possibly, a danger to others. According to their most recent policy manual, they have instituted the following measures to ensure client safety and protection:

⊕ *"The intake process has been refined to identify markers that would give suspicion to potential suicide.*

⊕ *Better screening and testing methods are being used to assess the presence of even trace levels of mood altering drugs.*

⊕ *Case histories are now more detailed and extensive so as to capture personal and medical data that would flag potential mental health issues.*

⊕ *Clients are carefully monitored for signs of personality change, depression, anxiety, and evasion.*

⊕ *Staff will be better trained to recognize certain markers that may flag potential suicide victims.*

⊕ *Should client(s) become suspect, we have immediate access to mental health professionals"* (p. 44/45).

It remains unclear whether NADACA is admitting clients with known mental health issues.

ACTION: Specific policies, procedures and staff development with respect to clients with mental health issues be reviewed across the Atlantic Region to provide more integrated services to people showing more visible signs of trauma.

CHAPTER THIRTEEN: PRIORITIES RECAP

In closing, a key question underlying the Atlantic NNADAP Needs Assessment was: What are the priorities for enhancing and improving addictions prevention and treatment services for First Nations and Inuit in the Atlantic Region? Key priorities have been identified throughout the text having to do with **Cultural** Healing; Historical and Structural **Contexts** of Addiction; Recovery as a **Community** process, and Challenging to **Change** the current power structures that continue to impeded First Nations and Inuit communities quest for healing and autonomy. Each priority comes with a specific action component.

SECTION ONE: CULTURE: CHAPTERS 1, 2, 3, 4

CHAPTER ONE: GENERAL

- **Recognition of diversity of geography, history, and tribal groups**

Due to the diversity of First Nations and Inuit communities in the Atlantic Region, there is a need for caution in generalizing issues, healing approaches and determining best practices.

ACTION: That the diversity of geography, history and tribal groups with the Atlantic Region be recognized in any and all processes of negotiation and partnership with the Federal Government.

- **Accurate and detailed record keeping**

Lack of access to important health, mental health and addictions information for Atlantic First Nations and Inuit is a key concern. Basic statistical information is unavailable in order to carry out research that is based on solid evidence.

ACTION/RESEARCH: A rich source of future data would be the creation of a more accurate, detailed and simple system of record keeping, that would be designed to assist First Nations and Inuit in understanding the

trends, issues, and strengths within their own communities. This system would need to be developed by technicians in consultation with First Nations and Inuit, and funded by Health Canada.

CHAPTER TWO: FIRST NATIONS AND INUIT CULTURAL PRACTICES ARE HEALTHY

- **Health, wellness and cultural continuity**

Healing is connected with self-determination. Autonomy in dealing with health and addictions issues is key to cultural connections and safety. First Nations and Inuit control over the direction and day-to-day operation of the system would help address many of the current challenges and complications.

ACTION: There is a growing recognition for the need to continue to move towards self government, enhanced cultural revitalization, and to have culturally appropriate programming integrated into the provision of addiction services and other health care services for all First Nations and Inuit.

- **Access to community-based, culturally safe services and service providers**

The need to support and enhance the capacity of First Nations individuals and communities to develop and deliver their own programs and services, including: addictions and health resources and services that are timely, culturally-appropriate, and accessible; and more programs, more funding, more emphasis on recruitment of First Nations and Inuit addictions service and program deliverers. Currently there is a huge gap in the mainstream approach to addictions. All communities agreed that First Nations and Inuit approaches to healing and recovery are the most effective with First Nations and Inuit clients, and advocated for more culturally-based approaches and the employment of more traditional First Nations and Inuit addictions and mental health workers.

ACTION: Increase access to funds for contributing to the development of traditional activities as necessary "diversion" for successful prevention and aftercare programming.

⊕ **Moving towards cultural holism**

Holistic services could include: "meditation not medication", self-esteem workshops, sports, crafts, alcohol and drug free social gatherings and incentives around healthy lifestyle through exercise and diet; mentoring programs; more evening programs; youth/elder conferences; more youth workers and youth centres; cultural teachings and practices including relationship counselling and Family Resource Centres; and more Elder involvement in the health and well-being of communities, including the provision of addictions services. Holistic approaches embrace the First Nations and Inuit reality that: Healing is for all.

> **ACTION: As substance abuse has been used as a coping mechanism for the growing loss of identity and culture, programs that revitalize and reinforce culture be appreciated as a culturally appropriate form of harm reduction. Workers be hired to facilitate cultural awareness and activities appropriate to each territory and community.**

⊕ **Cultural healing in practice**

Many participants from all across the Atlantic region shared the specific cultural approaches they use presently in their programs. When asked to speak about what is working, many commented that regaining language and rebuilding culture are key pieces to building a strong community and strong individuals.

> **ACTION: Resources to support cultural healing practices are required, including appropriate honorariums for Elders and cultural knowledge holders who share their time, teachings and talents. Elders who are engaged in their healing journey, who are on the red road, and can offer traditional teachings to communities can be honored as Role Models and the information can be shared between communities to encourage capacity building across the Atlantic.**

⊕ **Blending traditional and western approaches to healing**

In varying degrees traditional practices of the sweat lodge, smudging and healing circles have been blended with mainstream treatment and psychotherapeutic methods within many First Nations and Inuit operated healing centers. However, traditional healing methods are often not recorded, nor do healers subject themselves to the rigours of

scientific research. Holistic, integrated models will need to evolve in a spirit of collaboration rather than scientific investigation.

> **ACTION: More sharing between First Nations and Inuit about use of traditional approaches and the blending of traditional and non-Aboriginal approaches is needed.**

CHAPTER THREE: INNOVATIVE CULTURAL PRACTICES

Innovative approaches and practices have been developed at the community, tribal, and regional level to address addictions prevention and wellness needs. The best practices of leading First Nations and Inuit health and healing programs in Canada are based on values of: Equity, Holism, Culture, and Community.

> **ACTION: Following *The Aboriginal Mental Wellness Strategic Action Plan* (AFN 2006) goals and objectives, the development of a coordinated continuum of addictions and wellness services for and by First Nations and Inuit must include acknowledgement, recognition and funding for traditional and cultural approaches.**
>
> **RESEARCH/TRAINING: Knowledge about promising traditional and cultural approaches to addictions and wellness needs to be gathered and shared as part of capacity building in training, certification of workers and accreditation of First Nation and Inuit facilities. This would include an inventory of community members and role models as guides and Elders as a resource.**

CHAPTER FOUR: CULTURAL SAFETY

While many people view cultural integration as the revitalization of traditional practices for First Nations and Inuit, it can also include expectations of cultural safety for non-Aboriginal workers: Culturally-safe social workers, counsellors, clinical therapists, psychologists, and healing centres are a method of integrating cultural knowledge. Culturally sensitive care can only be achieved by First Nations people, both in terms of developing services and providing services.

> **ACTION/TRAINING: Knowledge of respectful cultural approaches to health and wellness is required for cultural safety on the part of all service providers. Cultural safety will mean training, mentoring, and**

supervision of Aboriginal and non-Aboriginal workers, as well as a functional system to adjudicate complaints of unsafe care.

SECTION TWO: CONTEXT: CHAPTERS 5, 6

CHAPTER FIVE: FIRST NATIONS AND INUIT ADDICTIONS CONTEXT

According to the Assembly of First Nations (2007), there is no conclusive evidence that First Nations and Inuit are genetically prone to alcohol problems. Exceptional problem drinking, or harmful use, among First Nations and Inuit relates more to certain environmental factors, including history of abuse, family history of alcoholism, and other structural forms of victimization. A history of alcoholism in the family is linked to future alcohol and substance dependence, and increases the risk of childhood abuse. Other risk factors include: exposure to alcohol and drugs; childhood neglect; depression; attendance at residential/boarding schools; and, being a victim of violence.

ACTION/TRAINING: Understanding of these determinants and conditions be mandatory training for all addictions, mental health, health, anti-violence workers, as well as all policy and administrative workers in FNIH.

⊕ Historical and structural context

The roots of addictive behaviours are found in the impacts of colonial processes, including mass psychological trauma and widespread human rights violations.

ACTION/TRAINING: Mandatory training of all addictions workers on the methods of the colonial process and the consequences and impacts on First Nations and Inuit.

⊕ Links between health and structural inequality

Critical housing shortages, high rates of unemployment and low levels of educational attainment are making First Nations and Inuit more vulnerable to substance misuse and addictions. Participants in the ANNA processes frequently raised the historical and structural context, naming many interlocked political and social processes, including: Colonialism, Indian Residential School, Indian Act, Health Canada, Band Cards, Poverty,

Poor Health of Women, Reserve System, and Relocation. These socio-economic issues also drive and restrain the efforts of those attempting to address the needs of those struggling for healthier lives within the Atlantic Region.

> **ACTION: As the current health and addictions patterns of First Nations and Inuit are impacted by poverty, housing, employment, and educational attainment these conditions must change in order for levels of addictions to change.**

⊕ **Community conditions are interrelated with addictions**

Poverty and social exclusion increase the risks of divorce and separation, disability, illness, addiction and social isolation. Further, addictions and recovery are not simple linear processes. The same factors both contribute to addictions and result from addictions, including: losing one's children; loss of jobs; mental health issues; loss of self esteem; isolation from family; conflict; loss of social status; lack of education; dropping out of school; and lack of exercise.

> **ACTION: Much more work will be necessary, both to identify the extent to which lack of basic needs may impact on First Nation health, addictions, suicidal behaviours, and to commit resources to dealing with these issues.**

⊕ **A gender based analysis**

First Nations and Inuit women are affected differently by structural inequities and therefore by policy and program decisions. Social issues are interactive, they reinforce one another – and shape Indigenous peoples experiences of violence.

> **ACTION/RESEARCH/TRAINING: There is a critical need to take gender into account when analyzing historical and current struggles with addictions and in developing solutions.**

⊕ **Violence against First Nations and Inuit women**

First Nations and Inuit women continue to report high rates of male violence. Violence against women and girls takes many forms including lack of respect for women, sexual assaults, and domestic violence.

> **ACTION/TRAINING: Given that sexual abuse is often related to drugs and alcohol, both when sexual assault occurs, and as an underlying factor for people who abuse substances, and given that there is currently no Aboriginal-specific program for dealing with sexual assaults, an Aboriginal-specific community-based service be developed and delivered regarding sexual assault, including the training of all addictions workers and in links between colonization, sexual assault, and substance abuse and all sexual assault center workers in cultural safety.**

⊕ **Violence against self: Adolescents, Addictions and Suicide**

Suicide among adolescents was one of the biggest issues raised in the Atlantic NNADAP Needs Assessment. While suicide attempts by First Nations youth is five times more often than among non-native youth, First Nations and Inuit youth remain underserved and at times seemingly unreachable by mental health and addictions workers in the Atlantic Region.

> **ACTION: Chandler and Lalonde 2008 research shows that suicide, and in particular youth suicide is a social act, clearly related to socio-economic and cultural conditions in communities. As those communities with more progress in reclaiming cultural and political autonomy have less youth suicide, supports and resources towards communities in their work to reclaim cultural and political autonomy are required to resolve this problem, in addition to more resources towards addressing the specific programming needs of youth immediately affected.**

⊕ **Violence turned outward: Corrections**

There is a drastic overrepresentation of First Nations and Inuit within both the Canadian criminal population and the criminal justice system. ANNA participants identified links between abuse, addictions and legal problems. The need for a holistic approach to dealing with offenders was stressed.

> **ACTION/TRAINING: Given the link between addictions, corrections, and colonization, a greater collaboration between addictions and justice**

workers to develop a more seamless healing program based on an understanding of historical and structural impacts, and the Aboriginal principles of restorative justice be initiated. This could include cross-training opportunities to network and build stronger interrelationships.

CHAPTER SIX: SPECIFIC ADDICTION AND SUBSTANCE ABUSE CHALLENGES

⊕ Alcohol

Alcohol addiction is a high priority for communities. According to AFN report (2007), higher rates of abstinence and a lower frequency of alcohol use in some First Nations and Inuit populations can be linked to a rediscovery of traditional cultural attitudes and values towards alcohol and other substances.

ACTION: Prevention material regarding the link between substance use, binge drinking, historical factors and the role of culture as a recovery tool be explored.

Alcohol is rarely used in isolation of other substances and as a result workers are facing a new pattern of consumption, that of mixing a "cocktail" of alcohol and various other prescription and illegal drugs. Youth participants in ANNA indicated that they found it challenging and frightening that drugs and alcohol are so easily accessible in their communities.

ACTION/TRAINING: Information and training for workers, Detox staff, community members, and youth, on the effects and potential behaviours from the effects of mixing alcohol and various other prescription and illegal drugs.

Another key alcohol related issue First Nations and Inuit communities are now facing is the prevalence of intergenerational FASD. While prevention programs are in place in some communities there is a large gap in services to young adults who have FASD and are now of drinking/child bearing age.

ACTION: Enhanced community services for FASD remain a necessity, including services for FASD young adults who are now of drinking/child bearing age.

The establishment of "dry communities" has produced mixed results. While some communities have experienced positive results, others have found that the practice has

driven people out of their communities in order to consume. Effective prevention efforts are dependent on enforcement policies and infrastructure.

> **ACTION: Prohibition efforts need to be incorporated into broader community prevention strategies**.

⊕ Prescription Drugs

Abuse of non-prescribed prescription drugs is identified to some extent in the literature. However, further research and training is required due to the enormity of the issue and the lack of information on prescription drug abuse**.**

> **ACTION/RESEARCH/TRAINING: The prescription drug issue becomes especially complex with those dealing with mental health issues, and requires an immediate strategy for both prevention and treatment.**

The ease of availability and the widespread misuse and the combining of prescription drugs with other substances is an overwhelming issue for the region in general and more so for certain communities. Addiction service workers and communities need information/data on drug use, misuse, and abuse, as well as information on drug prescribing trends in order to target appropriate interventions. Some NNADAP locations in the Atlantic region have launched successful programs to work on prescription drug misuse.

> **ACTION/TRAINING: Information on the work of DUPPWG in Elsipogtog, and program developed by Rising Sun/Eagle's Nest be shared with other First Nations and Inuit as examples of innovative strategies to work on prescription drug abuse.**
>
> **ACTION: A collaborative infrastructure between FNIH, doctors, pharmacists, RCMP and Band Councils to lesson double doctoring, combined with public information on the dangers and warning signs of frequently misused drugs, as well as innovative healing strategies will be necessary to address this issue.**

Older First Nations and Inuit face specific concerns with respect to prescription misuse. Language barriers and inability of health professionals to provide culturally safe healing environments lead to confusion about prescribed medications, interactions, side effects,

and expiry dates. The safety issues of this population and the risk of having medications stolen are also significant concerns.

> **ACTION/TRAINING: Culturally safe methods of engagement with Older First Nations and Inuit be taught to doctors and pharmacists, and advocates/translators provided, to ensure clarity and safety of prescription drug use, along with a re-examination of policies and practices regarding refilling lost or stolen prescriptions**.

⊕ Methadone

Methadone, currently promoted as a harm reduction approach to opiate-type drugs is a controversial issue. Those involved in these programs see the positive benefits of Methadone. Others see a need for a more comprehensive community program around the use of methadone and the supports needed and received in order to gradually reduce their dependence on methadone.

> **ACTION/RESEARCH/TRAINING: Greater information, training, services and supports regarding reduction of dependence on Methadone for those currently receiving Methadone treatment.**

The cultural appropriateness of Methadone as a form of harm reduction has not been validated among the First Nations population. Given the historic link between substances and colonial oppression, honouring abstinence is seen in some communities as the only strategy that has worked; Methadone creates a conflict between the medical use of a substance, and a traditional drug-free way of life. The ANNA process revealed that Methadone is not widely accepted by the NNADAP/NADACA workers in the communities who are generally opposed to giving a drug to treat drug addiction. Fears of mixing abstinence-based treatment centers and harm reduction models centre on diluting programs and nothing working well.

> **ACTION/RESEARCH: Culturally based forms of harm reduction need more exploration along with collaboration between health and addictions programs to create infrastructure to provide supports to methadone clients without diluting abstinence based healing programs.**

Currently there are gaps in the knowledge about methadone including dependency and detoxification issues.

ACTION/RESEARCH/TRAINING: There is a lack of knowledge about detoxification and prescription medication, including methadone. This needs to be addressed as a research and training issue.

There is also a lack of information on the long term effects of Methadone and a deep concern of the effects of Methadone on mothers and their unborn children.

ACTION/RESEARCH: Methadone, short and long term impacts and reactions, including effects on fetus.

⊕ Illegal Drugs

Illegal drugs (such as designer drugs, GHB, cocaine, crack and Crystalline methamphetamine or Cystal Meth) are the most concerning issue in some communities. Addictions and substance abuse problems have changed and information and education about substances is not readily available.

ACTION/RESEARCH: A method of obtaining current information and education about the addictive substances available in communities.

The current complexities of addictions and the link to health issues require specific information about the link between opiates, HIV infections, and Hepatitis C.

ACTION/TRAINING: Information regarding the link between opiates, HIV infections, and Hepatitis C.

⊕ Solvent Abuse

Among Innu communities, solvent abuse was identified as being of the highest priority in addictions for addictions workers, youth, and community members.

ACTION: Review of current needs and utilization of Charles J. as a multi-addictions Treatment Center.

⊕ Smoking

Research says that approximately 60% of First Nations people are smoking as compared to 22% in the general population, responsible for almost one in five adult deaths among First Nations people, and the smoking rate among First Nation youth is twice as high than for non-Aboriginal youths.

ACTION: First Nation smoking prevention programs must recognize and acknowledge differences between ceremonial tobacco and commercial tobacco use.

⊕ **Gambling and other Addictions**

Gambling is consistently identified as pressing problem for adults, youth, and families.

ACTION/RESEARCH/TRAINING: All addictions are interrelated and should be treated together. This concept has implications for research, training, treatment, and policy changes.

⊕ **GAPS IN ADDICTION SERVICE PROVISION**

Underserved clients: It was frequently mentioned that all First Nations and Inuit (including status, non-status, on-reserve, off-reserve) are underserved by the current system, especially obvious are: homeless, at risk of homelessness, women and youth. Smaller and isolated communities are particularly underserved.

ACTION: Review funding structures and decision-making process in terms of defining and delivering programs for youth, women, two-spirited people, residential school survivors and people with mental health issues.

Accountability and responsibility: Due to a combination of lack of funding and jurisdictional issues, there are no First Nations or Inuit Detox or Family Wellness programs in the Atlantic Region. Long waiting lists, lack of long-term healing facilities, limited prevention and aftercare programs illustrate a general failure of funders to recognize a holistic perspective that would enable programs to provide services such as transportation to programs and services that are not currently provided for under medical and dental.

ACTION: In general participants noted the lack of accountability and responsibility on the part of Health Canada to follow through on their promises to invest in culturally appropriate practices delivered by First Nations and Inuit to First Nations and Inuit. Health Canada can move towards the increased funding of much needed services rather than ongoing "evidence-based" needs assessment.

SECTION THREE: COMMUNITY: CHAPTERS 7, 8, 9

CHAPTER SEVEN: IMPACTS AND SERVICE NEEDS FOR POPULATIONS

⊕ Youth

As youth suicide is a social act, clearly related to conditions in communities, and those communities with more progress in reclaiming cultural and political autonomy have less youth suicide. Priorities for children and youth are urgent and substantial. Priorities range from prevention (such as education about street drugs, alcohol, prescription drugs, HIV/AIDS, sexuality education) to treatment (such as First Nations healing centers that served youth, youth specific detoxification programs, a youth-centered continuum of care that includes detoxification, rehabilitation, and aftercare) to programs which train and support youth role models and youth workers and increasing parental involvement in youth programs and community contexts.

> **ACTION/RESEARCH/TRAINING: Develop both an interim and long term plan to address the absence of youth treatment programs and services in the Atlantic Region. This would include: prevention programs (i.e. providing programs to train and support youth role models and youth workers); identify youth needs, peer issues, relationship issues, concerns, and values; identify youth participation in community process and initiatives and their participation/connection to mainstream society; provide accessible healing centers, youth-specific detoxification programs, and more youth-centered community-based programs and activities; provide youth with a youth-centered continuum of care that includes detoxification, rehabilitation, and aftercare; and, find create ways to encourage parental involvement.**

⊕ Family Wellness

Few programs address the link between addictions and the intergenerational impacts of sexual violence on both women and men. There are no specific policy initiatives in the Atlantic Region that address the particular needs of girls and women with respect to their roles as mothers, their experiences of violence, or their need for female counsellors or Elders. The needs of women include: addiction healing services specific to the needs of women; shelters for First Nations and Inuit women who are experiencing violence; access to shelters for young First Nations and Inuit women; community programs for women and their children; community prevention programs with the aim

of stopping violence against women in all its forms; and programs for victims of sexual assault.

> **ACTION: As addictions are understood to affect all members of the family, including children and youth, and women's access to treatment is at times affected by being primary parent, a family wellness center, with a dual focus on addictions and violence be established in Atlantic Canada.**

⊕ Women-specific programs

In the Atlantic Region there are no other programs specific to women other than transition houses/shelters, and shelter workers are not specifically trained to work with women who are struggling with addictions. Although some Transition House workers, particularly in Cape Breton, have received addictions training as past NADACA workers, this is the exception rather than an expectation.

> **ACTION/TRAINING: Transition House workers receive training in addictions and cultural safety, and addictions workers receive training in violence and in particular sexual assault prevalence and intervention to provide a more seamless service for women.**

⊕ Community programs to support all family members

Young women face yet another barrier in seeking shelter when experiencing violence: the age of admission. These young women are falling between the cracks – no longer considered children and considered to be in need of care and not yet old enough to have obtained legal status of adulthood.

> **ACTION: More family violence and sexual assault workers are also needed in all communities, for education and to support families to become safe environments for all members.**

⊕ Maternal health

There remains a lack of knowledge about the effects of various addictions on maternal health and the health of children. At the Moncton Gathering several key points were raised with respect to services for women as mothers: there needs to be family planning so mothers have choices or options, including pre-natal services; ongoing parenting

support for those who are struggling with addictions; more knowledge about methadone effects on pregnancy; and prevention education about addictions and the effects on pregnancy. A concern was also expressed that fathers and in particular single parent fathers also need acknowledgement and support.

> **ACTION: A more holistic maternal health program can help address the interconnected health needs of mothers and their families, including the positive cultural affirmation of the role and value of traditional Aboriginal reproductive, pregnancy and birthing knowledge.**

⊕ Two-Spirited

Two-spirited are a non-served and underreported gap in service; there are no programs specific for two-spirited people with addictions in the Atlantic Region. Further, there is little success in keeping two-spirited people in current programs if they enter. Two-spirited family members have to leave the Atlantic Region to receive services and support tailored specifically to their needs.

> **ACTION/RESEARCH: There is a critical need to address the gaps in the provision of health and healing programs and services to address the needs of two-spirited individuals, and in particular the link between isolation and invisibility of two-spirited youth and suicide.**

⊕ Residential School Survivors

The links between residential school trauma and addictions is a focus of concern. Issues include the lack of resources for specific addiction and mental health services to address the many needs arising from the legacy of HTT (Historical Trauma Transmission) and the levels of sexual violence against women and children frequently raised in relation to HTT, and the intergenerational impacts of this feeding the need for addictions. Gaps in services for Residential School Survivors include: lack of transportation to programs and services; lack of resources and inclusion of family members in Residential School Survivor healing; lack of intergenerational work; a safe environment to begin a journey with supportive people around survivors so they can begin to trust; and, a lack of services in Mi'kmaq language.

ACTION: Long-term funding for service providers and programs specifically for Residential School Survivors need to be provided throughout the Atlantic Region. Specifically resources be provided for an Elders' advocate program to hear and act upon the needs of Elders and Residential School Communities.

ACTION/TRAINING: Training for workers on: knowledge of RST impacts; awareness of specific services for RST clients; awareness educational programming regarding RST for clients; and increase all workers knowledge about Aboriginal culture and Aboriginal safety.

⊕ **Concurrent Issues**

Community members with mental health issues face additional obstacles when it comes to receiving treatment. For some jurisdictional issues are creating gaps in services. For others, there is a need to address underlying problems relating to addiction. For adolescents, the link between addictions, suicide and the mental health needs immediate attention. The widespread use of prescription drugs as a primary form of healing for grief, depression and anxiety has lead further addictions issues. There are serious concerns about the increasing misuse of prescription drugs (including methadone, cancer medications and mood-altering drugs) and the combining of prescription drugs with street drugs and alcohol.

ACTION/RESEARCH/TRAINING: Research and education for and with addiction, health and mental health workers on the specific affects and interactions of prescription drugs for First Nations and Inuit is desperately needed. Inappropriate prescribing patterns and the need for stronger monitoring of doctors as well as blocking other access routes (known dealers/internet) for these substances, and widespread prevention programming about the risks of these drugs is called for.

⊕ **An integrated community-based recovery model**

An emphasis on strengthening community-based counseling, self-help and after-care support services as services closer to home create more accessible and cost-effective programs and services. Individuals and families can be empowered to set wellness goals in partnership with addictions workers. An integrated practice requires workers who are specifically dedicated to addictions, who are knowledgeable of relevant First Nations

and Inuit cultural philosophies, languages and practices, who recognize the relationship between trauma, loss and problematic substance abuse, and who have access to standardized training and skill development opportunities as needed.

> **ACTION: The Nunatsiavut plan could be explored as a template for the Atlantic Region. Healing/Treatment Centre mandates could also include providing clinical consultation and support in the areas of trauma, loss and violence to First Nations and Inuit communities and workers.**

8. A FULL CONTINUUM OF SERVICES

⊕ **Prevention**

Prevention includes a wide array of strategies such as turning the front office of the treatment centre into a community room and providing daycare, Head Start programs, and school education. Prevention is a long-term approach. Some well-established treatment centers in the Atlantic region have developed ways and means to incorporate prevention programming into their facilities. In other locations, concerns regarding access to and use of the facilities for after-hours prevention initiatives need to be addressed.

> **ACTION: Support and resources are needed to deliver messages to communities in a holistic manner, emphasizing the maintenance of overall good health.**

⊕ **Detoxification programming**

For many service providers across the Atlantic Region, First Nations and Inuit detoxification programs are a high priority. Moreover, different geographic areas are all struggling in their own ways to deal with the known problems with provincial detoxification programs.

> **ACTION/TRAINING: There needs to be dedicated First Nations and Inuit beds and cultural safety training and supervision for provincial detox staff.**

⊕ **Hiring First Nations and Inuit workers in detoxification programs**

First Nations and Inuit face many barriers in securing employment at the existing Detoxification Centers including union issues and racism. The high turnover in the workplace reflects these struggles.

> **ACTION: An employment equity policy needs to be put into place and monitored to ensure that Aboriginal people are hired, mentored and supported to work in the provincial Detox systems.**

⊕ **Detox and prescription drugs**

There are limited services for detoxing from prescription drugs in the Atlantic region; admissions policies restrict clients on prescription drugs.

> **ACTION/RESEARCH/TRAINING: Accurate and current materials on detoxification from various drugs and combinations of drugs be gathered and training provided to Detox staff as well as NNADAP/NADACA workers.**

⊕ **Detox and youth**

Detoxification programs for youth is also a big issue some identify the need for a youth-specific program as a safety issue.

> **ACTION/TRAINING: An Aboriginal youth Detox program be developed, and in the interim, adequate training and resources be provided to Charles J. to deal with the Detox issues that arise with youth admitted to the program.**

⊕ **Detox and women**

A gender based analysis recognizes the need for women-specific services throughout the provision of programs and services, including detoxification.

> **ACTION: Given the need for other women specific services, a gender based analysis should be considered when exploring the need for First Nations and Inuit Detoxification Programming.**

⊕ **Aboriginal detox center(s)**

Culturally sensitive detoxification centers staffed by First Nations and Inuit are better equipped to address the needs of First Nations and Inuit and are considered a high priority.

ACTION: Establish First Nations and Inuit driven and medical and non-medical detoxification programs that are culturally relevant for both adults and youth.

⊕ Aftercare

Due to lack of resources, aftercare is limited in the Atlantic Region, particularly for smaller and more isolated communities. Issues related to after care and long term treatment were raised in all communities visited, including: long-term support especially for people who do not have the family or community support in order to maintain their sobriety; day programs for people interested in follow-up services; and the need for resource buildings so people, especially young people, can gradually re-enter home and community. Eel River Bar is a best practice consideration.

ACTION: Further exploration of Eel River Bar aftercare as an innovative practice is recommended.

9. COLLABORATION

⊕ Inter-agency teams

The lack of a coordinated approach resulting in communities not feeling well connected with each other was identified by Atlantic participants, stressing that more communication and collaboration needs to occur among communities. Interagency collaboration would strengthen programs and services, make efficient use of stretched program dollars, support more community-based events, and create key collaborative partnerships.

ACTION: The feasibility of a culturally-appropriate Atlantic-wide crisis line be explored.

⊕ Service-management

Collaboration across sectors can help with service management issues for groups of underserved clients. Conne River, MCPEI, Elsipogtog Health Center, and Natuashish Healing Lodge provide best practice team approaches to services and programs.

ACTION: Each of these four locations could be further explored as models of innovation regarding positive collaboration.

⊕ **NADACA**

NADACA is the only agency of its kind in the Atlantic Region, and has received rave reviews for the "sensitive and supportive partnership between NADACA (which brings its expertise and support to the communities) and community-delivered programs."

> **ACTION: That the NADACA model, that provincial wide organizations to support, advocate, and train First Nations and Inuit workers, as well as collaborate on best use of available funds be explored for the Atlantic Region overall.**

⊕ **Struggles in collaboration**

Struggles of interagency collaboration include: busy schedules; scheduling inter-agency meetings; lack of information and funding for collaboration; questions of coordination; burnout; jurisdictional issues; and confidentiality. Collaborations with non-First Nations providers and services produce even more struggles including: racism; off reserve treatment isolation; lack of sensitivity to First Nation and Inuit clients; and lack of communication.

> **ACTION/TRAINING: That cultural safety training be mandatory for all service providers, and in particular provincial Detox and addictions programs.**

SECTION FOUR: CHANGE: CHAPTERS 10, 11, 12

CHAPTER 10: JURISDICTION, FUNDING AND AUTONOMY

⊕ **Jurisdictional issues**

Many of the issues that are standing in the way of service providers addressing the needs of First Nations and Inuit in recovery are outside of their ability to influence directly including: jurisdictional issues and boundaries, funding formulas, and stable funding and resources to meet the service delivery needs of clients.

> **ACTION: National: A process to resolve issues of jurisdictional responsibilities at the provincial, First Nations and federal levels.**

⊕ **First Nations and Inuit Detoxification Program**

One addictions programming priority that is hindered by jurisdictional boundaries is the lack of First Nations and Inuit Detox.

> **ACTION. Regional and/or TC: At least one First Nations and Inuit specific Detox Center in the Atlantic Region, or alternatively some detox beds assigned to each Treatment Center, with resources to staff them.**

⊕ **Funding**

Lack of resources is a huge barrier providing services for First Nations and Inuit groups in the Atlantic Region. It is hard to plan when there are insufficient resources. Funding is a huge limitation faced in terms of providing staff training, staff certification, and meeting the service delivery needs of clients. Lack of adequate funding hinders organizational success. According to the AFN report on public health (2006), "a public health system is a long term agenda; it does not compete on a yearly basis for new funds". Long term programs require long term funding.

> **ACTION: Stable funding and resources should be in place to support the important role that NADACA workers are playing to address addictions/substance abuse issues in First Nation communities in Nova Scotia and extended to NNADAP in the Atlantic Region.**
>
> **ACTION: More money and more long-term money.**
>
> **ACTION: A review of the funding formula based on the geographical logistics and cultural landscape of four provinces within the Atlantic Region is essential.**

⊕ **Capacity building**

Capacity building is recognized as a key issue for the Atlantic regional by all workers and community members. In this report capacity building refers to: staff training, certification, and on-going professional development; building capacity in self determination and governance in addictions; and, working with internal and external agencies to share knowledge and experience.

> **ACTION/TRAINING Capacity building address issues of wage disparity, training, community support, and the social and economic disadvantages faced by First Nations and Inuit.**

⊕ **A coordinated approach**

The lack of a coordinated approach in service delivery is a national issue. A lack of a coordination approach was also identified by Atlantic participants. Communities do not feel well connected with each other and therefore more communication and collaboration needs to occur amongst Atlantic communities.

> **ACTION: RAPC continue to be consulted with and provided resources as a coordinating body for renewal and reprofiling initiatives in the Atlantic Region.**

⊕ **Mediating the program concerns of staff, clients and community members**

As NADACA is the primary force for policy development and implementation in the Atlantic Region. There were some concerns expressed in the communities served by NADACA that there is nowhere to turn with grievances against the organization by either staff or regarding client treatment, especially if directors or political authorities are implicated. Conflict of interest regarding treatment centre boards was raised in communities in both New Brunswick and Nova Scotia.

> **ACTION: An independent community-based or Atlantic association, ombudsperson, or grievance officer be created to mediate concerns by staff, clients and community members involved with NNADAP/NADACA services.**

⊕ **Accreditation and certification**

Generally accountability for practice rests with a governing body familiar with the practice. A current gap in the accreditation and certification processes is the lack of inclusion of First Nations and Inuit culturally specific counseling courses or materials in the programs. Currently, people can become certified to provide services as an addictions counselor in a First Nations and Inuit Treatment facility or prevention program with no resources on First Nations and Inuit history, philosophies or counseling strategies. Likewise, First Nations and Inuit counselors receive no credit for experience or training in First Nations and Inuit methods. This gap in the certification process does

not support the vision of addictions programming that would incorporate First Nations and Inuit healing methods.

> **ACTION/TRAINING: That a training institute built on the knowledge and practice of key members of the Atlantic additions networks be developed and used as a springboard for certification and accreditation based on criteria relevant to practice within First Nations and Inuit communities in the Atlantic Region.**
>
> **ACTION (Accreditation): Require organizational practices with Accreditation Canada be rewritten to eliminate exclusively Western medical approach to health, and include materials, practices and categories specific to Aboriginal philosophies and practices. All pressures towards accreditation by Health Canada should cease until this is completed.**
>
> **ACTION (Certification): Certification requirements require review as there is a lack of inclusion of Aboriginal culturally specific counseling courses or materials in the programs. That a Certification body for Aboriginal counselors independent of existing bodies be actively pursued.**

11. ATLANTIC ADDICTIONS WORKFORCE

⊕ **Workforce priorities**

That sustainable workforce must be knowledgeable and skilled in providing a comprehensive range of addictions services that are culturally appropriate. Issues such as staff shortages, attraction and retention of staff, worker burnout and self-care, and wage parity were consistently raised across the Atlantic region. An independent community-based or Atlantic association could help to mediate concerns by staff, clients and community members.

> **ACTION/TRAINING: More staff are required to operate the current programs. Accessible and culturally relevant training opportunities are urgently needed to increase the number of qualified First Nations and Inuit addictions counselors. Recruitment policies are needed for Northern remote communities.**
>
> **ACTION: Personnel policies developed for consistency across the Atlantic Region, and to help new staff. Policies should be reviewed for a gender-based analysis and to be in keeping with aboriginal views of**

egalitarian decision making and self-determination.

ACTION: Care for Caregiver programs be developed and made available on a regular basis, individually on a bi-weekly and staffing groups on a monthly basis, funded for all addictions and wellness workers to have the support they need to care for themselves.

⊕ **Emergency response program**

While a few communities currently have a crisis team, many have no critical incident team or plan in place and very few maintain a critical incident file. Every community is unique and program strategies need to fit the needs of small and isolated communities, especially where other key agencies are limited or non-existent.

ACTION: Develop an emergency response program and training program in coordination with NNAPF that is sensitive to geographic and cultural landscape of the Atlantic Region. This could also include a 24 hour crisis line for the Atlantic Region.

⊕ **Wage parity and salary review**

Inadequate salaries and wage parity is a challenge for treatment and prevention programs in the Atlantic Region. Both treatment and prevention programs are dependent on workers who extend themselves beyond available resources. Inadequate wages is a gap in human resource development thus jeopardizing the maintenance of the current level of program and service delivery. Similarly few training and research opportunities exist in the region. Consequently, the high turnover of staff and staff burnout are constant challenges for effective program and service delivery.

ACTION: Achieve wage parity with the public sector to ensure the retention of staff and the delivery of effective programs and services.

ACTION/TRAINING: Ensure ongoing and up-to-date training and professional development to meet the changing needs of clients and thus staff to confidently address these needs.

⊕ **Research gaps and program development**

There is still very little published research specific to Atlantic First Nations and Inuit Addictions. Most material collected is to meet reporting requirements for governmental financial accountability, especially for transferred programming, rather than based on a regionally driven process for research or program development as a whole. A First Nations and Inuit-specific addictions research and training institute for the Atlantic Region would help to address this gap.

> **ACTION/RESEARCH: Hire a consultant to work with RAPC, to move forward with the plan to establish a First Nations and Inuit-specific Addictions research and training institute for the Atlantic Region. This would include an exploration of all options of potential links with existing post-secondary institutes, especially tribally controlled institutions, including the UNBI in Fredericton. Given the range and number of previous training initiatives undertaken, implementation of a PLAR (Prior Learning Assessment and Recognition) process in assessing and assigning post-secondary credit would be beneficial to workers in the Atlantic Region.**

12. ADDICTIONS SERVICES POLICIES

⊕ Addiction services policies

The policies relate to both the employees of NNADAP/NADACA and to the clients aspiring to or residing within Treatment Centers. Policy issues identified by communities and addictions service and program providers include: zero tolerance policies; fair and safe treatment protocols; lengthy waiting lists; services to off-reserve/non-status/non-aboriginal; house rules and their impact on individual treatment processes; polices relating to mental health issues, suicide and prescription drug use; transportation policies; lack of gender based analysis of policies, and the impacts of policies on specific groups such as corrections and geographic discrimination. To address these policy issues we suggest a multi-level policy analysis and the creation of a position and a process be established to provide this analysis on an on-going basis.

⊕ Zero-tolerance

Like the policy on self-care, the responsibility rests with individuals, and has the potential to infringe on self-determination. This, of course must be balanced with safety for clients and co-workers.

> **ACTION: Eliminate gap in the Zero Tolerance policy regarding lack of similar policy with respect to the leadership.**

⊕ **Lengthy waiting lists**

Existing assessment standards include the requirement that the full pre-assessment process must be complete. While these processes have evolved to work towards greater success of clients once in treatment, participants indicated that length of waiting lists for treatment are too long, creating unnecessary barriers to healing addictions.

> **ACTION: Rotating intakes across the Atlantic region be explored as a strategy to address lengthy waiting lists.**

⊕ **Gender based analysis of policies**

Although there is an expressed desire to provide services to women as well as men, there is gap in terms of referral policies regarding pregnant women, access to or provision of child care for women or men responsible for children. There is also a gap in terms of family wellness facilities, policies regarding special considerations for victims of violence or sexual violence, and the identification of issues around sexual orientation.

> **ACTION: That a position and a process be established to provide a gender based analysis (GBA) of policies and practices affecting women workers and clients in addictions services in the Atlantic Region, with special attention to hearing and mediating claims of sexual harassment/abuse.**

⊕ **Transportation**

Given the geographic distances within the Atlantic Region, and in particular the geographic isolation of some, policies regarding transportation are a concern for many participants. Further, changes in the guidelines for the provision of transportation though Medical Services presents a gap and may deter workers and bands from making referrals to treatment facilities as they do not want to see community members “stuck” without transportation home.

ACTION: Changes in the guidelines for the provision of transportation though Medical Services are necessary to acknowledge geographic disparities, to fund transportation to preventive and aftercare services, to encourage access to treatment in a timely manner and to give more flexibility in treatment options. Recovery is a long-term process and may take many attempts before being successful. Transportation policies need to account for this.

⊕ **Self Determination**

Current NADACA/NNADAP policies and protocols flow from the stated commitment to the development of treatment protocol that is fair, protective from harm, and in the best interests of clients. But, as William Nevin says" "it's about offering choices to sobriety, the person chooses".

ACTION: Explore best practice and policy options for NADACA/NNADAP based on traditional philosophies of self determination.

⊕ **Mental health issues: suicide and prescription drugs**

NADACA has recently enhanced their case management efforts to monitor and protect clients who may be dealing with various mental health issues, to identify who may be in danger to themselves and possibly, a danger to others.

ACTION/TRAINING: Specific policies, procedures and staff development with respect to clients with mental health issues be reviewed across the Atlantic Region to provide more integrated services to people showing more visible signs of trauma.

First Nations people are now on a path of healing, including renewing our traditions and languages, strengthening families and communities and rebalancing gender roles[45].

As First Nations and Inuit we can respect our diversity and support each other to achieve real forms of self-determination that will affirm and preserve our unique cultural identity. The closing comment from the NADACA Manual summarizes the strength and resiliency of the communities of First Nations and Inuit struggling to assist their relatives in recovery:

"Since the beginning, we have been a contingent of ordinary people trying to do extraordinary things for our people. We are proud of our accomplishments, and we are proud of our solid relationship with the First Nation communities we serve. We look forward to the day when we are no longer needed, but until that day comes, we continue to provide a vital service to our native people throughout the (Atlantic) native community."

ENDNOTES

[1] National Native Addictions Partnership Foundation "NNAPF and the NNADAP Renewal Process". 2003.

[2] In 2006 The Toronto Star http://www.thestar.com/specialsections/article/144902 reported that "Despite lofty intentions and even some victories, the program's worst enemies are the people who run it and who have shut the Innu out of the decision-making process. It has created an ever-widening gulf between the healers and the people to be healed." At the five year mark, two evaluations were completed: 1. The Health Research Unit at Memorial University in St. John's; and 2. IER Planning and the Aboriginal Research Institute of Ottawa. According to The Star, both evaluations concluded that not only do the Innu need to be involved in making decisions about the healing of their communities, but they also need to be the ones doing the healing.

[3]This statistic is from the analysis of the data collected from the Canadian Community Health Survey-Mental Health and Well-being as reported in the Public Health Agency of Canada Epidemiological Review, available on line at:
http://www.phacaspc.gc.ca/canada/regions/atlantic/Publications/Mental_Health_Scan/4-eng.php

[4] We were able to obtain one year of statistics for the use of Treatment Facilities, and a log of trips paid in 2007. No other statistics were provided.

[5] Addictive Behaviours Among Aboriginals in Canada. Prepared for the Aboriginal Healing Foundation By Deborah Chansonneuve. 2007.

[6] Addictive Behaviours Among Aboriginals in Canada. Prepared for the Aboriginal Healing Foundation By Deborah Chansonneuve. 2007.

[7] RHS refers to the First Nations Regional Longitudinal Health Survey 2002/03: Results for Adults, youth and children living in First Nations communities. RHS National Team: Ottawa: Discussion and Recommendations Assembly of First Nations/First Nations Information Governance Committee. 2007.

[8] At the five year mark, two evaluations were completed of the L: 1. The Health Research Unit at Memorial University in St. John's; and 2. IER Planning and the Aboriginal Research Institute of Ottawa. In 2006 The Toronto Star http://www.thestar.com/specialsections/article/144902
http://www.thestar.com/specialsections/article/144902

[9] NNAPF website, retrieved, February 25, 2007.
[10] Youth Solvent Addiction Committee Annual Report for year ending March 31, 2007
http://www.members.shaw.ca/ysac/annual_report/full_content/annual%20report%202006-2007%20e.pdf

[11] The information about this program was taken from their site: http://www.nogemag.ca/ You can find also find working copies of useful tools and resource currently in development on their site.

[12] NAHO Cultural Safety Fact Sheet.
http://www.naho.ca/english/documents/Culturalsafetyfactsheet.pdf(please refer to the NAHO Cultural Safety Fact Sheet for a full discussion on this)

[13] Lots of current statistical material from a National First Nations and Inuit perspective can be found in the AFN discussion paper called: Discussion and Recommendations Assembly of First Nations/First Nations Information Governance Committee (2007). First Nations Regional Longitudinal Health Survey (RHS) 2002/03: Results for Adults, youth and children living in First Nations communities. RHS National Team: Ottawa.

[14] In 2005, the Public Health Agency of Canada launched the determinants of health as a tool for policy research, to work to address how inequalities in social conditions impact on health. There are 12 key determinants of health, including: income and social status; social support networks; education and literacy; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture. The *Blueprint on Aboriginal Health: A 10-Year Transformative Plan*, prepared for the meeting of First Ministers and Leaders of National Aboriginal Organizations in November of 2005, was based on the determinants of health. All parties agreed to collaborate on actions to address determinants such as housing, education, food security, violence against First Nations and Inuit women, children and elders and environment, including clean water and environmental contaminants; to address regional realities; and to identify and implement best practices that take a holistic collaborative approach.

[15] Source: The Canadian Encyclopedia: http://www.thecanadianencyclopedia.com/index.cfm?PgNm=TCE&Params=M1ARTM0012281

[16]article referenced in The Canadian Encyclopedia:

http://www.thecanadianencyclopedia.com/index.cfm?PgNm=TCE&Params=M1ARTM0012281

[17] Dr. Frank Tester, a UBC social work professor and author of "Tammarniit (Mistakes): Inuit Relocation in the Eastern Arctic, 1939-1963" quoted in IPS: Health: Native Suicide Surge Rooted in Colonial Traumas by Am Johal
http://ipsnews.net/news.asp?idnews=40697

[18] This issue was raised consistently in other documents including, Acting on What We Know: Preventing Youth Suicide in First Nations, The Report of the Advisory Group on Suicide. Preventionhttp://www.ihs.gov/nonmedicalprograms/dirinitiatives/Documents/preventing_youth_suicide.pdf)

[19] GENDER-BASED ANALYSIS (GBA) Gender-based analysis (GBA) uses sex and gender as an organizing principle to bring forth and clarify the difference between men and women, boys and girls within the context of their social relationships and life experiences. It shows how social conditions affect women's and men's (and girl's and boy's) health status and their access to, and interaction with, the health care system. GBA provides a framework that should be overlaid with a diversity analysis that considers factors such as race, ethnicity, level of ability and sexual orientation. Some key questions arise from the GBA framework: In what ways are both First Nations and Inuit women's and men' (girls and boys) experiences considered in identifying the issues, creating the policy or program? Is the outcome of the programs and/or policies reflective of First Nations and Inuit values and inclusive of

both First Nations and Inuit men and women (boys and girls)? AFN is exploring these same concepts through the language of a Gender-Balanced Approach.

[20] Material was obtained from this newspaper article:
http://findarticles.com/p/articles/mi_6964/is_6_15/ai_n28544278

[21] Found in Indigenous Law Journal: University of Toronto:
http://www.indigenouslawjournal.org/node/62

[22] This quote is from the news story entitled "Elsipogtog Takes a Stand Against Drug Trade". It can be found online at: http://www.mapinc.org/drugnews/v09/n306/a05.html

[23] National Institute on Drug Abuse (NIDA) International Program: Fostering International Collaborative Drug Abuse Research, Training and Exchange.
Methadone Research Web Guide December 2006
http://international.drugabuse.gov/collaboration/PDFs/MethadoneResearchWebGuide.pdf
United Nations Office on Drugs and Crime: Principles of Drug Dependence Treatment, 2008
http://www.who.int/substance_abuse/publications/principles_drug_dependence_treatment.pdf
Canadian Center on Substance Abuse
http://www.ccsa.ca/Eng/Pages/Home.aspx

[24] More information is available at: http://www.micmaccentre.ca/direction180/methbackground.htm

[25] This material comes from *First People Child & Family Review: A Journal on Innovation and Best Practices in Aboriginal Child Welfare Administration, Research, Policy & Practice.* Volume 3, 2007, Special Issue PP. 52-55. The article is called *A Smoking Prevention Program for Aboriginal Youth.* It is available on line at
http://www.fncfcs.com/pubs/vol3num2/McKennitt_pp52.pdf

[26] "With a few exceptions, the evidence on the effectiveness of the interventions considered comes from studies that have not specifically targeted First Nations or Inuit communities or individuals and the generalizability of the results to these peoples needs further research", say Ogborne, Paglia-Boak, and Graves.

[27] The Cape Breton Post: *Eskasoni struggling with Suicides*
http://www.capebretonpost.com/index.cfm?sid=217511&sc=145

The Cape Breton Post: *Eskasoni looks to past for answers* http://www.capebretonpost.com/index.cfm?sid=227191&sc=145

The Cape Breton Post: *Aboriginal Stars bring positive messages to Eskasoni*
http://www.capebretonpost.com/index.cfm?sid=227192&sc=145

[28] Covered in the Miramichi Leader by Wendy Patterson Eel Ground, Elsipogtog drama students spread message about prescription drug misuse, Friday February 20th, 2009

[29] Art of Resilience http://www.youtube.com/watch?v=ngxV6b-49vo

[30] Vancouver Native Health Society: Sheway: http://www.vnhs.net/index.php?option=com_content&view=article&id=49&Itemid=56

[31] Other anti-violence centers can be found through the Canadian Association of Sexual Assault Centers, at www.casac.ca.

[32] Recommendations are from the *Aboriginal Holistic Approaches to Healing and Wellness: A Policy Paper,* prepared by the Native Women's Association of Canada, for the Second National First Nations and Inuit Women's Summit II July 29-31, 2008 Available at: http://www.nwachq.org/en/documents/AboriginalHolisticApproachestoHealingandWellness.pdf

[33] For more information about Healing Our Spirit: BC Aboriginal HIV/AIDS Society, see *Aboriginal Concepts of Healthy Sexuality in BC: Final Report*. Submitted by Hasina Samji and Jonathan Potskin 9/1/2008. Available on line at :http://www.healingourspirit.org/education/Final-Report-Youth-2008.pdf

[34] For more information check out:
Aboriginal Healing Foundation at http://www.ahf.ca/ Indian Residential Schools: Truth & Reconciliation Commission http://www.trc-cvr.ca/
Legacy of Hope Foundation http://www.legacyofhope.ca/Home.aspx
Aboriginal Healing Foundation: Research Series http://www.ahf.ca/publications/research-series
YouTube: Canada Apologizes for Residential School System
http://www.youtube.com/watch?v=-ryC74bbrEE&feature=related
YouTube: Canada Apologizes: Aboriginal Women: Beverly Jacobs
http://www.youtube.com/watch?v=jxc1TNWKFoM&feature=related
Health Support Services for Former Indian Residential Schools Students
Nova Scotia, New Brunswick, Newfoundland, and Prince Edward Island 1-866-414-8111

[35] James Douglas Gloade of Millbrook First Nation, was given a 15 year sentence Friday, Jan. 23, 2009 for manslaughter in the killing of his grandmother Nora Bernard. The court states that Gloade consumed $500 worth of crack cocaine, OxyContin and Valium when he went to his grandmother's house on Dec. 26, 2007, looking for more money. Gloade is quoted in court as saying his "head was buzzing" before he killed his grandmother in a drug fueled rage. In the late 1980's, native rights activist, Nora Bernard began organizing abuse victims who attended a residential school in Shubenacadie, N.S. The original lawsuit argued that tens of thousands of children had been robbed of their culture and language while attending the infamous schools, run by six Christian denominations until the 1960s. Until her death, she spent 15 years fighting to win compensation for generations of native children.
http://www.cbc.ca/canada/nova-scotia/story/2009/01/23/ns-gloade-sentencing.html
http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20090123/nora_bernard_090123/20090123?hub=Canada

[36] http://www.nnapf.org/content/re-profiling-useful-information

[37] As told in Addictive Behaviours Among Aboriginals in Canada. Prepared for the Aboriginal Healing Foundation By Deborah Chansonneuve. 2007.

[38] More information about the Moose Hunt is available on the rcmp-grc web page: http://www.rcmp-grc.gc.ca/ns/prog_services/community_policing-police_communautaire/adps-spai/moose-eng.htm

[39] Reproduced from the *Miramichi Leader* by Laura Wells, Friday, October 24, 2008: D2.

[40] The Aftercare form and booklet is available from Rising Sun Treatment Center in Eel Ground, NB.

[41] The news story entitled "Elsipogtog Takes a Stand Against Drug Trade" can be found online at: http://www.mapinc.org/drugnews/v09/n306/a05.html

[42] http://www.thestar.com/specialsections/article/144902

[43] "In the early 1980s, a regional two year training program was initiated in consultation with St. Francis Xavier University. Another regional program was launched for Community Health Workers with the Maritime School of Social Work, Dalhousie University in the late 1980s. Aside from these regional approaches, many workers in the addictions field have been localized. NADACA workers participated in a Mi'kmaq Bachelor Social Work Programme of the Maritime School of Social Work in the mid 1980s which coincided with the development of the Mi'kmaq Family & children Services of Nova Scotia. Following the establishment of Treatment Centers in the late 1980s, NADACA participated in a two year Native Certificate Programme specializing in addictions affiliated with the Faculty of Health and Bachelor of Social Work programs of Dalhousie University 1993-1995. The Labrador College has also attempted to address human resource development for addiction workers through specialized programming. The problem with these approaches to training is that due to limited resources, the training programs are one time programs and take a considerable amount of funding, resources, coordination and implementation".

[44] According to the Atlantic Regional Client Status Report (ARCSR) (01.01.2007 to 31.03.2007).

[45] Native Women Association of Canada (NWAC) (2007) has identified some key values for a gender based approach which can be applied to any program or policy analysis. These include: ***Holism*** - Policies will recognize the whole person, recognizing the relationship of spiritual, emotional, mental and physical health within the individual and the importance of family and community. ***Voice –*** First Nations and Inuit will be given a voice in decision making and opportunities to participate in processes that supports sustainable communities. ***Equity*** – Sustainable First Nations and Inuit communities should be provided services and resources to compensate for historical and social injustices, aligned with First Nations and Inuit and Treaty rights. Outcomes achieved should be in line with those available for other Canadians. Equity leads to Equality. ***Cultural Diversity*** – Sustainable First Nations and Inuit communities must be founded on a respect for cultural diversity. Cultural Diversity is strongly linked to Equity. ***Control*** – Sustainable First Nations and Inuit communities should be controlled by First Nations and Inuit themselves, not imposed from the outside. ***Cultural Identity*** – Services and policies will recognize and affirm the cultural identity of First Nations and Inuit.

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