

You Really Are Going to Make a Difference...Right?

A Partnership between the First Nations Health
Council and Health Canada

Mostly Salish Consulting

2009

Acknowledgements

Valerie - Louise - Theresa - Mildred - Anita -
Graham - Paul - Yvonne - Clinton - Pat - Richard -
Marilyn - Rosemary - Gary - Gina - Sandra -
Concern - Lina - Rosie - Janice - Charmaine -
Jill - Mosty Salish Consulting conducted a series of
Brener - phone interviews, on-line surveys, focus
Sheldon - Crystal - Robert - Laura - Sabine -
Gordon - Lynda - Joanne - Jeremy - Patti - Shawn
Ray - Dawn - Antoine - Marion - Joe - Virginia -
Chuck - Darby - Mavis - Teresa - Etta - Wanda -
Rachel - Peter - Akimi - Luke - Evan - Desiree -
Peggy - Louisa - Willie - Sean - Hayden - Jeri Lynn
- Lisa - Myrna - Carla - Joyce - Darcy - Cecelia -
Viki - Phyllis - Christine - August - Ron - Lynn -
Victoria - Manina - Dor - Mary - Sheila - John -
Cristel - Norm - Charlene - Janine - Aileen -
Freddie - Phyllis - Leo - Hertha - Joan - Gerard -
Jocelyn - Michelle - Vina - Patrick - Cheryl - Betsy
- Janelle - John - Teena - Robert - Vernon - Lisa -
Bea - Giselle - Gayle - Marcia - Bonnie - Darlene -
Gerard - James - Willard - Donna - Morgan - Anita
- Grahame -

The BC Addictions Advisory Team for their countless hours of guidance and support for this project:

Kitsumkalum First Nation

Valerie Genaille, Executive Director, Association of BC First Nations Treatment Directors

Paul Hanki, Executive Director Aboriginal Health, Northern Health Authority

Richard Mayuk, Executive Director Stehiyaq Aboriginal Healing Society

Yvonne Rigsby-Jones, Director Tsow Tun Lelum Treatment Society

Andrew Robinson, Associate Deputy Representative for Advocacy, Aboriginal and Community Relations, Representative for Child and Youth BC

Charmaine Thomas, NNADAP Addictions Counsellor, Squamish First Nation

Rosemary Trehearne, Sto:lo Elder

Carrie Victor, Youth Representative

Paul's Place

Ahousaht Healing Project

Ad hoc members of the committee were:

Jean Allbeury, Mental Health and Addictions, First Nations Health Council

Michelle Degroot, Health Policy and Advocacy, First Nations Health Council

Joanne Nahanee, NNADAP, Health Canada

Jody Olsson, Wellness Coordinator, First Nations Health Council

Carrie Reid, Mostly Salish Consulting

Urban Aboriginal Justice Society

Squamish Nation

Further we wish to thank:

- Richard Mayuk, Executive Director of Stehiyaq Aboriginal Healing Society for looking at the Treatment Centre findings;
- Laura Cranmer, UBC PhD student, for looking at the Community findings;
- Sandra Good, Health Director, Snuneymuxw First Nation for looking at the Health Director Data

Tsow Tun Lelum Treatment Centre

Qualicum First Nation

Janelle McMillan, FASD Educator

Table of Contents

Table of Contents4

 Preface.....6

Introduction and Context:8

What’s going on in the water?9

 The people in the water9

 And how are the people impacted?.....9

 Why do people drink?13

Beside the Water, Planning a Journey: Methodology.....14

 Limitations in the Methodology.....16

Who is Skipping the Canoe?17

Who are the Pace Setters?.....19

 Association of British Columbia First Nations Treatment Programs (ABCFNTP).....19

 BC Association of Friendship Centres.....23

 Circle of Life24

 Tribal Journeys25

 NNADAP Worker Success Stories25

Pulling: Who are the Paddlers and what are they doing?.....28

 First Nations Health Directors28

 Youth Workers in BC29

 Treatment Centers29

 NNADAP Workers.....33

If Culture is the Canoe, what is the Relationship with the Water?.....38

Good and Bad: The Sails40

 Mental Health.....40

 Traditional Teachings42

 Harm Reduction44

 Methadone.....45

Where is the Next Journey?	47
Prevention	47
Prevention Programs.....	47
Family Treatment as prevention	47
FASD Support and Prevention	48
NNADAP workers and Wage Parity	48
Partnerships with Youth Workers and the public education system.....	50
Training.....	51
Treatment.....	52
Treatment Centre Re-profiling	52
Aftercare.....	53
Gender.....	55
First Nations	55
Culture	55
First Nations Leadership.....	55
Non-Insured Health Benefits.....	55
Non-Insured Health and Travel	56
Detox	57
Recommendations to NNADAP	58
Recommendations to the First Nations Health Council	58
Considerations for further research.....	60
Appendices	61
Appendix I: Key informant interview questions with Community Health Directors:.....	62
Appendix II: Youth Worker Survey	63
Appendix III: NNADAP Worker Survey	65
Appendix IV: Questions asked of Treatment Centres	69
Appendix V: ABCFNTF Chart.....	71
Appendix VI: Community Member Survey.....	74
Appendix VII: Why do so many First Nations people think it's not a good idea to drink? Clustered Community Member Responses	77
Appendix VIII: First Nations Addictions Certification... ..	79
Appendix IX: ABCFNTF Discussion Paper on Patient Travel.....	81

Preface

Within this document we are choosing to use the analogy of a canoe journey. A canoe journey requires a crew, a canoe, paddles, and the waters to navigate. It suggests a destination. Additionally, not only is the canoe essential, but skilled canoe builders, and those who taught the canoe builders and the canoe builders before them. Throughout this paper we will refer to necessary components of a canoe journey:

- The skipper who from the back of the canoe, leads.
- The pace setter, who from the front of the canoe, sets the pace for the pullers
- The pullers, who if well nourished, rested, and prepared and strong, pull the canoe towards its destination
- The paddles, who the pullers work together with. They ensure that the pullers are not just added cargo.

Sometimes a sail is a component of a journey. And while the sail might get the canoe to its journey faster, and allow the pullers to rest, they can be controversial. Some people say that First Nations did not use sails before contact, and others say they did. Sails can be seen to occasionally slow the canoe down; tip the canoe, cloud vision and speed the canoe up to a point where other elements are missed. They can create tension.

The design of this paper suggests the following with regard to substance use and misuse in BC First Nations:

- The ocean represents substances and the people floating in that water. It includes the harmful effects of alcohol and drug misuse on First Nations and Aboriginal people in BC.
- The skipper represents leadership and most specifically the unsung leaders of the addictions communities in BC.
- The pace setters are best practices and include the Association of BC First Nations Treatment Programs and BC Friendship Centres; specific programs such as the Circle of Life program in Terrace; and cultural strongholds such as Tribal Journeys on the west coast of BC.
- The paddlers represent programs and service areas including Treatment Centres, Community NNADAP workers, Youth workers in community and within the school systems, Provincial programs and more.
- The sail represents challenges and areas that may be seen as controversial, in particular areas of Mental Health epistemology, harm reduction approaches and methadone maintenance programs.
- And the canoe is the story: it is the culture.

We assume the right to refer to ourselves in the collective, and therefore understand that we are the Aboriginal voice in BC in this momentary truth and that all others will be identified.

Introduction and Context:

In BC Chief Medical Health Officer Perry Kendall's report (2005) he noted strongly that Aboriginal health was about more than symptoms; that it is rooted in the histories of trauma: "The key considerations are a long history of colonization, cultural deprivation, political impotence, and systematic discrimination, as well as genetics, lifestyle, socio-economic factors, poor quality housing and community environments, unemployment, and low levels of education." (p. xix)

The BC Region wishes to state this strongly because while our survey respondents worded their answers simply, the pain behind why Aboriginal people drink is far from simple and continued support is essential and in some cases should be mandatory.

In 2008 the National Native Alcohol and Drug Abuse Program (NNADAP) set out across Canada to gather information to inform the federal government of the gaps in substance misuse and on good practices within each region. They recognize that alcohol and other substance use problems have been consistently identified as a priority health concern by First Nations. In light of the profound health, economic and social costs associated with substance use and addiction, the necessity for an array of services that reflect best and promising practices and are informed by both evidence and the voice of the people are essential.

The duty to consult with First Nations was established in the Haida Nation and Taku River Tlingit Decisions. (2005) and in 2008 the First Nations Health Council in BC undertook the BC Regional Addictions Needs Assessment, intending to consult with as many First Nations people in BC as possible in the allotted time frame. The following criteria was set by Health Canada to ensure a smooth and collaborative needs assessment process

- The needs assessment must consider the needs and equalization of funding for the following groups/lenses: gender, youth, pregnant women, and mental health (concurrent disorders). Other lenses may be utilized at the discretion of the Region and their partners;
- The needs assessment should seek out and emphasize arrangements or best/promising practices that are already being delivered within the NNADAP system¹;
- The needs assessment considers existing services in relation to an integrated continuum of services (e.g., protective factors, prevention, detoxification, assessment, referral, treatment, and aftercare) when identifying gaps and assets. In doing so, current and potential linkages with key provincial services including specialized addictions and mental health services will be explicated.
- The addictions funding envelop will not be impacted negatively by the outcomes of the Evidence-Base exercise; further, recently announced resources provided through National Anti-Drug Strategy will be used in support of NNADAP's ongoing modernization;
- The needs assessment will inform recommendations to modify and maximize the impact of existing investments;

¹ Because we have no way of quantifying 'best', we are calling them good practices.

- The needs assessment is driven by First Nations as they will be responsible for making decisions in partnership with First Nations and Inuit Health Branch (FNIHB) regarding how to renew their national and regional addictions systems;
- The underlying premise of the needs assessment and the Addictions Evidence-Base is to establish a renewed addictions system which ensures that First Nations are receiving the best possible care.

What's going on in the water?

The people in the water

While they recognize that substance misuse happens to anyone, Health Canada identified four main target areas to be included within the parameters of this study. They are youth, pregnant women, gender, and people with concurrent disorders of addiction and mental health. The challenge is that not all services are provided in all communities. Across BC an entire person can be theoretically served. Unfortunately, many people are in isolated communities with no accessible services. Or people are in semi-isolated communities with no access to travel to nearby opportunities.

In general, looking at longitudinal care, all the First Nations Health Directors we interviewed identified healthy programming for pregnant women, with some identifying specific FASD prevention strategies. Programs cover: prenatal education, nutrition, doulas, Healthiest Babies, Post natal programs, Aboriginal Head Start and parenting programs.

Children (those 14 and under) are generally served in pre-school and head start programs, and are sometimes offered hot meal programs in school, clubs, activities, workshops, cultural programs, after-school programs and recreation with education built in. Parenting programs, including one fathering program, are accessed.

Youth (ages 15-30) are served often through sports and athletic programs, cultural programs, and arts (both traditional and contemporary). School programs have a significant role. Other programs include boys and girls groups, youth councils, food programs, reading programs and camps. Specific youth workers were also identified, including a youth and justice worker, a youth wellness worker, a suicide prevention worker and elders.

And how are the people impacted?

83% of community survey respondents rated their own wellness as good or better (41.8% good; 27.6% great; 13.9% excellent). While our data tells us that First Nations people in BC are more likely to feel healthy than not, there are alarming statistics with regard to alcohol related harms amongst First Nations in BC. Our research shows that alcohol and cannabis are the most prevalent drugs of choice of BC First Nations people and this is further supported by other research. (First Nations Regional Longitudinal Health Survey, (2002/3 BC); AHF, 2007). In addition, amongst high risk populations front

line workers have identified high cocaine use amongst at-risk populations. (Centre for Addictions and Research BC's Alcohol and Other Drug Monitoring program).²

We asked our survey respondents what substances they themselves use. 39% indicated that they use alcohol. 8% use cannabis. 3% use 'other substances'³. Less than one percent of respondents use cocaine and stimulants and hypnotics and sedatives. We were also curious to know about prescription medication and note that 15% of respondents indicate using prescription medication for pain; 7% for depression; and 3% for anxiety. Less than 1% use prescription medication for hyperactivity. 26% of respondents indicate using other prescription medications. Respondents were more likely to use prescription pain medication than cannabis.

We also asked youth workers "How many children or youth do you work with, within a week, who use drugs or alcohol?" They reported that they work with between 5 and 30 children per week who use substances, mainly alcohol and cannabis.⁴ We were curious about the use of prescription medication, and note that prescription drug use is high. 74% of respondents work with youth on medication for hyperactivity; 60.5% with youth on medication for depression; and 37.2 on medication for anxiety. We note this because the incidence of overdosing on prescription medication is higher than overdosing on illicit drugs. (Poulin, Stein and Butt, 2000) Alcohol is the drug of choice on the downtown eastside as well, although our sources noted that crack cocaine was also a significant force.

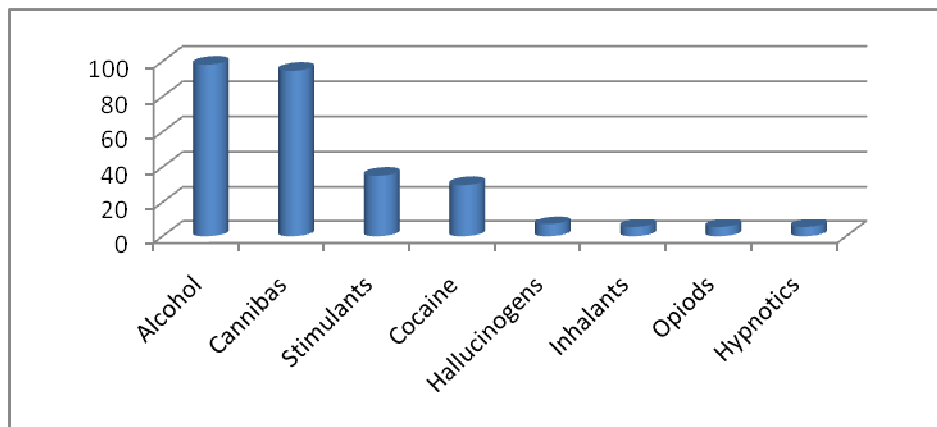


Table 1: The drugs of choice amongst the client base of Aboriginal youth workers.

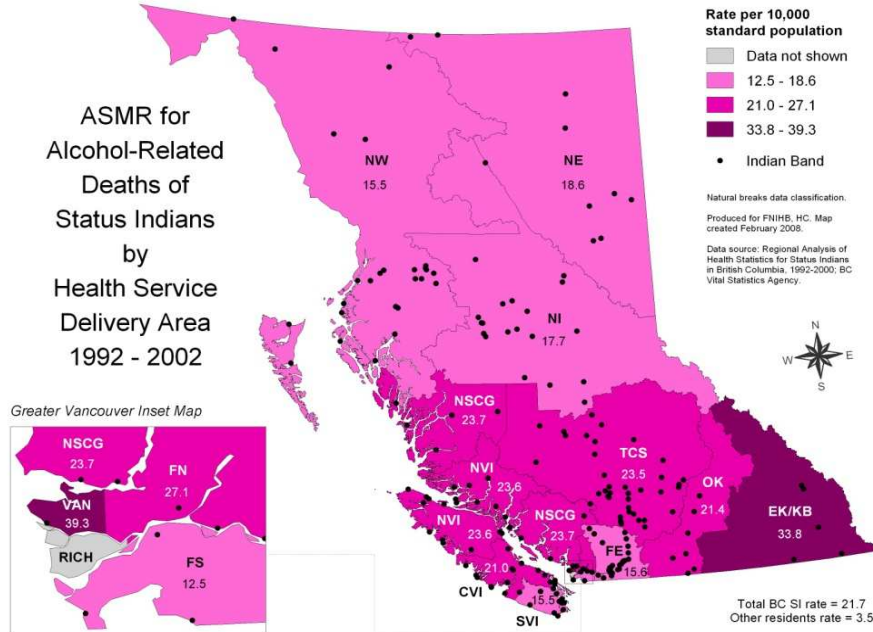
First Nations people experience alcohol related deaths seven times the non-Aboriginal population in BC. (Perry Kendall, BC Health Officer, 2008; INAC, 2008) Geographically the alcohol related deaths are highest in the East Kootenay and in Vancouver where rates are 11 and 13 times higher than other BC residents. Further to this CARBC reported in 2008 that the "Geographical regions have distinct differences.... For example, the highest rate of alcohol caused hospitalizations in 2007 belongs to

² Accessed June 12, 2009 at <http://carbc.ca/MonitoringProject/HighRiskPopulations/tabid/424/Default.aspx>

³ Compared to the data in the First Nations Regional Longitudinal Health Survey (2003) our results show lower incidence of alcohol and drug use. We suspect that because of the nature of this study, we accessed more of the people who do not drink, than a clear random sampling.

⁴ Again this is consistent with data from the Regional Longitudinal Health Survey (2007).

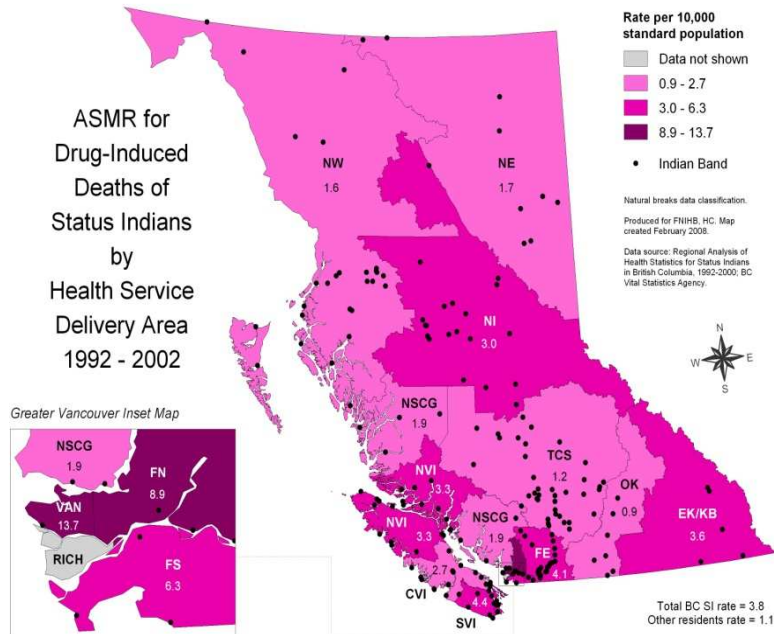
Northern Health, at 657/100,000 people, an increase from 608/100,000 in 2002 ($p = .022$). In comparison, the rate of alcohol caused hospitalizations in Interior Health was also considerably above the provincial rate (Interior Health 460/100,000; BC 404/100,000), although it has not shown a significant increase from 2002 to 2007.”



First Nations people are three and a half times more likely than non-Aboriginal people to experience drug related deaths. (BC Health Officer, 2008; INAC, 2008) Geographically the lower mainland, especially Vancouver and North and South Fraser regions show the highest numbers.⁵

Drug Related Deaths:

⁵ We note that the Okanagan region is shows fewer drug related deaths than the non-Aboriginal population.



In addition, Aboriginal populations are over represented in suicides (BC Coroners Report 2008⁶); drinking and driving and fatal car accidents (CCSA, 2008⁷); Foetal Alcohol spectrum disorders (Tait, 2003; Asante, 1990); child abuse (Hughes, 2006); liver cirrhosis (INAC, 2008); and cultural genocide (AHF, 2007).

Even though, according to the McCreary Centre (2009), youth drug and alcohol use is decreasing, High risk drug use and methods of drug use are seen as way too high across the province (as per data in this report) and while the common belief and statistics show that the prevalence is in the lower mainland, it in fact reaches farther than this. During a recent visit to one community, the band councillor grimaced as a car drove by. *“That’s the drug runner.”* she said, *“He delivers.”*

In isolated communities bootlegging and drug dealing are a community norm. One young man interviewed began bootlegging at age 13. The government licensed liquor knowingly and illegally sold alcohol to him. Community members were hired to drive because he did not have a licence. He sold to band councillors, counsellors, youth, youth workers and to anyone who could pay. By age 15 he was purchasing \$5000.00 of liquor per week. Who is accountable? Band Leadership? The young man? His parents? His customers? The liquor agent? The police?

We know that alcohol and drug use is problematic amongst First Nations. We wonder why?

⁶ Something to Look Forward To: 5-year Retrospective Review at Child and Youth Suicide in BC can be found at <http://www.pssg.gov.bc.ca/coroners/child-death-review/docs/cdru-suicidereportfull.pdf>

⁷ Can be accessed at <http://www.ccsa.ca/2008%20CCSA%20Documents2/ccsa0115282008.pdf>

Why do people drink?

Research shows that First Nations people are more likely to binge drink than other Canadian populations. (Thatcher, 2004;)We asked community members and youth workers why people drink. It is important to note that the majority of respondents assumed that ‘to drink’ means ‘to get drunk’ or ‘get addicted’. There were scant responses that assumed First Nations people can drink responsibly and socially. We acknowledge too that this is an addictions needs assessment and that fact may have clouded people’s perspectives.

The answer that was given the most is that First Nations people drink to numb, hide, or overcome pain. In fact 26% of respondents stated this. Following this answer, the next most frequent answer was people drink to escape or hide, and because of childhood abuse and trauma. The vast majority stated that people drink for ‘negative’ reasons. The reasons are supported by Mate (2008); AHF (2007); and Flores (2004). Given the amount of pain and hurt mentioned, it is surprising so many people rated their health so high, and gives rise to wondering what health could look like with no painful history.

Significant too, is the norm of drinking in mainstream culture. For example, recent television ads proclaim ‘I am Canadian’ in advertisements for beer. The stereotype of drunken Indian can be traced back generations in BC. In speaking with a group of young men in one community, one of them stated with a grin on his face:

“People are filled with memories. Some are memories that people want to never remember, or take the time to heal. Drugs are an escape from those memories or a numbing property so people can feel detached from themselves to the point where they can deal with the memory. People learn what they live. If all I knew was drugs, and the examples and lifestyles I knew was only drugs...i imagine I would spend my time and energy getting high. So many people are uneducated about what the drugs they do consist of, what the short and long term damage is, a holistic approach to drugs needs to be taken. What are the damages to our entire selves and the ones around us?”

“Look, I got an Indian car...a real rez car: whiskey bottle dint in the side and lucky cans in the back seat!” The young men laughed and beamed. For them it was entirely okay.

Why Aboriginal People Drink:

1. Numb, hide, overcome pain
2. To escape or hide
3. Childhood abuse/trauma
4. To fit in/ peer pressure
5. To forget
6. Sadness or depression
7. Low self esteem
8. Now work or money
9. To socialize
10. Boredom

We note that key informants in our interviews spoke of the lack of safety they feel in community and posit that this is a First Nations issue and not necessarily a NNADAP issue. However, the intricate web of dynamics created by parental drug and alcohol use; lack of relationship skills; domestic violence patterns; drinking and driving and gangs for example, impact the work of NNADAP in community.

Beside the Water, Planning a Journey: Methodology

We recognize that the research in this document represents a hybrid of western and Aboriginal research paradigms: perhaps an epistemological dichotomy. While western research methodologies are colonial, neutral and commodify knowledge for consumption (Denzin, 2005; Smith, 2005, Reid and Lindsay, 2009) they hold a place of privilege in mainstream academics and Canadian governance. In response to this, Indigenist research paradigms were important, where researchers sincerely believe that the informants are the experts on themselves and their needs. As insider-researchers we are as one with our constituents and posit the vulnerability inherent in it. (Smith, 2005) Given this, we choose to privilege the voice of the people and support that voice with evidence-based research where possible, and allow their voices to stand where necessary.

Mostly Salish Consulting undertook a number of processes to collect information and data for the Addictions Needs Assessment. A broad literature base provided by NNADAP was reviewed as well as additional documents as listed in the bibliographic section. A list of key information was made and presented to what was to become the BC Addictions Advisory Team. A draft methodology was submitted to Health Canada's National Advisory Panel in August 2008. This BC Addictions Advisory Team met in person for the first time in August 2008. Members of the team represent a broad spectrum of addictions services in BC.

Working with the NNADAP Needs Assessment document, the advisory team formulated questions to ask of various target groups. The team met four times throughout the year to determine the data gathering, guide the data gathering, analyze data, and make recommendations for further inquiry based on information gathered between meetings.

In addition to the evidence-base provided by Health Canada, a web-based search was conducted to determine the spectrum of services available across the province. Six target populations were identified, including First Nations Health Directors, community-based NNADAP workers, Treatment Centres, Youth Workers, Addictions specialists and Community members. In addition to the methods described below, individual interviews were held with key informants across all of the sectors listed.

A list of First Nations Health Directors was provided by the First Nations Health Council. Phone calls were made to the majority of those listed, and eleven telephone interviews were conducted with those Health Directors willing to be interviewed. (Health Director Questions can be found in Appendix I) We interviewed one Health Director in person. Health Directors are seen as integral in the formation of overall health programs and processes in First Nations. In most cases, the NNADAP worker is hired under the umbrella of the Health Directors where transfer agreements have occurred.

Youth Workers were invited to participate in an on-line survey. The survey was created using Survey Monkey, and links were sent out initially to education list-serves and school districts. (Youth Worker Survey Questions can be found in Appendix II.) It proved challenging to rely solely on the education network, when several workers were under school district policy that would not allow them to complete

surveys. A broader net was then cast, relying on the Internet as a means of spreading the word about the survey. In some instances people were contacted by email individually. Others were encouraged to fill out the survey at large gatherings (such as the Native Courtworkers Conference) and others were able to access the survey on the First Nations Health Council website or the Mostly Salish Consulting website. A total of 62 people responded to the on-line survey.

A list of NNADAP workers was shared with us by the Association of BC First Nations Treatment Programs, and phone calls were made to all of those we had current information for. In some cases, Band Offices were contacted and new NNADAP workers were identified. Each NNADAP worker was asked to participate and given the choice between completing a comprehensive on-line survey or a phone interview. All chose to complete the on-line survey, which had been previously vetted by two NNADAP workers, Charmaine Thomas of Squamish Nation, and Jocelyn Edwards of Snaw Naw As First Nation. An incentive program was attached to the NNADAP interviews, and all that completed the survey were eligible to enter a draw for gift certificates. 47 NNADAP workers took an on-line survey after being contacted individually by phone. Four NNADAP workers were interviewed in person. The exact number of NNADAP workers in the province is elusive; however an outdated list provided by Health Canada indicated approximately 150. For a list of the questions asked of the NNADAP workers, please see Appendix III.

While initial contact was made with all of the First Nations Treatment centres in BC, we were only able to interview six of the 11 NNADAP funded centres. Phone interviews were conducted with seven individuals and in person interviews with five. In addition, members of the BC Addictions Advisory Team met with the treatment centre directors at their December 2008 meeting to ask specific questions arising out of the data gathering. (For the treatment centre interview questions, see Appendix IV.) Further less formal (as per western standards; formal as per First Nations values) data collection was conducted with two intake workers. Print materials were also provided by the ABCFNTP⁸ were analyzed.

Community Members were surveyed using an on-line survey tool. (Survey questions can be found in Appendix VI.) The survey was piloted in Laxgaltsaap with a group of students in the Justice Institute of BC's Aboriginal Leadership Diploma Program, in their course on Individual and Community Wellness. Links to the survey were provided at the Mostly Salish and First Nations Health Council websites. Emails were sent out, with the intention that they would snowball. In addition, community members were invited to complete the survey at the 2008 Native Courtworkers Conference, and in various adult education classrooms. Individuals were interviewed by phone, if they responded to general emails sent to various list serves or were engaged in the topic at other events. Individuals were also interviewed both formally and casually in scheduled meetings and at opportune moments. At one point in the data gathering we became aware of the low number of respondents from the Fraser Region, and Rosemary Trehearne facilitated a discussion at a Sto:lo elder's gathering in December 2008.

Other interviews were conducted with individuals working in fields such as probation, FASD education, counselling, health, social work, youth suicide prevention and more. We spoke with parents, children,

⁸ For the specific chart developed by ABCFNTP, see Appendix V.

grandparents, grandchildren, aunts, uncles, people proud to be sober and some who like to take a drink. Some interviews were formal and structured. Other times more 'indigenous' methods (Palmer, 2003) like visiting, were used. For example, researchers would stop people while they were chatting and say, "Hey, I'm doing a province-wide Needs Assessment on addictions..." While we have made attempts at acknowledging everyone's truth, we present the data below as conglomerate and anonymous.

Once the findings were written up, specific sections were sent to individuals for their feedback. In addition, Health Canada took a copy of a working draft and made comments on a teleconference on April 16th, 2009. The BC Addictions Advisory Team vetted the final recommendations on April 17, 2009.

Limitations in the Methodology.

There were a number of limitations in our methodology. And there were many questions we wished we had asked, and people we wished we had contacted, after our data gathering was complete. The most significant of our limitations were:

- The bulk of our community and youth worker data came from on-line surveys. We recognize that we were only gathering data from people with access to the Internet; people who comfortably read on the Internet; and people who have the physical ability to be on the computer.
- We did not have the capacity to do an absolute random sample. We are specifically conscious that our on-line participation from the Fraser Health Region was low. While we made efforts to make up for this in other data gathering, it remains a limitation.
- We were not able to find up-to-date lists of NNADAP workers in BC. While we made many attempts to contact as many of the workers as possible, we remain concerned that we did not contact them all.
- Because of ethical issues, we were not able to speak to youth about themselves.
- Because of ethical issues, we were not able to access as many of the Aboriginal liaison workers in the school systems as we would have liked.
- We believe that men are less likely to complete surveys than women.
- Due to a number of constraints (budget; scheduling; weather) we chose to speak to as many people as we could over the internet and by phone. We recognize that the richness of data that we receive doing in-person interviews is significant. We would have liked some more of that richness.
- Because the on-line surveys were anonymous, we have no way of knowing if the same person completed the surveys for community people, youth workers and NNADAP workers.
- Many people expressed exasperation at being over-researched. They indicated that they were always filling out surveys and questionnaires and they were "tired of it". They were also very concerned that when they were researched they were never given the results of the research.
- Using a hybrid between First Nations and Western research paradigms, means that neither is adequately validated. Evidence-based research is important. Community-based research is important.

Who is Skipping the Canoe?

There is some uncertainty as to who is leading the movement against the misuse of psychotropic substances in BC.

The governance of First Nations in BC is large. There are over 200 First Nations and each First Nation has its own band council. In addition there are 27 Tribal Councils. There are over 30 language groups in BC and the complexity and cultural diversity make it challenging oftentimes for First Nations to work together, much less to work with the colonizing body.

Each First Nation has some form of agreement with Health Canada through First Nations Inuit Health, informing its health practices. These range from contribution agreements to health transfer agreements. The First Nations Health Council has an active role as well: “The role of the BC First Nations Health Council is to support and assist BC’s 203 diverse First Nations communities to realize their health aspirations and priorities. The First Nations Health Council (FNHC) was created in 2007 as a coordinating body mandated to implement the 10-year Tripartite First Nations Health Plan. The purpose of the First Nations Health Plan is to improve the health & well being of First Nations and to close the health gap between First Nations and other British Columbians.” (<http://www.fnhc.ca/index.php>)

Certainly survey participants want First Nations leadership involved in the fight against drugs and alcohol. In fact they called loudly for leadership to model healthy lifestyles, [supported by the McCreary Research group who cited this in their research of street-involved Aboriginal youth in 2004] and to be part of the political push for more policing and awareness of addictions issues.

The Association of BC First Nations Treatment Programs plays a lead role in networking and maintaining communication amongst Aboriginal and First Nations addictions workers in BC.

According to their print materials (including their approaches to implementing the tripartite First Nations Health plans⁹) the Regional Health Authorities have varying degrees of Aboriginal consultation and /or programming. The Interior and Northern Health Regions appear to have strong partnerships with First Nations according to survey respondents in their catchment areas. Respondents state that service strength is not consistent across regions which speak to both the strength and challenges of regional representation. For example, jurisdictional issues are not seen as consistent, and there are areas in the province that are not defined as culturally competent.

Health Canada relies on evidence-based practices and while they do the best they can with what they have got and recent advances in methodology are opening up new knowledge bases, there is as yet no new methodology to study First Nations spiritual practice that can meet the rigors of their evidence-based philosophy. Until such methodology exists, there is some resistance amongst many of our informants to follow Health Canada’s lead. The structures of the federal government, the Assembly of First Nations and the Regional Health Authorities are not conducive to creating First Nations governance over programs and services. The policies and processes do not allow for First Nations driven priorities.

⁹ These can be accessed at http://www.fnhc.ca/index.php/about/tripartite_process/health_advisory_committee/

*what all this means
is that we are as yet
unclear.
who is skipping the canoe?*

Who are the Pace Setters?

We made the decision to speak about Good Practices in BC. We were uncomfortable calling them Best Practices for two reasons. First, we were simply unable to visit enough programs to determine the best and secondly, we had no methodology to quantify what would make a program the best. We did however find some very good programs. We note that the good practices mentioned below, all have elements of culture.

We asked the people what kinds of helpers they would like to see, if they themselves felt the need to find a helper. Overwhelmingly people identified elders (67.6%), traditional healers (60.1%) and spiritual healers (59.4%). Doctors came next at 41%. Far down the list we found western therapeutic models like psychologists (32%) and psychiatrists (16%).

There is significance in the high number of culturally-based helpers being identified. It speaks to culture as healing. It speaks to First Nations traditional models of care. It speaks to faith in pre-contact histories. People noted that alcohol and culture do not mix. Activities like pow wows Tribal Journeys, longhouse and potlatches draw large crowds of people where drinking is taboo. And we wish to acknowledge that there are other very good practices that are not necessarily mentioned here.

Association of British Columbia First Nations Treatment Programs (ABCFNTP)

There are treatment centres who work beyond their financial means and work so hard at doing more with the very very little they have. They are creative and really this is based on the work of the people themselves: the people wanting to do the best that they can; and their personal skills and integrity.

In its own words, the Association is an inter-agency network of residential/outpatient addictions programs operated by First Nations in the province of B.C. Currently, the Association has a membership of 10 programs located both in rural and urban settings. Their mission is "To provide a First Nations forum that promotes culturally relevant best practices to enhance, excel and advance the continuum of care in addressing addictions." The association lists the following as their overall program description:

- To assist in promoting excellence in programming in primary and/or secondary treatment for alcohol and drug addiction.
- To encourage high quality services by the development of resources, information networking and by working co-operatively.
- To co-ordinate regular meeting of the First Nations-operated Treatment Programs for the purpose of sharing information, developing resources, discussing current treatment and training issues and identifying needs.
- To provide a supportive environment that will encourage the development of suitable training programs for the staff of the treatment programs
- To assist treatment centres in the provision of high quality services
- To advocate on behalf of BC First Nations Treatment Program and those serviced through those organizations.
- To participate in the decision-making process related to treatment and act as a resource to the decision-making bodies.

Members of the association work together to help improve services for alcohol and drug treatment in BC. They meet to discuss how to stretch services to the widest possible audiences. They work with economies of scale in training programs. They deliver support to treatment centres and community NNADAP workers in BC. The ABCFNTP encompasses the following:

1. Culturally relevant addictions programming offered by all NNADAP treatment centres:
NNADAP treatment centres offer cultural program components to build a positive identity and self-esteem, foster positive First Nation's values, beliefs and cultural practices, and to provide a treatment approach that is meaningful to First Nations clients' life experience.
2. Evidence-based Counselling Modalities:
NNADAP treatment centres offer many evidence-based counselling modalities that may include Brief Intervention, Cognitive Behavioural, Existential, Family Systems, Gestalt, Motivational, Narrative, Person-Centred, Rational-Emotive, Solution Focused and Transactional therapies. Some treatment centres have developed treatment models based on multiple clinical principles.
3. The NNADAP treatment centres developed a Mental Health Services Description:
It is recognized that while clients are enrolled in NNADAP-funded Treatment Programs, deep-seated issues rooted in the addiction/addictive behaviour can surface. As these issues are being uncovered there is a need for specialized mental health care. The Mental Health Services at NNADAP-funded Treatment Programs are meant to address the Mental Health needs of clients while they are participating in a treatment cycle. The frameworks for the types of services are designed by the NNADAP-funded Treatment Program and include philosophy, clinical principles, descriptions of mental health issues, objectives, mandates, levels of service, legal issues, ethics, management practices, clinical files, quality assurance and reporting.
4. Commitment to Accreditation:
All centres are either accredited or in the process of becoming accredited through either Accreditation Canada or the Commission on Accreditation of Rehabilitative Facilities. Accreditation verifies that the treatment centre meets and/or exceeds the applicable standards, regulations and laws as set in Canada. The accreditation process results in an assessment and action plans for improving every aspect of care and services delivered.
5. Family Treatment Programs are offered by Carrier Sekani Family Services, Hey'-way'-noqu' Healing Circle for Addictions, Kakawis Family Development Centre, Nenqayni Wellness Centre and Wilp Si'Satxw House of Purification. The NNADAP program and the Royal Commission on Aboriginal Peoples (1996) both identified not only individual but also an Aboriginal family and community systems approach as important to healing.
6. Early Recovery/Stabilization Programs are offered by Gya' Wa'Tlaab Healing Centre. Pre-treatment services and identified gaps in service. Treatment centres continue to experience issues with bed occupancy rates because of no shows or non-completion of treatment. Some clients have not been stabilized, are unable to maintain sobriety prior to admission and are not ready for residential treatment. These clients require more intensive support services than out-patient treatment.

7. Residential School/Trauma Programs offered by North Wind Healing Centre, Tsow Tun Le Lum Treatment Centre, and Wilp Si'Satxw House of Purification and Residential School/Trauma Counselling Services offered all the programs. All treatment centres had a pivotal role in providing addiction and trauma healing services for residential school survivors before the Truth and Reconciliation process, the Aboriginal Healing Foundation and other residential school supports. Residential School issues have long been a root cause for core issues addressed in residential addictions treatment. The services are supported by counselling and referrals provided by community NNADAP workers. Services have been there when no other services were available thereby filling a gap. The propensity of residential school survivors to use alcohol and drugs to cope has been identified by NNADAP workers across BC. The treatment centres have developed programming and continuously improved services for residential school survivors. The treatment centres have actively supported and collaborated with many organizations who have sought to develop support services.
8. Youth programs offered by Carrier Sekani Family Services, Hey'-way'-noqu' Healing Circle for Addictions, and Nenqayni Wellness Centre. Youth addictions programs are an identified service gap at ABCFNTP.¹⁰
9. Elders programs offered by Hey'-way'-noqu' Healing Circle for Addictions, North Wind Healing Centre, Three Voices of Healing Society (formerly Ktnuaxa/Kinbasket Wellness Centre), Tsow Tun Le Lum Treatment Centre, and Wilp Si'Satxw House of Purification.
10. Specialty programming is developed to respond to trends in addictions service demands. Programs may be one-time, pilot, discontinued, current or future programs depending on funding status or sustainability with regular program funds.
 - Round Lake Treatment Centre has offered several pilot and specialty programs including a mobile addictions program, adolescent substance abuse, mobile community solvent abuse, trauma treatment, and methadone programs.
 - Three Voices of Healing (formerly Ktnuaxa/Kinbasket Wellness Centre) offered a crystal meth program and is currently developing a long-term rehabilitation program.
 - Tsow Tun Le Lum has offered several specialty programs including grief and loss, co-dependency, sex offenders programs and both addictions and trauma GLBTQT (gay, lesbian, bisexual, transgender, queer transsexual) programs.
11. Maternal Child Health Programs:
The Maternal Child Health Program service delivery was targeted for mothers, pregnant mothers, future mothers, fathers, grandparents and extended family. The programs were intended to improve health outcomes, to increase opportunities in the continuum of services and to increase the involvement of fathers, grandparents and extended family. Based on the objectives of the program deliverables, each treatment centre determined the program curriculum and financial resources required. The programs were delivered with the support of cultural resources, community resources and partnerships. Several centres have permanently embedded the Maternal Child Health program curriculum in the treatment components to ensure continuing service and benefits.

12. Research:

¹⁰ We also wish to include Spirit Bear here, although they are not officially an ABCFNTP member.

- Round Lake Treatment Centre conducted a Client Outcome study which evaluated the outcome of the treatment centre during the period of the outcome study (1991-1995). The Centre also produced a research report titled “Research on Native Adolescents and Substance Abuse.” (1992)
- The NNADAP treatment centres, through the ABCFNTP partnered with Nechi to research best healing practices for residential school survivors. This research resulted in the report titled, “Report on the Research Project exploring: The facilitation of healing of sexual and physical abuse in residential schools, including the intergenerational impacts and the cycle of abuse that began in residential schools.” (2002)
- Tsow Tun Le Lum Treatment Centre conducted a study titled “How does treatment affect the quality of life for First Nations people and what then are the cost savings to government agencies.” (2006)
- Jim Chorney of Nenqayni Healing Centre conducted a Master’s thesis study titled “Towards an Effective Aftercare Program.’ (2007)
- The Namgis Treatment Centre partnered with Kimberly Ann van der Woerd for a Doctorial thesis titled “A Participatory Evaluation of a First Nations Substance Abuse Treatment Centre.” (2005)

13. Professional Development / Continuous Learning in Addictions and Related Training.

- *Debriefing & In-House Training*
 NNADAP treatment centres schedule regular program evaluations, client program evaluations and staff debriefing sessions. Emergent issues, data, and recommendations in all aspects of programming and operations are reviewed to identify in-house training needs and to assess the need for improvements in programming, clinical protocols, operations, etc. NNADAP treatment centres schedule in-house training events for all staff to ensure continuous improvement based on program monitoring, funder requirements, and current addictions trends.
- *Core Skills Training*
 NNADAP treatment centres, through the ABCFNTP, has coordinated training events for treatment and front-line workers to support professional development and proficiency in the core skills required for quality addictions service delivery. The training activities are intended to assist addictions specialists to obtain or maintain certification.
- *FASD Training (no longer funded)*
 NNADAP treatment centres, through the ABCFNTP, provided FASD training to treatment staff and front line workers in identifying adults with FASD, ensuring that trainees have an understanding of FASD and are able to answer questions in relation to Common Manifestations of FAS: Physical (Body), Emotional (Heart), Intellectual (Mind), Spiritual (Spirit) with a degree of confidence and feel prepared for the work they will be doing with individuals with FASD. Presentation materials were developed to support the training. FASD Education and Awareness was also provided to schools throughout BC by offering one-day information sessions to educate youth of the life-long effects of alcohol consumption on females in their childbearing years with special focus on her unborn child. The goal was to educate the youth and young adults prior to and during their childbearing years.
- *ASIST Training (no longer funded)*
 NNADAP treatment centres, through the ABCFNTP, provided ASIST training in combination with the FASD training for front-line workers. The training was made available because suicide was identified as a prevalent issue within First Nations people and in particular as recent research identified a link between FASD and suicide. (Rouleau, Levichek, Koren,2001; O’Malley and

Huggins, 2005) The ASIST training was provided with the FASD training to increase capacity and skill in community service delivery. ASIST has been recognized as an evidence-based training program. This program is discontinued because of funding.

14. First Nations Wellness Addictions Certification Board:

The ABCFNTP believes that it is important that standards for First Nations Wellness/Addiction Counsellor practice be established by First Nations. They sought funding to establish an independent society for the certification process which thus became known as the First Nations Wellness/Addictions Counsellor Certification Board. The goals of the certification board are to ensure a level of excellence in individual performance; to establish standards that are relevant to traditional First Nations' healing philosophy and which are comparable and generally accepted in the field; to gain reciprocity with the National Association of Alcoholism and Drug Abuse Counsellors, (NAADAC), and the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, (ICRC/AODA); and to support the continuation of First Nations wellness programs by providing a measure of competence which will be recognized locally, nationally and internationally.

15. Referral worker or helper programs are offered by Carrier Sekani Family Services, North Wind Healing Centre, Round Lake Treatment Centre and Tsow Tun Le Lum Treatment Centre: NNADAP treatment centres have long recognized the need for care givers to address issues related to vicarious trauma and compassion fatigue. They have also recognized the enormous responsibility and, at times, unrealistic expectations placed on front-line workers who have heavy case loads, reduced work days, service multiple communities, have few community resources and who often are isolated from peers in the field. Addictions trainings have also provided sessions on self-care. NNADAP treatment centres also recognize the benefits of supporting the assessment and referral skills of community front-line workers and have provided periodic training on-site. NNADAP treatment centres have conducted "Think Tanks" and other networking events with community front-line workers to address issues in the addictions field, to develop rapport and professional relationships, and to develop a cohesive approach to addictions programming.

16. Promotion: Website Development and Program Brochure:

NNADAP treatment centres, through the Association of BC First Nations Treatment Programs, have developed a website which promotes services of all its members, contains links to websites for its members. Various levels of information is available including service descriptions, contact information, intake schedules, referral packages, and education.

A program brochure collectively outlines the program types; accessibility, substances and addictions treated and program components available at each centre, as well as general programming descriptions. (See Appendix VI)

BC Association of Friendship Centres

In BC there are 24 Aboriginal Friendship Centres offering a wide variety of services including prenatal programs, early childhood, family support, alcohol and drug counsellors, adult education, youth programs, advocacy, language and culture and more. They are an excellent example of the ideal sweep of prevention and after-care support. While the centres are primarily urban, and support urban

populations, they model the ideal of an aftercare program that NNADAP workers describe on page 52. Provincially the friendship centres are supported by the BC Association of Friendship Centres whose mandates are quoted on their website <http://www.bcaafc.com/content/view/13/281>.

"The purposes of the BC Association of Aboriginal Friendship Centres are:

1. To promote the betterment of Aboriginal Friendship Centres in the Province of British Columbia.
2. To establish and maintain communications between Aboriginal Friendship Centres and other Provincial Associations and the National Association of Friendship Centres.
3. To act as a unifying body for Aboriginal Friendship Centres. To provide an Association for Government Agencies to communicate through and obtain information from. This, in no way takes away a centre's right to negotiate directly with any agency.
4. To advise the Government, when requested by the collective centres, on how and what programs may assist Aboriginal Friendship Centres, in the development programs to better the lives of Aboriginal Native people in British Columbia."

While we witnessed many excellent programs, including the Family nights at the Prince George Friendship Centre; the FASD prevention program at the Wachiay Friendship Centre in Courtenay; and the Substance Abuse Counsellor training at Tillicum Lelum in Nanaimo, we specifically wish to identify the Circle of Life program at the Kermode Friendship Centre in Terrace.

Circle of Life

The Circle of Life program in Terrace is run out of the Kermode Friendship Centre. It is funded by the First Nations/Inuit Health Branch and is based on the Birth to Three Project (Parent/child assistance program) PCAP developed in 1991 at the University of Washington School of Medicine. The program is open to First Nations women who are within child bearing years and are affected by Foetal Alcohol Spectrum Disorder (FASD), or have a family member who is. It is also open to women who are currently using alcohol and/or drugs or have a history of alcohol or drug misuse and/or who have previously had a child with a FASD. Each woman in the program has a peer mentor or mentor, who understands and support them in maintaining healthy life choices. The three year program mentors women in programs such as budgeting, parenting, family planning, social skills, and assertiveness; and while they are a harm reduction program, they assist the women in maintaining a recovery plan.

Partnership programs in the same building create further support for the women. The added supports include the Aboriginal Infant Development Program, Community Action Program for Children (CAPC), parenting programs and support, early literacy, Aboriginal Early Childhood program that host Pregnancy Outreach workers and support workers and the Complex Developmental Behavioural Conditions Program¹¹. In addition, The Circle of Life and other programs house a Low Cost Pantry and Low cost baby pantry which is a program that help women budget and provide healthy low cost food and diapers for their families.

Our visit to the program found a 'jolly' atmosphere. In our meeting program participants reported having success in the program. One participant spoke of how the Low Cost Pantry helps her get by from

¹¹ This encompasses FASD and Attention Deficit Disorder, among others.

cheque to cheque. Program staff spoke about client centred solutions. Their first goal is joining with families in a 'grandmother approach'. They are gentle: "We're not drill sergeants." They spoke of the importance of relationship building and meeting the clients where they're at. In fact, no intake with clients is done until the client is really comfortable, usually after two or three visits. The client has a choice of which helper they want to talk to. The staff work with high needs populations and yet their support for and of each other shows, as they wrap their clients in adequate programming in an inadequate world.

The client-centred approach in an environment of safety is a key observation. It is also significant to note, that this program is a coming together of many services, and speaks to the power of partnerships.

Tribal Journeys

On the west coast, for the past twenty years, Tribal Journeys has become a movement embraced by international coastal First Nations communities. Although initially Tribal Journeys included Washington State and British Columbia, recent years find participants from across Canada. For two weeks in the summer, canoe families from up and down the coast join together in a drug and alcohol free journey to a host community. The program impacts thousands of people each year. While the two (or more) week journey is a highlight for canoe families (paddlers, ground crew, and escort boats) the arrival at First Nation for 'the night' also impacts the host community. It has profound therapeutic value and promotes a healthy lifestyle, not just for the time of the journey, but in the months leading up to it. Spiritual, emotional, social, physical, cultural, and mental challenges are supported by elders and knowledge keepers such as canoe builders, skippers, traditional food gatherers, cooks, elder, and paddlers. Stories abound of how the journey changes lives. Echoes of drumming and singing can be heard across sounds as aching bodies, tears flowing, and push to get around the next corner with the support of ancestors in the waves beside them. Team meetings allow individuals to speak of their emotional experiences. Skippers meetings recognize the skills of those who know the water and embrace the longing of others to learn. In each First Nation, community members feed their visitors. Road crews support the paddlers and allow for a range of generations to participate. It is normal to see young babies and elders in the same canoe, providing experiences in the manner of the best of our ancestors.

The successful components of tribal journeys include strong doses of culture that embrace the past in a modern world. Family involvement allows for intergenerational healing. Relationship building that spans decades, where families and friends celebrate in sobriety reflecting strong ancestral processes. It is again another example of the strength of culture.

Tribal Journeys is not a NNADAP program, but many NNADAP workers from many communities use the journey as a forum for their client populations to experience healthy, sober activity as prevention, intervention and aftercare.

NNADAP Worker Success Stories

As part of reflecting on things that work, we asked NNADAP workers to tell us about situations where they feel they have been successful. Certainly there are commonalities amongst the success stories. The majority of examples speak to relationship building, and taking time to build trust and sincerity in the

relationships. And the relationships themselves are seen as client-centred. The successes often include an education component; and culture is a significant aspect. We share a sampling of them below:

I had a client who came in because she did not know why she was crying all the time. The session lasted for 5 hrs. But through that time we were able to look in her past and revealed that there was a succession of grief & losses, sexual abuse which we worked through. She needed that one session and has not come back since.

Referred a client who was seeking more than just being sober to a personal growth seminar. As a result influenced family members to get sober and later referred their family to the seminar. The family continues to remain sober and has encouraged others to seek counselling.

A community member who was significantly abused in residential school, in every respect, did not come into the Health Center at all. He felt very devalued and not worthy of any assistance. Substance use was huge for him. I started inviting him in for coffee during my walkabout. Several weeks went by and he showed up for coffee. After several weeks of coffee in the public areas with me, he asked to go to my office. I managed, by being very patient and moving at his pace, to get his medical needs addressed, to connect him into additional services, and get him on disability. His substance use has dropped significantly. After 11 months of patience, he attended his first support circle ever. He is gradually attending our programs. This is a man who was so socially isolated that his family ignored him.

This one client related gratitude to me for being there for him, listening to him, encouraging him and supporting him. This particular person presented with late stage alcoholism. At first I was focused on 'fixing' his problem, however, he taught me to become a more client focused helper and to move with him at his pace. Just by being with him, respecting where he is at and what his boundaries are, he has managed nearly 11 months of sobriety. He found a way to maintain sobriety one day at a time when it seemed hopeless.

One client, who totally avoided contact for about the 1st year of me being here, slowly became aware of some issues she was running from. She embraced the process and went out to Aurora Centre for Women. Upon her return she quickly gave her spouse the choice of either getting his life together or moving on, he too decided to get sober, they ended up separated but still talk and both maintain sobriety. She has moved on to obtain her degree in Addictions. She has successfully overcome too many obstacles to mention -- I see her as a colleague now. It's been almost 5 years for her, she has made the choice to drink occasionally, but she is definitely making the choice now whereas in the past it was a choiceless choice when it came to drinking.

A young lady I am thinking about who after years of abuse and neglect at an early age, was unable to trust anyone, particularly men, was slowly able to open up to me (a man) and share her trust and begin to learn to tolerate good feelings and beliefs about herself.

Worked with client and her family for 3 months; family proceeded to Kakawis; continued to work with family upon completion of treatment program; client continued to attend Women's Drop-In and eventually facilitated the occasional session. 3 clean and sober years later, the client was hired as a Mentor to work with women in their child bearing years or pregnant who were using alcohol and/or drugs. Ex-client-now-colleague excelled her position for almost 3 years before leaving to attend university full time to obtain her degree!

My cultural activities such as drumming I started out with only 4 people now have over 30 and have ordered 50 drums for others that want to join. We start by making drums and giving a lesson into why and to protocol of owning a drum. I have babies to elders in the group everyone is welcome.

Client going to AA meetings 20 miles away on his own. Getting involved with community events and moving forward with his carving and native art work.

I worked with a young woman who has struggled with a massive alcohol addiction since she was 15. She is a lovely young person who loves her children very much and understands her addiction as she is very bright. But when her addiction would sweep away her actions would devastate herself and her family. She used the counselling program in her community and both Wilps and Neqanyi treatment centers and became sober. At 30 years of age, she and her partner are now raising their young family in a drug and alcohol free home. They have strong recovery language and are very realistic about their addictions. They deserve this, both are wonderful young people with dreams and are loving parents.

A young man came to me for counselling, he didn't go to treatment, just quit cold turkey, he wasn't a heavy user, he is still clean today, which is about 4 years now.

Coke smoker and dealer, quite a gangster, gets involved with a man who has rare knowledge of traditional songs. Becomes obsessed with learning the songs, becomes expert, discovers his cultural identity, pride, strength, through the sacred songs, has now been clean and sober 5 years and a big success in his career. He teaches songs to the community with passionate missionary zeal. Give me ten men like him, and I'll change the future of ten reserves.

We have twelve individuals that have returned to school for upgrading and transition to trades programs. Two have won scholarships for their achievements.

I worked with a lady who would be drunk in the park all the time, she came in for some help, I worked with her for months and months, and she was very consistent. Today, she holds a full time job, sober, and very clean looking and always has a smile on her face. I really enjoy running into her while in town.

Pulling: Who are the Paddlers and what are they doing?

In the past year in BC, addictions and/or drug misuse made mainstream news. During the summer of 2008 the BC Construction Workers Union implemented policy for random drug testing and support for treatment¹². And during the summer of 2008 the Downtown East Side of Vancouver saw the creation of the Community Court. CBC reported “At least 50 per cent of offenders in downtown Vancouver have a mental illness, a drug addiction, or both, and many are chronic offenders, according to court officials. The community court, located at 211 Gore Ave., will cost about \$3 million a year to run and will work with about 1,500 offenders each year.”¹³ Our visit to the site showed us comprehensive wrap-around programs that have the best interest of the clients in mind. Both bring awareness of addictions to the mainstream population.

While NNADAP comprises a significant Alcohol and Drug presence in BC, there are further provincial services under the five regional Health Authorities; Child and Youth Mental Health and recently Aboriginal Child and Youth Mental Health; and Mental Health and Addictions. Primarily they provide alcohol and drug counselling in most BC communities, but the province also helps fund some residential treatment and detox. In addition, through the BC Mental Health and Addictions Services, tertiary care is provided although primarily in the lower mainland.

Non profit and for profit treatment centres are spotted throughout the province. Many of the non-profit centres are faith-based.¹⁴ Child and Youth Mental Health provides youth counselling in many communities, including some First Nations. Aboriginal Child and Youth Mental Health is still fairly new within the provincial structure and we were unable to find provincial information on the new service, but did have community feedback about them that notes that some regions offer alcohol and drug counselling through them, and others do not.

Otherwise, the Key Players in addictions include the following:

First Nations Health Directors.

The majority of First Nations Health Directors we interviewed stated addictions as either the top or a high priority. In terms of where addictions fits into the communities’ health plans, one community identified it as being ‘in the middle’ and the remaining respondents stated it as either the top priority (7/12) or high. All Health Directors indicated that they have relationships with treatment centres in BC.

¹² http://www.ctvbc.ctv.ca/servlet/an/local/CTVNews/20080821/BC_Construction_Workers_080821/20080821/?hub=BritishColumbiaHome (accessed March 27, 2009)

¹³ <http://www.cbc.ca/canada/british-columbia/story/2008/09/10/bc-080910-community-court-opens-vancouver.html> (accessed March 27, 2009)

¹⁴ A fairly comprehensive overview of treatment services can be found at <http://www.drug-rehab.ca/BCrehabcenter.htm> (accessed March 27, 2009)

Most health directors spoke about cross-sectoral partnership existing within their organizations. Several spoke about linking with outside agencies such as schools, the RCMP, and justice programs. One indicated working with housing.

Youth Workers in BC

In BC, there are a number of provincial youth initiatives to work with youth, as well as First Nations and community-based programs. Included amongst service providers are FASD Key Workers; Aboriginal support workers in virtually all school districts in the province; First Nations youth programs; Boys and Girls Clubs; Friendship Centre Programs; Child and Youth Mental Health; Aboriginal Child and Youth Mental Health; Child and Family Service Agencies; Recreation workers; and more.

In our data gathering, we asked youth workers where they are able to refer children and youth who struggle with substance abuse. By far, the majority answer was to the drug and alcohol counsellor in the community. It shows that youth treatment is accessible for youth if they want it.

Many of the youth workers we surveyed have strong cultural components to their programs:

- Singing and Drumming
- Values
- Ceremony
- Visual Arts
- Dance
- Literature and Storytelling
- Faith
- Traditional philosophies, protocols and laws

We note the prevalence of arts-based processes that model many First Nations traditional modes of healing.

Many of the Aboriginal Support Workers within the BC education system, provide academic and social support but have too a significant role in providing cultural instruction. (MOE, 2001) They are likely the largest collective body of Aboriginal youth workers.

Treatment Centers

There are eleven First Nations Treatment Centres in BC. They work with clients who have been deemed treatment-ready. In their brochure, the ABCFNTP states:

“The client is informed of the treatment process, is ready and committed to be present and is able to participate in a highly structured and concentrated day—seven days a week, 10–12 hours per day. The client is prepared for an intense experience that requires full attendance, free of any legal or outside commitments for the program duration. The client application and referral process is fully completed, including a minimum of 6 counselling sessions, current medical exam and TB test, finances in place, solid travel plans in place (to and from)¹⁵ and meets the sobriety requirement on arrival.”

¹⁵ We note that this is in conflict the FNHI’s travel policy.

Treatment centres rely on referrals for screening and assessment, part of which is assisted by the application and referral package. It is also expected that during the 6 pre-treatment counselling sessions, clients will be informed of the treatment process and the centres' house guidelines, be guided to begin establishing a sober social network and related activities, and be assisted with the logistics for treatment funding, travel, finances, and general preparation such as taking care of immediate medical or dental needs, legal obligations, information of necessities required for treatment. Ideally there will be pre-treatment support in addition to the community NNADAP worker.

Counselling Support	Social Support	Physical Health	Spiritual Support
<ul style="list-style-type: none"> •Community NNADAP workers •Province of BC Mental Health and Addictions •Friendship Centres •AA/NA •IRS Survivor's Society programs 	<ul style="list-style-type: none"> •Visit and socialize with sober people •attending pow wows, tribal journeys, ceremonies, friendship centre gatherings, etc. •Art groups •Music/drumming groups 	<ul style="list-style-type: none"> •Doctor and dentist visits •Massage therapy •Walking, swimming, snowshoeing, etc. •being on the land •Band recreation programs 	<ul style="list-style-type: none"> •Pow wows, longhouse, sweat lodges, being on the land, etc. •Faith communities •Meditation •Healthy elders •drumming groups

TABLE 2: PRE/POST TREATMENT SUPPORT OPTIONS

Referrals for treatment come from a variety of places. While only some treatment centres allow self-referrals, others receive them from parole, Ministries, First Nations workers, Mental Health and Addictions workers, Friendship Centres, and Native Courtworkers and more. While the majority are from BC and the Yukon, clients will come from across Canada to attend treatment in BC. Some are mandated and some are not.

Clients for most treatment centres require a degree of stabilization. Stabilization appears to follow two patterns. Clients find their way to a hospital bed or a Detox centre. Detox centres are generally in larger urban settings and not easily accessed by people from small and isolated communities. Secondly *“They actually stay in the community near their prescribing doc until they’re stabilized”*. In some communities there are safe houses. In the larger centres there may be the possibility of sending clients to group programs or retreats. Clients who are not stabilized can also be referred to the Gya Wa’Tlaab Healing Centre which is an early recovery stabilization program.

All Treatment Centres we spoke to have waitlists. They vary in length and can be up to five months. There appears to be no provision for support for people on their wait lists other than the treatment

centres allow clients to call them occasionally. However, Hey'-way'-noqu' offers support groups. The treatment centres rely on the referral workers for client support while they are on the wait list. Ideally there would be pre-treatment support within the community other than the NNADAP worker. The involvement of First Nations leadership is needed to support a positive and supportive community environment for individuals and families recovering from addictions.

<p>Youth Treatment</p>	<ul style="list-style-type: none"> •Carrier Sekani •Hey'-way'-noqu' •Nenqayni
<p>Women's Programs</p>	<ul style="list-style-type: none"> •Carrier Sekani •Hey'-way'-noqu' •Three Voices •Wilp Si'Satxw
<p>Family Treatment</p>	<ul style="list-style-type: none"> •Carrier Sekani •Hey'-way'-noqu' •Nenqayni •Kakawis •Wilp Si'Satxw
<p>Men's Programs</p>	<ul style="list-style-type: none"> •Carrier Sekani •Gya'Wa'Tlaab •Hey'-way'-noqu' •Three Voices •Wilp Si'Satxw

Table 3: Specific Program offerings at various treatment centres

The table below shows Programs for clients with issues of mental health. Survivors of FASD are least likely to find a treatment program.

	Clients with minor FASD issues ¹⁶	Clients with moderate FASD issues ¹⁷	Co-occurring disorders	Mental Illness Stabilized/Managed by Psychotropic medication
Carrier Sekani	Yes			
Gya'Wa'Tlaab	Yes		Yes	Yes
Hey'-way'-noqu'	Yes		Yes	
Three Voices	Yes	Yes	Yes	Yes
Wilp Si'Satxw	Yes	Yes	Yes	Yes
Kakawis	Yes	Yes	Yes	Yes
Tsow Tun Le Lum	Yes	Yes	Yes	

¹⁶ FAS clients are assessed individually.

¹⁷ FAS clients are assessed individually.

Round Lake	Yes	Yes	Yes
Nenqayni	Yes	Yes	
North Wind	Yes	Yes	Yes
Namgis	Yes		Yes

TABLE 4: TREATMENT CENTRES THAT ACCEPT SPECIFIC MENTAL HEALTH POPULATIONS

If the treatment centre is residential, the available beds vary between 12 and 36. The majority have 8 intake dates per year, but the intake changes based on specific programming. For example, one treatment centre spoke of a situation where applicant numbers were too low to fill the treatment beds. In order to fill the beds and ensure the occupancy requirements were met, they put the date back.

Most programs are 6 weeks but occasionally programs of shorter duration are offered. In addition, Ktunaxa-Kinbasket and Gya Wa Tlaab offer longer programs specific to their target audiences.

The majority of funding comes from Health Canada, with occasional supplemental funding from the health regions and Corrections Services Canada.

Treatment centres show a variety of relationships with both federal, provincial, First Nations and Aboriginal organizations. Many are bound by what is available, particularly those in isolated and rural areas. Specifically they note, the Health Regions, First Nations Health Centres, Family Services organizations, Detox, Universities, Employers, Women’s programs, dental services, probation and parole, Native Courtworkers, Friendship Centres, RCMP, Mental Health services, Hospitals, Doctors, Dentists, therapists in private practice and urban outpatient clinics.

It is becoming more difficult for treatment centres to make the budget fit the funds committed. Budgets are already maximized, and contingency funds are being drained. There have been a recent 3% budget increases through NNADAP, however there have not been any significant increases to budgets to keep up with the cost of operations. With no new funding, increases for necessary budget items are diverted from other line items. For example, fuel and food costs have risen dramatically in recent fiscal years. Fuel costs impact prices of many services and products indirectly because of higher production and distribution costs. Increased funding is required for attraction and retention of staff, capital projects, rising operating costs, staff training, etc.

Staff retention rates vary. Some centres have long term staff and others have difficulty keeping staff because the salaries are too low. One centre reported that clinical staff is easy to keep but maintenance staff are not. One curiosity of the advisory team was about retention of non-Aboriginal staff; however, there appears to be no difference between Aboriginal and non-Aboriginal staff. There is some concern that the centres are not attracting young Aboriginal people into the field.

The majority of treatment centres are able to support their staff in any conference with the treatment centre association, in-house workshops, and sometimes Nechi training. Some staff members are able to access funding through their bands. At an individual level, staffs are also engaged in other post secondary opportunities. At the same time, the treatment centres find that travel to training is often

“hard and expensive” or unavailable. Regulatory bodies can create increased requirements on staffing and wages. New regulations by WorkSafe BC and Labour Canada have been enacted to address workplace violence prevention and staff working alone on shift. Employers are required to complete an internal risk assessment that would include factors such as location, isolation, potential for violence, alcohol and drug related issues, immediacy of available assistance, and procedures to protect persons working alone. A recent incident resulted in a WorkSafe BC representative informing the treatment centre that a minimum of two staff per shift is required or they would be subject to fines and compliance or closure. An initial risk assessment at the Centre was completed that substantiated a second staff member is required. The maintenance of accreditation status requires adherence to standards of regulatory bodies.

The commitment for accreditation is a positive benefit that has a financial impact. Recommendations by Canadian Council on Health Services Accreditation during a recent accreditation survey at one of the centres addressed the safety of staff working alone on shift. Some treatment centres do not have the budget to add a second staff member and operate with one staff on during evenings/night shifts, carrying risk on a daily basis. Centres that have scheduled two staff have done so at the expense of operations, maintenance or program budgets which have created financial hardships. The impact on the budgets creates obstacles to provide staff training for personal safety, dealing with difficult/angry clients and other violence prevention measures. The second staff person on shift for all centres requires significant funds.

The majority of treatment centres have a client-counsellor ratio of 3:1 and sometimes 4:1. (to a high of 6:1) The number of full time staff amongst those we interviewed varies from 8 to 37. By far the majority of employees working with direct client support are certified. Many of these are certified by First Nations Wellness/Addictions Counsellor Certification (FNWACC). Other levels of education and training include certificate programs, bachelor’s degrees and master’s degrees. However, Health Directors have mentioned a need for workers to have training in cultural competency.

NNADAP Workers

There are many community-based NNADAP workers spread throughout the province, working out of First Nations. They are sometimes specifically called NNADAP workers, and are other times working dual roles as Community Health Representatives and NNADAP workers. Many of the NNADAP workers do not work in full time positions. Their training levels vary from none to master’s degrees. A significant number have no western training, rather relying on their own lived experiences, sobriety, cultural competency, and/or mentorship. Many (25%) are not currently involved in any training opportunities and other only in workshops or conferences. Several are currently attending university or college (often through distance education). Still others read books. And several plan to do something in the future but respondents did not identify anything specifically. Individual training likely connects to specific needs of community/job.

Individuals have been in their roles for varying lengths of time, from less than six months to more than 15 years.

	Response Frequency	Actual Number of Respondents
less than 6 months	8.7%	4
6 months to a year	4.3%	2
1-2 years	13.0%	6
2-4 years	21.7%	10
4-6 years	13.0%	6
6-8 years	10.9%	5
8-10 years	8.7%	4
10-12 years	4.3%	2
12-15 years	4.3%	2
15 years +	10.9%	5

TABLE 5: NUMBER OF YEARS IN SERVICE OF NNADAP WORKERS

Their hours of operation for the most part, are regular Monday to Friday daytime hours. Several NNADAP workers work Monday to Friday with evening programs. A smaller number have flexible schedules. And fewer yet work only part time. However, we note that: *“The community is small and many times just walking to the store requires some form of work.”*

We asked survey participants what after-hours supports are available for their client populations. Cultural events and prevention activities were the largest response, followed by ‘nothing’. Many respondents identified crisis lines, including the Indian Residential School Survivors’ Society helpline. Several NNADAP workers are on call, and most of those who are, are on 24 hours. Provincial programs are sometimes available after hours, and in several communities there is a nursing station that may be accessed. A few communities have emergency response teams or critical incident/suicide response teams. We also heard that while services outside the community are made known, they are not always accessed. *“We always share that with the community, but you know they are very reluctant to go outside to get help.”*

AA was mentioned by over half of respondents, as another support in the community. It is also the number one support cited in the provinces HealthlinkBC.ca website. Other than AA, there are a number of cultural groups and programs, support groups (Strong and Sober Group; Lifestyle Redirection; Concurrent Disorders; Women’s; Men’s; Elder’s Groups, Groups for parents with children 5 and under; youth groups; girls’ groups, young men’s groups,). School programs and presentations within the school are noted, as are after school programs. Treatment, Detox, and needle exchange programs are seen as supports in some communities. In some communities there are workshops, recreation programs, healing picnics and faith communities. Friendship Centre programs are mentioned.

The length of time a client stays in relationship with the NNADAP worker varies. The majority answer was from six months to a year. Others indicated that they stay from zero to three months, or one to

two years. Still others indicated that clients can stay “as long as they want” or “forever”. Others stated that clients may stay “until they get into treatment”.

The majority of community NNADAP respondents do not have a waitlist for their services, although some do. For those who do have a waitlist, they vary from weeks to months.

The services for people on a waitlist also vary. In some communities there is nothing. “We have a CHR and others when they are here if they are not here then there are no supports.” Other communities rely on AA meetings or families. Some communities do have counselling in the community such as a “clinical therapist is in the first two weeks of the month.”

We asked the NNADAP workers where they are able to send clients who are not stabilized. The majority answer was to the hospital or to emergency. Detox was mentioned but is often problematic. Detox can be far away and beds not always available. In more isolated communities the nursing station is accessed and in others, the doctor.

In several communities, the local mental health agency and/or provincial addictions programs can be accessed. Individual counselling, psychologists, support groups, and/or family violence programs. The use of friendship centres and homeless shelters was identified. Several communities utilized the policing available to them.

“Nowhere” and “myself” were given as answers, as was having destabilized clients leave the community.

We wondered why clients end their formal relationship with NNADAP workers, and note that the majority answer is that they choose not to get clean and sober. This may prove the need for harm reduction strategies. However, we also notice almost 60% are referred to treatment.

	Response Frequency	Actual Number of Respondents
they choose to not get clean and sober	79.5%	31
drop out	61.5%	24
referral to treatment	59.0%	23
they find work	56.4%	22
they no longer need support	51.3%	20
they move	46.2%	18
they choose to see a different counsellor	30.8%	12
other	30.8%	12
referral to other agency	28.2%	11
they are spending more time recreating	23.1%	9
referral to detox	17.9%	7
they are unhappy with their service	17.9%	7

TABLE 6: WHY COMMUNITY NNADAP CLIENTS CHOOSE TO END THEIR TREATMENT

For the most part, the NNADAAP workers see after-care as being specific to post-treatment. They do not speak to relapse-prevention specifically, and in most cases are under staffed and underfunded to provide long term services to people who have been to treatment. Many people stated that there is no aftercare program in their community. Some communities rely on the 12 step programs, while others have cultural activities and specific groups that they encourage people to attend. Additionally, they rely on the supports of provincial services such as Mental Health and Addictions counsellors or Friendship Centres or counselling with band services which may include psychologists, counsellors, or art therapists.

Most survey respondents noted offering programs for women; however that decreased with pregnancy and further decreased with children. Communities were more likely to offer programs for women than for men, and are far less likely to offer programs for men and children than any other programs. Youth programs are likely to be offered. Some programs are offered for mental health, but less so for FASD and brain injuries.

	Yes	No	Have in the Past	Plan to in the future
Women	80.0% (32)	7.5% (3)	5.0% (2)	7.5% (3)
Pregnant women	61.1% (22)	27.8% (10)	0.0% (0)	11.1% (4)
Women and children	59.5% (22)	21.6% (8)	8.1% (3)	10.8% (4)
Men	72.5% (29)	12.5% (5)	10.0% (4)	5.0% (2)
Men and children	2.4% (14)	45.5% (15)	3.0% (1)	9.1% (3)
Youth	71.8% (28)	15.4% (6)	7.7% (3)	5.1% (2)
FAS victims	32.3% (10)	51.6% (16)	6.5% (2)	9.7% (3)
Sex offenders	21.9% (7)	62.5% (20)	6.3% (2)	9.4% (3)
MH	52.8% (19)	36.1% (13)	2.8% (1)	8.3% (3)
Brain injuries	31.3% (10)	56.3% (18)	3.1% (1)	9.4% (3)

TABLE 7: TARGET POPULATION PROGRAM LIKELIHOOD IN COMMUNITY

The Addictions Advisory Team was concerned about NNADAP worker self care, vicarious trauma, and compassion fatigue. (Pearlman, L.A., & Saakvitne, K.W. 1995; Stamm, 1999; O’Neill, 2008) They wanted to ensure that the workers were able to access support because the Advisory Team was concerned that NNADAP workers are under unreasonable stress. Elders and colleagues were identified as the helpers of choice. NNADAP worker were less likely to identify traditional and cultural support for themselves than community members. In all likelihood they are the providers of this service and recognize their need for additional self-care.

	Response Frequency	Actual Number of Respondents
Colleagues	61.5%	24
Elder	56.4%	22
Other	46.2%	18
Doctor	43.6%	17
Other NADAAP workers	41.0%	16
Traditional Healer	38.5%	15
Psychologist	35.9%	14
Spiritual Healer	33.3%	13
Counsellor outside the community	33.3%	13
CHR	30.8%	12
Other Drug and Alcohol Counsellor in the community	28.2%	11
First Nation's Treatment Centre	20.5%	8
Referral Worker or Colleague programs at Treatment Centres	10.3%	4
Art Therapist	7.7%	3
Psychiatrist	5.1%	2
Women's Treatment Centre	5.1%	2
Men's Treatment Centre	5.1%	2

TABLE 8: WHERE NNADAP WORKERS SEEK SUPPORT

If Culture is the Canoe, what is the Relationship with the Water?

We were curious about the strength of culture and language in communities¹⁸.

% of language fluency among community members	Response Frequency
90-100%	0.7%
70-80%	3.8%
50-60%	12.0%
30-40%	22.7%
10-20%	29.6%
Less than 10%	25.8%
Gone	5.5%

TABLE 9: LANGUAGE STRENGTH IN COMMUNITY

In particular we wanted to see if there was a correlation between language and culture, and alcohol use. People were slightly less likely to drink alcohol in communities where language was rated above 40% usage. Our sample was too small to identify accurate trends in cannabis use.

People who participate in cultural activities more frequently are less likely to use alcohol but are equally as likely to use stimulants or cannabis as those who less frequently participate in cultural activities. The correlation is not strong, but it does exist. The cultural component further noted when community members state that alcohol is not to be part of cultural events. However, we wonder what the consequences are in community, for cannabis and stimulant use?

Frequency of cultural participation	Response Frequency
10 or more times per month	12.2%
Once a week	13.6%
Twice a month	14.7%
Once a month	26.5%
Less than Once a Month	21.1%
Never	11.8%

TABLE 10: FREQUENCY OF CULTURAL PARTICIPATION

¹⁸ We note that 82% of respondents come from communities where language is less than 50% strong.

We asked First Nations Health Directors how community elders are accessed by the health programs, and the answers varied from “*all the time*” to “*never*”. In some instances the elders are used as advisors. Culture is used in programs in various ways. Formally they appear to include fasting, sweats, circles, prayers, community dinners, a beginning of life ceremony, and cultural nights that include storytelling. Other elements of culture do not appear to be programmed. One community indicated that culture is strong and it does not need to be programmed.

Traditional medicines and teachings are both used and not used.

Culture is a large part of every treatment program we looked at. According to the ABCFNTP, they are part of every First Nations Treatment Program. It shows that the cultural component provided by treatment centres mirrors what is being asked for by communities, youth workers and NNADAP workers. All treatment centres we talk to integrate spiritual practices. The majority of Treatment Centres utilize elders. All the treatment facilities we talked to use traditional ceremonies as part of their programs. Traditional teachings are used across the board. Traditional medicines are generally not used, with the exceptions of smudging and brushings.

NNADAP workers use culture as well, and in fact, their best practices show a significant cultural component, including drumming, singing, and other traditional arts.

Youth workers are mostly likely to use arts-based therapeutic tools such as singing, drumming, visual arts, traditional tools and storytelling. The provision of culture matches the community ideal of cultural healers.

We asked people if they were going to see a helper themselves, what kind of helper they would like to see? Elders, Spiritual Healers and Traditional healers were the most popular answers, supporting perhaps the ideal that culture is a solid vehicle for healing.

There is significance in the high number of culturally-based helpers being identified. It speaks to culture as healing. It speaks to First Nations traditional models of care. It speaks to faith in our pre-contact histories. The more cultural events the less drinking? Or will cannabis use become normal at cultural events, as per the evidence in our findings?

Land-Based Programs

We were curious about land based programs. Of the people we interviewed we note that all those who identified land-based programs are in the northern half of the province. They include fishing, culture practices and ceremony, fasting, hunting, justice, gardening, and are primarily aimed at youth and families. In one instance the camp is a partnership with the RCMP. Tribal journeys is an example of a land-based ceremony in the south.

Good and Bad: The Sails

The use of sails on traditional canoes is controversial. Some feel they have always existed, and they know this because there are words in the language for sails. Others feel they came with contact. We feel it's important to mention that there are controversial issues in the addictions fields, and present those below.

It is also important to again acknowledge the diversity of First Nations in BC. While traditionally, First Nations existed in harmony with their environment collectively, colonization has brought with it individualist thinking and a low-context relationship with the land. In many senses, First Nations have had to acculturate because we cannot totally assimilate: we give in to some bureaucracies because of fiscal needs but will also refuse to extinguish many cultural values.

Mental Health

The integration of mental health and addictions in BC came under review in 2006. (CARMHA, 2007) One of the challenges identified under the integration of services is the inability for integration to support isolated communities. Of the 203 First Nations in BC, most are in rural/isolated areas... and integrated services are only in urban areas. There are further issues that need to be addressed to integrate Aboriginal and western practices. Recognized NNADAP worker training is western. There is no acknowledgment of Aboriginal knowledge in governing bodies. This is noted further in the request for evidence-based research within this report. Wilson (2008) talks about research as ceremony; therefore an indigenist research paradigm needs to lead indigenist research. Mental Health then, in Aboriginal community must be seen through Aboriginal eyes. There's no acknowledgment of Aboriginal worldviews.

We asked the health directors if they had the capacity to provide for mental health issues; their answers varied. In some cases the professionals come into the communities and in others travel is provided for people to go outside the community. Some refer to professionals and others have both traditional and mainstream counsellors on staff. Some provide only medical services. And some state isolation is a barrier. All felt obligated to recognize western psychiatric methods of healing.

We asked the health directors where they were able to send people who are not stabilized. Their answers varied and isolation plays a key here. They indicated that they can send people to detox or the hospital if there is a bed, or to treatment. Otherwise they look at AA or other support groups; professionals such as health nurses, Child and Youth Mental Health, Counsellors, Restorative justice or a half way house. One community partners the individual with other sober community people. And yet others have no idea where, other than 'away'.

There has also been an increased recognition in recent years that substance use and mental health issues problems are interrelated, especially when considering the prevalence of concurrent disorders. While mental health and addiction services have historically operated in separate spheres, today in BC

they are integrated. (BC Ministry of Health. 2009¹⁹) Part of the challenge in mental health and treatment is the perception of what mental health is. According to the BC Addictions Advisory Team mental health is *defined differently traditionally, than it is in the western psycho/social paradigm*. For example, it is seen as a gift by some nations; by others it is seen as something 'normal'. Traditional healers have had the capacity to conduct curative rituals forever. In the AHF document Aboriginal Healing in Canada: Studies in Therapeutic Meaning and Practice (2008), the word 'diagnosis' was not mentioned once.

We therefore asked those we surveyed what the words for mental health are in the First Nations languages. We share this. Across the languages we accessed, we found many definitions translated into English. We also heard that First Nations traditional healers can work most effectively with issues that existed pre-contact.

Language	Word	Translation	Source
Kwakwala	Nawalakw	means the mind is in integrity with the spiritual or metaphysical world.	Wedlidi Speck
Kwakwala	Baxus	means the mind is secular, ordinary or profane	Wedlidi Speck
Kwakwala	Dusikla	means the mind is crazed or out of sync	Wedlidi Speck
Kwakwala	Wanathla	means the mind is inebriated or drunken.	Wedlidi Speck
Kwakwala	Nogad	means the mind is wise, intelligent or smart	Wedlidi Speck
Kwakwala	Ninogad	means the mind or thinking is exceptionally wise	Wedlidi Speck
Kwakwala	Gwigwatala	is a slang term used to refer to inferior thinking people....	Wedlidi Speck
Kwakwala	Nunelkwalta	Crazy	Maggie Sedgemore
Kwakwala (Namgis)	nenulu, with an accent on the u.	Stupid	Maggie Sedgemore
Kwakwala	"na noot looh"		Survey
Kwakwala	eka nokae		Survey
Censothen (Straits Salish)	WES SLA LO TTE SKALECENS	(His mind is not right, but we can fix it)	Adelynne Claxton
Central Salish: Hulqaminum	Kwam kwum tun shkwawum	be strong in your heart	Survey
Hulqamelem:	Xwam xwam shqualowens	Be strong in the mind that lives in your heart (not your brain)	Survey
Hulqaminum	Shpopi	Drunk (crooked)	Survey
Hulqaminum	Qi'qa thut	Dance the wrong way around the fire	Chuck Seymour
Central Salish: Hulqaminum	siem t'en shqualawun:	you have a respected heart	Survey
Northern Salish:	eejim-ma thot-	Mental Health	Survey
Git'xsan	Um:	good	Survey
Git'xsan	m'a lu':	crazy in the head	Survey

¹⁹ Website accessed June 30, 2009: <http://www.health.gov.bc.ca/mhd/>

Shuswap	neku7	your are number 1	Survey
Nuu Chah Nulth	Tiic?aq	Mental Health	Survey
Nuu Chah Nulth	ha-hope-pah	to teach about the right and the wrong	Survey
Nuu Chah Nulth (Hesquiaht)	kincee	Mental Health	Survey
Stl'alt'imx	n'xemen	Mental Health	Survey
Cree	myatishen	ugly spirit	Survey
Nisga'a	Gwe'ee	Poor	Survey
Nisga'a	K'ido'o	unbalanced	Survey
Nisga'a	Mimps	means not all there	Survey

Table 11: Cross Cultural terms for Mental Health

Given this we posit that mental health as determined by North American psychology may be treated by North American psychology. Mental health as defined within the language can likely be treated within the language. One of the elders at one of the treatment centres we visited is a gifted healer. However, her son told us that she herself thinks she is 'stupid' because she cannot speak good English. In Hulqaminum however, she is brilliant and can do significant healing work in the language. A concern for focussing on best practices for Mental Health and Addictions is that there is no capacity in this approach for recognizing Aboriginal knowledge, values and culture. As a result Mental Health & Addictions services tend to re-colonize rather than encourage blendedness. We recommend that Health Canada and the healing industry support and recognize traditional healers and healing approaches that are different from the western philosophies. (AHF, 2008)

Another recommendation is that Health Canada provide resources to establish standardized accredited training for all Band health staff such as NNADAP workers and MH workers for the purpose of protecting and sanctioning Aboriginal world views and blending western philosophy in their services.

We are concerned that Health Canada does not have the capacity to speak fluently, in the mental health dialects of each of the 203 First Nations in BC. We recommend that measures be undertaken to begin training Health Canada employees on community-based living and mental health; and that the training be accredited; offered at more than one time per year; and utilize cross cultural pedagogy. (Grande, 2004; Archibald, 2008; Atleo, 2001)

Traditional Teachings

One of the underlying principles for the cultural approach to treatment is the belief that First Nations and Aboriginal people with a history of substance misuse are often disconnected from their First Nations identity because of the historical impacts of colonialism, attempts at assimilation, residential school, foster care and their resulting effects. It is further believed these impacts caused disruptions to family and community systems which also resulted in the loss of the customary instruction of traditional practices. Part of the rationale for the treatment philosophy of NNADAP Treatment Centres is that many First Nations people have not had the access or opportunity to learn or be exposed to native culture or spirituality. Therefore "not knowing their cultures" is the basis for the cultural methodology.

We asked community members and youth workers how traditional teachings are shared in their communities. The impetus for this question came from the common-place criticism that treatment centres use pan-Indian (or traditions that do not belong to any one specific nation) approaches as cultural teachings and people go home not knowing, embracing or respecting their cultures of origin. Centres accept clients from all regions and so must respect the diversity of the First Nations culture in BC. It is not possible to teach all or one culture. The introduction of common First Nations principles, values, beliefs and practices is intended to build a positive self-identity, Aboriginal and First Nations world view and an interest in learning the traditional practices of the clients' own nation. Similar to addictions recovery, treatment centres are only the beginning of the life-long journey toward cultural learning. Clients are advised and expected to learn the specific practices of their nation from the Elders and cultural resources in the community. The cultural teachings available in treatment centres cannot replace the traditional teachings and practices of the clients' own nation. The provision of cultural teachings is a community responsibility and the motivation to continue cultural learning is an individual responsibility within the support of the community. Finally, while the cultural/spiritual components are important to methodology and as tools in recovery from alcohol and other drugs, the main focus and purpose of residential treatment is addictions treatment.

Treatment Centres believe that communities have the Elders and cultural specialists, resources and ability within the community to teach the traditional knowledge to community members. The treatment centres also believe that culture is not being shared in the communities. So we asked.

With traditional structure decimated, colonial infrastructure is now widely utilized for recovery, so we asked the communities how traditional teachings were shared. The majority of culture is taught in schools and classrooms. In fact, if we add K-12 public education, daycare, community education classes and universities together, education ranks above the total of longhouse/feast halls/potlatch and ceremony, which ranks higher than home and family. It speaks to the importance of First Nations schools, Aboriginal liaison workers and teachers in the maintenance of culture. It also shows that home and families may not be passing on or teaching culture. Further it may also show that more community resources such as language programs, immersion camps and similar supports be established for families.

In some communities and/or in some families, teachings are shared. Where it is deemed important by individual First Nations, traditional teachings from their nations are utilized. However, teaching and learning culture is called for across the province.

Questions arising out of this response include:

- What will the long term impact be, of giving authority for cultural teachings to westernized organizations such as schools?
- How are teachers and Aboriginal support workers in the school, supported in being responsible to the teachings?
- How can families be supported to generate and model cultural teachings in the home?

Harm Reduction

The harm reduction discussion amongst Aboriginal addictions specialists is fraught with misperceptions, righteousness and a sense of not being heard. Health Canada has embraced the idea of harm reduction, as have the Canadian Centre for Substance Abuse and organizations such as the Dr. Peter Centre. Many community NNADAP workers see it as a way for individuals to meet with successes. It has an added benefit of saving health care dollars. It has not yet though been embraced by others and Wardman (2006) notes that community readiness should be assessed. Recent trips to several bookstores show many self help books on addictions that are abstinence based and no books on harm reduction.

According to the Regional Longitudinal Health Survey, the percent of Aboriginal people who drink is lower than the percent of non-Aboriginal people. We asked survey respondents why they feel so many First Nations people think drinking is not a good idea.

“Bad things happen when there is drinking/drugging.”

The question confused some. And some others felt that the statement was daft: *“How would I know what they all think.”* However, the majority response points to culture: *“It’s not our way”*. It is seen as being harmful to families and creates situations of abuse, neglect, and trauma. It has an impact on health (presumably physical) and has the potential for addiction. Other respondents suggested that individuals’ personal life experiences with alcohol and drugs impacts their thought process. For the most part, people see the negative impacts on individuals and families.

This list shows the 10 responses given the most, in order from most to least²⁰:

- Affects families
- Not our way
- Bad for health
- It’s addictive
- Their personal experiences
- Negative historic impact
- Robs spirit or soul
- Robs culture
- Impacts generations
- Creates more trouble

There is a sense of pride that alcohol does not belong in tradition or culture.

People readily identify the negative harms of alcohol. This does not mean they do not drink. So we asked, why do First Nations people drink? They drink to numb and/or relieve pain, hopelessness and feelings of despair. They drink because of experiences with grief, violence, intergenerational trauma, secrets, shame and abuse. Along the same vein people drink to escape reality, feelings of inadequacy

²⁰ For a full list of responses see Appendix VII.

and low self esteem. They drink because of stress, anxiety, fear, anger, and loneliness. They drink to forget; because they are depressed; because they are bored. Drinking relieves the sense of overwhelm and is seen as a coping mechanism. Some people drink to die; to avoid intimacy; to be brave.

So the question then is, how does harm reduction speak to the needs of the people? Harm reduction creates more questions than it answers at a community level. Dialogue needs to happen so community workers and treatment centres do not feel colonized by new government initiatives.

Treatment Centre directors state that harm reduction is okay, but believe that abstinence is better. They state that harm reduction is educational, but it is not for a residential treatment centre. Harm reduction can improve the quality of life on an individual basis.

If Harm Reduction is good on an individual basis, is it recommended for mainly out-patient services? Harm Reduction is an area for research recommendations such as:

- Identifying a clearer definition of harm reduction.
- Exploring the beliefs and attitudes of NNADAP addictions workers related to harm reduction.
- Identifying how or if cultural principles and approaches are consistent with harm reduction.
- How can harm reduction principles be included in treatment models?
- Do harm reduction principles work within Aboriginal or rural/remote populations?
- How would program evaluations or outcome studies need to change, for example how would success be defined?
- Can communities who have a history of collective living, view individuals as responsible for their own choices?

Research questions would have to be defined with the consultation of key stakeholders.

If harm reduction principles are implemented, what is the impact on service delivery? What are the future implications and how will they impact future treatment philosophies or service delivery? Harm reduction dialogue needs to happen openly between community, traditional people, and treatment centres and Health Canada and the Canadian Centre for Substance Abuse. The worldview of harm reduction proponents need to listen to the worldviews of traditional First Nations, and vice versa.

Methadone

Methadone maintenance was not well received amongst the majority of key informants we spoke to in our data gathering. And according to Wood (2007) the rate of methadone users amongst Aboriginal people is lower than average. While it is seen by many as an answer to opiate addiction (Stevenson, 2001; Sproule, 2009;) and potentially a strategy to prevent HIV/AIDS (Wood, 2007, Centre for Addictions and Mental Health; Craib, 2003) many people stated that it is just another addiction. Ideally, methadone is a treatment itself that intends to wean people off of both their original addictive substance and then the methadone. (Health Canada, 2002) It is however, still controversial. People have similar responses to atavan and T3s: that they are substances that pollute the mind body and spirits of First Nations people.

Many treatment centres we talked to do not take clients on methadone, and if they do the clients need to be stabilized on a specific dose and closely monitored.

Otherwise we hear *“We require people to wean off of Methadone prior to being given an intake date. Those who are truly interested in attaining a healthier lifestyle have chosen this route and been successful.”* We also heard that methadone *“is still a mood altering drug and people still carry the addicted behaviours and nod off and abuse etc. This does not fit our program mission statement re: living a clean and sober lifestyle.”* Another informant stated that *“methadone is a symptom.”*

Clients who are under a methadone maintenance program are accepted at:

- Gya’Wa’Tlaab
- North Winds
- Round Lake
- Three Voices
- Wilp’ Si’Satxw

From this we deduce that methadone is not seen as a pathway to healthy lifestyles as per our data gathering. This does not appear to be a judgement based on use, but rather the ability to move forward in healing. This belief is not supported by the medical community.

There are a couple of reasons why the treatment centres do not take methadone clients. Access to a doctor is needed and dispensing is a problem because methadone can only be dispensed by qualified pharmacies. (College of pharmacists of BC) *“The regulations about storage and administering take time and staff, and these are currently not adequately funded.”*

Most treatment centres have the condition that the client must be stabilized enough to qualify for “carries”²¹ as this eliminates the need for the drive every day to take the daily dose of methadone. There is a limit for the amount of carries that will be dispensed, so the travel to the pharmacy is not eliminated. Patient travel to medical services is not formally provided.

Feedback from the communities shows resentment for methadone clients, by other clients, who weaned themselves off methadone to be able to go to treatment. For example, *“How come I had to get off it and they didn’t.”*

²¹ Take-home methadone which would be kept in locked storage and dispensed under supervision at the centre. (ABDFNTP, 2009)

Where is the Next Journey?

In this section we identify the gaps and overlaps in services, conscious of both the NNADAP lenses and existing services. We identify the specific gaps and make recommendations to those. In addition, we share recommendations based on information gleaned throughout the needs assessment process.

It is important to note that no one in the data collection reported having too many workers, too many treatment centres or too much help. We therefore determine no overlaps in services.

We also recognize that there are two truths at cross purposes: Existing Services are underfunded and Health Canada currently has no dollars to upgrade services so programs are being asked to do more with the same money. There are not enough resources to support current mental health and addictions services and so the purpose of this section is to realign services under the very strict Health Canada limitations.

Based on the data collected, the BC Region in conjunction with the First Nations Health Council and the Addictions Advisory Team, make the following recommendations.

Prevention

Prevention Programs

We support entirely the on-going prevention programs across the province, including ones like the FASD prevention program at Wachiay Friendship Centre; the MCFD programs within the school systems such as the Living with Tradition program developed by Carol Camille; and the First Nations Girls' Group as in Kispiox. The ripple effects of programs help with family-based prevention, and are not just programs designed for individuals.

Family Treatment as prevention

Family Programs are significant in terms of preventing addictions. Attachment and trauma experts speak to the need for healthy family activities. (Levy and Orlans, 1998; Brisch, 2002) The Prince George Friendship Centre for example, holds Community nights where entire families can come for dinner and a host of activities that include culture.

Given the number of Aboriginal Children in Care²² we fully endorse and encourage family treatment. When children are out of parental home and only one parent goes to treatment, the family gets torn apart. The scope of family treatment includes increasing cultural capacity, parenting skills, family systems, the impact of trauma on child development, life skills, co-dependency, household management, recreation, and/or academic support. We want to support the ideal that sometimes

²² "Aboriginal children account for approximately nine per cent of the child population, but make up 49 per cent of children-in-care (Chart 1) and 42 per cent of youth in custody." As per the MCFC Service Plan found at <http://www.bcbudget.gov.bc.ca/2006/sp/cfd/StrategicContext6.htm> on June 30, 2009.

helpers can go into a family home and ‘play’ with the family, teach the family to ‘play’ together, and support activities that support healthy attachment (Proulx, 2002).

We support the expansion of family treatment beds. Further to this we recommend more on-the-land programs for families, where they are able to bond in atmospheres that reflect those that our ancestors resided in.

FASD Support and Prevention

Foetal Alcohol Spectrum Disorders are ideally a prevention issue. However, the continuum of FASD problems throughout lifetimes is real. (FAS/E Support Network of BC, 2002; Chudley et. al. 2005) They include neuro-biological, social, academic and physical issues.

30% of street youth indicate their mothers had a problem with alcohol. (McCreary, 2008) and 11% of street involved youth indicate that they have FASD. (McCreary, 2008) Assessment can be done through all health regions in the province (<http://www.mcf.gov.bc.ca/fasd/assessment.htm>) and research shows that consistently, the numbers of FASD are higher amongst Aboriginal populations. (Assante, 1981; Tait, 2003) Although there is suggestion that FASD is more likely to be connected to poverty than ethnicity. (Abel and Hannigan, 1995)

We note proactive projects such as the book *Nlaka’pamux Women: a look at the traditional pregnancy and birthing practices* developed for families of Lytton First Nations. The huge response to the First Nations Health Council’s workshop on *Working with Women on Substance Use and Related Health Issues Before, During, and After Pregnancy* shows that it is in the consciousness of service providers. We support the prenatal health practices that exist on many reserves in BC, such as the Prenatal Outreach programs.

Studies in long term supportive housing, while not directed specifically at FASD, certainly look at working with risk factors associated with FASD (such as the need for routine, structure, and support). “There is consistent support for the positive impact of housing on health and social outcomes for people with substance use and mental disorders. Moreover, evidence suggests that this type of housing can have a minimal (or even positive) impact on the neighbourhoods in which they are sited.” (p. 4 CARMHA, 2007);

We support long term supportive housing with specific regard to FASD. We also support the continued funding of programs for high risk pregnant mothers such as the Circle of Life Program in Terrace, and Sheway in Vancouver. We further encourage culturally based parenting and child care initiatives such as the Lytton First Nation and the Coast Salish Employment and Training language CD.

NNADAP workers and Wage Parity

According to our survey data, the hourly rate of pay for community NNADAP workers varies considerably. While one person reported making less than 10.00 per hour, the majority make over 14.51 per hour. First Nations wages are often valued with the assumption that the employee will be working tax-free. The National Drug Strategy notes that it is hard to retain workers because employers cannot be competitive in their wages (Health Canada, 2009). NNAPF’S position paper on National

Training (2006) states there needs to be more dollars for treatment centres,²³ in order to increase wages. The cost savings to government in health care and incarceration because of treatment (Tsoy Tun Lelum 2006) can justify this.

Some NNADAP community counsellor positions are part-time. It may be that some communities must reduce the work week in order to afford a higher and more attractive pay rate, at the cost of reduced services available to the community. Some community workers divide their time providing one or two days of service in several smaller communities. These communities are partnering to enable the funding of an addictions service not otherwise available. These would be indicators for attraction and retention issues that are related to shortages in wage/program funding. While they may also be evidence that communities are managing funding creatively, it is still an indicator of funding shortages.

Hourly Rate of Pay

	Response Frequency	Actual Number of Respondents
less than 10.00 per hour	2.2%	1
10-12\$ per hour	2.2%	1
12.01-14.50 per hour	8.9%	4
14.51-17.00 per hour	17.8%	8
17.01-19.50 per hour	17.8%	8
19.51-22.00 per hour	20.0%	9
22.01-24.50 per hour	8.9%	4
24.51 per hour or more	22.2%	10

TABLE 12: WAGE BRACKETS OF COMMUNITY-BASED NNADAP WORKERS IN BC

Wage parity and worker training are key in looking at the current quality and retention of current NNADAP workers. There is nothing new in underpaying Aboriginal people in Canada, who have traditional knowledge compared to paying mainstream populations for having western education. For example, Aboriginal liaison positions in the hospitals come under the Health Employees Union with no professional designation. (Northern Health, 2009) Ideally, they should be under HSA because they have traditional knowledge. This is similar to the Aboriginal Support Workers in the education systems. So administrators are saying ‘we don’t recognize your knowledge’. There’s a legitimacy to Aboriginal worldview and knowledge that has to be recognized. (Reid and Lindsay, 2009)

On March 18, 2009 we took a sampling of similar job positions with the provincial health authorities and found the following:

Health Region	Job Title	Hourly salary
Fraser Health	Clinical Addictions Counsellor	29.39-36.66
VIHA	Youth and Family Addictions Counsellor	26.39-32.89

²³ Access at http://www.nnapf.org/sites/default/files/pdf/en/workforce/position_paper_on_aboriginal_health.pdf on April 22, 2009

Northern Health	Mental Health and Addictions Clinician	26.39-36.66
Vancouver Coastal	Alcohol and Drug Counsellor	26.39-32.89
Interior Health	Addictions Services Emergency Response Nurse	27.85-36.56

TABLE 13: HOURLY SALARIES OF SAMPLE OF ADDICTIONS WORKERS IN BC

80% of community NNADAAP workers make less than the minimum salary of their provincial counterparts. The low wages are considered significant in the ability to retain strongly qualified workers in the communities and at treatment centres.

If a band is given extra money for certified workers there is no control over how the money is spent. Does it get to the certified workers? It is important to note however, that just because a First Nation is given more dollars for certified workers; it does not mean there will be any control over how the money is spent or whether or not they can find certified workers.

We recommend that dollars be increased for wage parity for NNADAP workers and treatment centres to match their academic and traditional education to levels on par with their provincial counterparts.

We further make recommendation for funding for a recruiting initiative to bring awareness of opportunities in the addictions field, bursary sponsorship in the addictions field to encourage students to enter the field, funds for recruiting materials and participation in career fairs. This is a critical issue in relation to attraction and retention. If many of the workers are getting close to retirement age, there is an urgent need to attract students to enter the field. The current potential earnings in the addictions field do not bolster the call.

Partnerships with Youth Workers and the public education system

We recommend that efforts be made for more partnerships between education programs and health. Schools initiate an interest, but for the children they still have to go back to their communities. School is where they can first learn to be proud of who they are. The First Nations Education Steering Committee would be an ideal agency to begin this process. While some schools (such as the one on Haida Gwaii) have youth alcohol and drug workers in partnership with Aboriginal Child and Youth Mental Health, it is not consistent across the province. Given the importance granted to Aboriginal Support Workers in the schools (as per our data) their participation in the alcohol and drug continuum needs to have more exposure.

We also see the need for more dialogue between education, health and First Nations cultural teachers given that education workers are seen as significant cultural transmission agents by the people we surveyed. And finally, addictions training for education workers in the high schools could be provided along with NNADAP worker training. This is an opportunity for partnership and sharing of training dollars.

Training

While we did not ask specifically about training needs, we heard from all of our data sets, that more training was needed for drug and alcohol counsellors in all ranges. In our data gathering process we did have specific requests for training in the ‘new drugs’. We also heard in our interviews and in our surveys, that people still hold a belief that alcoholism is genetic and First Nations people are predisposed ethnically to alcoholism. While we also heard from people who understand the disease model, the impact of trauma and addictions, and attachment and addictions, we are of the belief that training is needed. We recommend that realistic training opportunities should be created for NNADAP workers that are accredited; offered at more than one time per year; and that utilize First Nations pedagogy in their delivery. Laddered programs that can lead to degrees would be desirable. We recommend that the NNADAP workers also be given ample opportunities to meet with their colleagues for this training, and wrapped into the training, opportunities for self care. NNADAP workers can sometimes be the only sober person working in their communities, and are not often given adequate support to do quality work for long periods of time. They become susceptible to vicarious trauma and burnout. It would be beneficial that a professional organization be created to support them in the work they do.

At times Community Health Representatives (CHR) or Social Development Workers request the opportunity to be included in NNADAP addictions training because the Band does not have a NNADAP Worker. This is always difficult because the training funds are limited and targeted to NNADAP workers. There should be a recommendation to provide addictions training to other Band staff where there is no NNADAP worker. To identify this, there would have to be an updated list of NNADAP workers.

The BC Addictions Advisory recommends that Enhancement Funding for training and the Canadian Drug Strategy dollars for research and networking flow through the ABCFNTP. Further, we encourage participating bodies to engage in conversation with the Justice Institute of BC, or a similar post secondary institution, to seek certifiable training. We do however note that this should not be at the expense of networking opportunities for community NNADAP workers. Another recommendation is that Health Canada provide resources to establish standardized accredited training for all Band health staff such as NNADAP workers and MH workers for the purpose of protecting and sanctioning Aboriginal world views and blending western philosophy in their services.

The advisory further recommends to support the First Nations Wellness Addictions Counsellor Certification Board in their efforts to develop certification standards for Elders and traditional/spiritual healers and the development of a method to recognize and verify authentic healers for stakeholders, support for the healers and reassurance for clients are critical for the implementation of Health Canada funded services for traditional/spiritual healers. For a full list of their process, see Appendix VIII

We recommend that Health Canada and INAC provide funding at the community level that includes vocational counselling; literacy training; physical health training and social skills training involved in aftercare delivery.

Further to our previous discussion on Mental Health, we recommend that Health Canada and the healing industry support and recognize traditional healers and healing approaches that are different from the western philosophies. (AHF, 2008)

Treatment

The BC First Nation Treatment Centres are seen as good things by the healing industry. They are supported and respected amongst community NNADAP workers, community members, youth workers. In fact the data collected in this process suggests that treatment itself is the goal for addictions clients. People speak about sending clients to treatment; that individuals want to go to treatment; and that all things should be cured at treatment. There is little suggestion that long term sobriety championed by the communities and First Nations leadership is the goal. Residential treatment provides safety, stability, a chance to recover from the lifestyle they had, and there is an acceptance of who individuals are as they walk in the door.

There needs to be a process for successful treatment centres to provide their knowledge and to have research capacity. We recommend partnerships with academic programs. We recommend that treatment centres who have had long term success provide their knowledge to the world. Where possible, mentorship opportunities should be made available. Partnerships with academic programs are also encouraged specifically looking at Indigenous research by Indigenous researchers on Indigenous peoples.

Treatment Centre Re-profiling

Health Canada indicated that there were dollars for three treatment centres to re-profile in this next fiscal year. At this time, we recommend the following three areas be prioritized for re-profiling: the acceptance of pregnant women into treatment; piloting four-week treatment programs; and a treatment centre with additional training in cocaine and cannabis use.

Pregnant Women

Programs in BC such as Sheway in Vancouver, and the Circle of Life in Terrace support high risk women during their pregnancies. The women are referred from a variety of places. The Mother-Child program that was recently discontinued at Alouette Women's Prison, had tremendous support for children of prisoners remain with their mothers. (Correctional Services Canada, 2007) And the FN Health Council's workshop offering on working with high-risk mothers, sees demand for a minimum of one more offering.

In 2008/2009 Valerie Genaille at the Association of BC First Nations Treatment Program Directors (ABCFNTP) created a comprehensive grid of services²⁴ at each of the treatment centres. We note the following because of their relevance to the Health Canada NNADAP criteria, and the feedback from the other data sets. We found no treatment centres who take pregnant women past their second trimester.

²⁴ See Appendix V.

Unless they are a family treatment or youth treatment facility, the treatment centres do not provide day care or schooling.

We do recommend that at least one treatment centre in BC be adequately funded and trained to receive pregnant women, with particular thought given to FASD prevention. This treatment centre should have access to appropriate medical services and be close to hospital facilities. Given that Health Canada's policy is not to allow travel for health reasons while individuals are in treatment, this directive should be waived.

In looking at the geographic realities of existing treatment programs in BC, we encourage conversation with Kakawis, given their upcoming move to Port Alberni which will give them close proximity to a hospital. Kakawis is also set up specifically to work with families. Tsow Tun Lelum Treatment is another option as they too are relatively close to hospital services.

Four week Treatment models

While there is some evidence that suggests that the length of treatment does not impact long term outcome (United Nations International Drug Control Programme, 2002) the community experts feel that longer treatment is more effective than shorter treatment. Given the long waitlists at many treatment centres, we propose that one of the NNADAP treatment centres pilot a series of four-week treatment programs. In addition to piloting them, it would be ideal to track the clients in both the six and four week models to determine short and longer term client outcomes. In this way, NNADAP would be able to gather evidence specific to Aboriginal treatment duration.

Poly Drug use

Information received from several NNADAP workers, spoke to the number of clients they are seeing who are likely to be poly drug users. They most often cite cannabis and cocaine, but also notice an increase in the new 'designer' drugs. Some of the addictions workers feel that they do not have a broad enough understanding of what they call 'the new drugs'. However, the Substance Abuse Information System data does not show an increase in poly drug use amongst treatment centre clients nationally. Given that the information is conflicting, we still feel that training in poly drug use and addiction would be of benefit, and recommend that at least one treatment centre specialize in this area.

Aftercare

According to community-based NNADAP workers, an ideal after care would look like this:

The clients would be welcomed home by their communities. In fact, it would be "robust ongoing community participation". There would be no liquor store. The treatment centres would send people out to the communities to work face to face with both the client and their referral worker.

They would have options for shelter that might include:

- *A safe haven*
- *A Halfway House*
- *The option of being in their home communities or somewhere else*

- *Being in a shelter that is not influenced by band and family politics*
- *FASD-friendly environments*
- *Individual and family accommodations*
- *The choice for people to stay as long as they need.*

They would be supported finding work and educational opportunities. They would be offered life skills, skills acquisition, mentorships, workshops on budgeting,

They would have adequate access to health care, including nurses,

They would have access to spiritual, mental and emotional support that might include counselling, 12 step programs, day treatment, 24 hr access to support, elders, meditation and visualizations.

They would also be able to access “a recovery club”, a drop in centre, recreational activities like card games, darts, pool tables, storytelling, computers, workshops, books,

There would be an emphasis on culture, where people could drum, sing, go out on the land, canoe, beading, gather plants, make snow shoes, make drums, sweat, smudge, have pipe ceremonies, cold water baths, hunt, fish, make regalia, and weave.

Given that there are 203 First Nations in BC, we recognize it is not possible for each community to have such a place. However, setting out the ideal to communities and First Nations leadership, and adequately funding treatment centres to go into the communities for after care would begin the dialogue and perhaps alter the mindset to believe that post-treatment is the goal: the impact of clean and sober people on the economic, educational and health norms of First Nations.

In addition we note that many Friendship Centres in the province have programs that fit the scope of this vision. We therefore recommend that aftercare become a priority of communities in general and that First Nations leadership embrace partnerships where possible with Friendship Centres, Recreation Programs and take the lead on this issue, supporting the hard work of their NNADAP workers.

There is a belief that treatment centres should do “*as much as we can*” with regard to after care, and then there is a financial reality. It is not in the budget. Treatment Centres are not funded to do after care. They cite programs such as 12 Steps and Friendship Centre programs as resources. Ideally, they would like to visit communities where their clients come from. Jim Chorney in partnership with Nenqayni, completed a research program in 2007. “The research conclusions and resulting seven recommendations addressed the needs of community workers and volunteers, focused on continuing care as a community-based service, outreach for communities, training for workers, communication, the continuing care plan, culture and spirituality. The willingness and enthusiasm of staff and community participants made clear the shared core values of the stakeholders and the communities that comprise the centre.” (<http://www.nenqayni.com/index.php?mod=continuing>)

We recommend that similar programs are addressed at the treatment centres. However we strongly encourage community leadership to create atmospheres of welcome and honour for those individuals returning from treatment.

Gender

The BC Regional Addiction Advisory Team supports initiatives that are gender specific. The NNADAP treatment centres occasionally have gender-specific intakes with varying degrees of success.

31% of women indicated an interest in attending treatment and 47% of men did. It is also notable that people were more interested in seeking help outside the community than in-community, although we recognize that we stipulated ‘drug and alcohol’ counsellor for the in community response.

While we support the idea of gender-specific treatment, we also recognize the successes of co-ed facilities.

First Nations

We feel that First Nations Health Directors within their contribution and transfer agreements should have adequate provisions for individuals to see the ‘counsellor of their choice’ and not just those on the approved service provider list developed by Non Insured Health Benefits.

Culture

The data collected in our study suggests that people are slightly less likely to drink alcohol in communities where language was rated above 40% usage. (This is also reflected in the youth suicide study done by Chandler and Lalonde, 1998.) People who participate in cultural activities more frequently are less likely to use alcohol but are equally as likely to use stimulants or cannabis as those who less frequently participate in cultural activities. *We therefore recommend that community programming include culture and language, in particular in smaller communities who are likely to have little or no access to human services agencies.*

First Nations Leadership

We recommend that First Nations leadership take a strong role in struggle against addictions in First Nations communities. Leaders can lobby with all governments to increase funding for addictions services and training, ensuring basic addictions training for education; health and social workers; ensuring Band-funded sober community supports run by all social development staff; encourage community members to actively volunteer to organize sober community support; recognize and celebrate all community and individual efforts toward recovery that can include culture and education.

Non-Insured Health Benefits

Given the call by community members to see elders, spiritual, and traditional healers we are calling for NIHB to explore options whereby First Nations traditional and spiritual healers can be utilized by community members and that they be paid at the same rates as their mainstream colleagues. We suggest that NIHB take into consideration, adding some of the elders to their list of service providers. The advisory has some concern that there are not enough service providers that are culturally sensitive. The sense is that some non-Aboriginal counsellors do not know about First Nations people much less

addictions. Another barrier is that people who are culturally sensitive often have full practices because people feel safe going to them.

Non-Insured Health and Travel

We recommend that NIHB review and discuss their travel policy with service providers; that the policy be made clear to both treatment centre and referral workers; and that the administration of the policy be consistent. In addition we recommend that return travel arrangements be allowed at the beginning of treatment, especially for detox and treatment centres along Highway 16. We further recommend an appeal process that is timely for patients.

Band government making decisions at the community level and choices about who gets patient travel are often subject to the internal process of bands. The reality is that many of our communities can not send people because there's no money at the band level.

Travel is an issue for treatment centres. Prominent issues for them include:

- Clients have to take the bus and bring their meds with them on the bus. Methadone clients have trouble getting their prescription for a three day bus ride. In addition, 'carries' require refrigeration.
- Health Canada funding for travel is inadequate. *"They spend too much time finding the cheapest route and it's not necessarily the smartest route."*
- The bus is the cheapest route, but it does not come to our community. *"There's no provision for travel between the bus station and the treatment centre."*
- There is an expectation that the client will get there *"on their own steam"*. While some clients and/or bands are in a good position to do this, many clients in crisis are not.
- Interpretation of health travel policy is inconsistent.
- The bus schedules do not match the treatment schedules.

It is important to note that when clients are in treatment, their travel is not covered to medical facilities.

In northern BC, Northern Health Connections provides a low-cost travel service program. We believe that the program has good intentions but given the geographic challenges of the Northern Health Region it is still a hardship for the addictions ridership.

Clients with HIV or diabetes can be fit and healthy enough to attend treatment. However clients who have compromised health maybe capable of attending treatment but likely have increased medical

"I spend far too much time in this position helping clients with their travel arrangements because FNIHB will only fund them for one way travel and I spend too much time helping clients with their return travel. And for some reason the travel clerks don't get it right...the ones from FNIHB. Like before Christmas I spent two solid weeks just on travel and I can't do this, I'm not their travel clerk. I'm an intake worker! It's really stressful, extremely stressful for the clients...so we start working on it as soon as they arrive so I help them right away so they can be here and not be worrying about those things. Somehow I want to set it up so that all clients arrive here with their return travel arranged."

-Treatment Centre Intake Worker

service and patient travel needs which are not funded. Budgets for client transportation are intended for program activities, for example to attend programming off-site, A.A., cultural or recreational activities.

We therefore recommend an overall policy and planning to support mental wellness and treatment. This can be supported by patient travel available through NIHB, while clients are in treatment. See Appendix IX for ABCFNTP’s discussion paper on travel.

Detox

The table below shows the publically funded detox facilities in BC. (We recognize that there may be others that we are not aware of.) The table covers both in-home and inpatient detox. The majority of services are in the Lower Mainland and on Vancouver Island. None of the facilities are Aboriginal specific. We have heard, that when people can get in to detox, they generally have good experiences. The challenge however, is getting in. In all of our data collection we had feedback that getting into and then getting to detox, is a huge need.

Name of the facility	Health Region	Type of outpatient rehab
Chilliwack General Hospital, Withdrawal Management Unit	Fraser	Medical Detox for alcohol and drug addiction
Creekside Detox	Fraser	Detoxification treatment at home and inpatient
East Kootenay Alcohol and Drug Counseling Service Society	Interior	Detoxification treatment at home and inpatient
Kamloops Society for Alcohol and Drug Service, Phoenix Centre, Detox Program	Interior	Drug and alcohol rehab inpatient detox
Prince George Regional Hospital, Prince George Detox/Assessment Unit	Northern	Medical Detox for alcohol and drug addiction
Fort Nelson General Hospital, Community Counseling Services/Detox Services	Northern	Medical Detox for alcohol and drug addiction
Vancouver Coastal Health Authority, Adolescent Day Program	Vancouver Coastal	Detoxification treatment at home for drugs and alcohol
Richmond Alcohol and Drug Action Team, Richmond Addiction Services	Vancouver Coastal	Detoxification treatment at home
Richmond Youth Daytox	Vancouver Coastal	Detoxification treatment at home
Saint Mary's Hospital, Sunshine Coast Home Detox Program	Vancouver Coastal	Detoxification treatment at home for drugs and alcohol
Cordova Detox	Vancouver Coastal	Drug and alcohol rehab inpatient detox
Daytox Vancouver/Vancouver Detox	Vancouver Coastal	Drug and alcohol rehab inpatient and at home detox
Downtown Eastside Youth Activities Society, Youth Detox Program / Alcohol and Drug Counseling	Vancouver Coastal	Drug and alcohol rehab inpatient detox
PLEA Community Services Society of BC, Youth Detox Program	Vancouver Coastal	Detoxification treatment at home
Vancouver Coastal Health Authority,	Vancouver	Detoxification treatment at home for drugs and

Raven Song Addiction Services	Coastal	alcohol
Vancouver Coastal Health Authority, South Addiction Services	Vancouver Coastal	Detoxification treatment at home for drugs and alcohol
Ann Elmore Transition House, Detox Program	Vancouver Island	Drug and alcohol rehab inpatient detox
John Howard Society of North Island, Upper Island Youth Services	Vancouver Island	Detoxification treatment at home
St. Joseph's General Hospital, Substance Abuse Intervention Program - Withdrawal Management	Vancouver Island	Medical Detox for alcohol and drug addiction
Comox Valley Transition Society	Vancouver Island	Drug and alcohol rehab inpatient detox
Cowichan District Hospital, Addiction Services	Vancouver Island	Medical Detox for alcohol and drug addiction
Clearview Centre, Communities Addiction Resource Society	Vancouver Island	Drug and alcohol rehab inpatient detox
Vancouver Island Health Authority, Tahsis Counseling Services	Vancouver Island	Detoxification treatment at home for drugs and alcohol
Vancouver Island Health Authority, Pembroke Supportive Recovery Services	Vancouver Island	Drug and alcohol rehab inpatient detox
Victoria Youth Empowerment Society, Specialized Youth Detox	Vancouver Island	Drug and alcohol rehab inpatient detox

Table 14: Publically Funded Detox in BC

We recommend that the Northern Health Region look at the implementation of “Wet-beds” where clients experience controlled drinking. The beds should be adequately funded and have patient travel arrangements wrapped into the responsibility of the detox centre. For example, the centre should be adequately funded for a vehicle and driver, to pick up clients and deliver them to detox. Health Canada presently funds physician locums to many of our communities. These physicians including nurse practitioners who need to be trained in detox protocols. Because of the rural nature of many of our First Nation communities in BC access to detox facilities is not realistic.

Recommendations to NNADAP

We recommend that a comprehensive list of NNADAP workers in BC be created and maintained by Health Canada. Integrated and transfer units mean that there is no comprehensive list to oversee this. Recommend that there be some form of network with community based folks.

Recommendations to the First Nations Health Council

As per the Transformative Change Accord, we support the First Nations Health Council taking a leadership role in substance misuse. Within their mandate, they plan to establish and support Mental Health programs to address substance abuse and to provide leadership in implementing addictions programming for First Nations people. We suggest that they spearhead an adult mental health and substance abuse plan in partnership with federal, provincial and First Nations agencies. Because of the issues specific to BC mentioned in this document, we support opportunities be created that allow

community members, community NNADAP workers, and treatment centres to meet to discuss waitlists and potential supports for people on waitlists.

Further, we also believe that alcohol and drug counselling be cross-jurisdictional. We believe that individuals should have opportunities to access the counsellor of their choice. For example non-Aboriginal clients might seek the services at a local band office. On-reserve clients might seek services at the next reserve. We therefore ask the health council to spearhead these discussions; to advocate for the idea through First Nations governance. The challenges will include limited budgets for health in many communities. Community members may find that they are not in a fiscal position to pay for services for people who are not on their membership rosters. We suggest then, that communities find ways of coming together to make this a possibility so that all First Nations people are embraced where they feel safe.

Considerations for further research.

Our first recommendation is that studies be done into the cultural therapeutic models employed at most First Nations treatment centres. Each of the treatment centres employs techniques specific to their communities, as well as shared cultural tools, that emphasize holistic therapy. We recommend that academic studies be undertaken to look at the models. The efficacy of the models we believe, can inform western therapeutic practices.

Secondly, we recommend a survey of NNADAP workers, to ask what they see as their specific training needs. This request came to the needs assessment from Health Canada after the data collection phase was complete, and we believe that this is still necessary.

Further to this report, a strategic plan for Addictions is also necessary for the BC Region.

Appendices

Appendix I: Key informant interview questions with Community Health Directors:

Band:

Health Region: Interior Northern Vancouver-Coastal Vancouver Island Fraser

Can you tell me where Addictions fits into the community's' health plans?

Are you linked with any of the treatment centres or other addictions services in BC?

What would make a good outreach program for addictions in your community practical?

What specific programs are offered for pregnant women? (generally and also in regards to FASD prevention)

How are children served?

How are youth served?

Where do/can you refer people who are not stabilized?

Do you have any land-based programs? (eg. Survival camps; fish camps)Tell us about them.

What do you have the capacity to provide for Mental Health issues?

To what extent are there cross-sectoral partnerships? (e.g. justice, education, employment, housing)?

How are band/community elders accessed by programs?

Are traditional ceremonies or practices acknowledged as part of programs? (e.g., longhouse, feasts, potlatches, rites of passage, dancing) Or how is culture used in programming?

Are traditional medicines and teachings integrated into services?

What do you see as the most immediate need in regards to substance use/addiction?

Appendix II: Youth Worker Survey

1. What Region of the province do you live in?

- Vancouver Coastal
- Interior
- Fraser Valley
- Vancouver Island
- Northern

2. What type of area do you live in?

- Rural
- Urban
- Isolated
- Other

3. Gender?

- Male
- Female
- Other

4. What grade ranges do you work with:

- K-7
- 6-8
- 7-10
- 8-12
- 10-12
- Other

5. How many children or youth do you work with, in a week, who use drugs or alcohol?

6. When you think of the kids you work with in any given week, which of these substances do they commonly use:

- Alcohol
- Opioids (heroin/methadone/)
- Cocaine (cocaine/crack)
- Stimulants (amphetamines/crystal meth/MDMA)
- Hallucinogens (LSD/others)
- Hypnotics and sedatives (barbiturates/benzodiazepines)
- Volatile inhalants
- Cannabis
- Other substances

7. Do any of the children you work with take prescription medication for:

- pain
- anxiety

depression
hyperactivity
other

8. What approaches do you find successful in working with children/youth?

9. Why do you think so many First Nations people think drinking is not a good idea?

10. Why do you think people drink or take drugs?

11. What traditional teachings shared in your programs?

12. How are they shared? (choose as many as you like)

Openly to everyone
All the time
At community gatherings
At potlatches, feasts, winterdances, or pow wows
In classrooms
One to one with children and youth
Only to people who belong to certain families
Rarely
in groups of Aboriginal children

13. Where are you able to refer children and youth who use drugs and alcohol and/or who struggle with substance abuse? (choose as many as you like)

Elder
Psychiatrist
Men's Treatment Centre
Spiritual Healer
Drug and Alcohol Counsellor in the community
CHR
Traditional Healer
NNADAP Worker
Counsellor outside the community
Art Therapist
Doctor
First Nation's Treatment Centre
Psychologist
Other
Women's Treatment Centre

14. If you said 'other', what kind of helper would the helper be?

15. What do you see as the most immediate needs in your community in regards to substance use/addiction?

Appendix III: NNADAP Worker Survey

Section I

1. What Region of the province do you live in?

- Vancouver Coastal
- Interior
- Fraser Valley
- Vancouver Island
- Northern

2. What type of area do you live in?

- Rural
- Isolated
- Other

3. What is your age?

- Under 18
- 18-25
- 25-35
- 35-45
- 45-60
- 61+

4. Gender?

- Male
- Female

5. Do you use any of these substances yourself:

- Alcohol
- Opioids (heroin/methadone/)
- Cocaine (cocaine/crack)
- Stimulants (amphetamines/crystal meth/MDMA)
- Hallucinogens (LSD/others)
- Hypnotics and sedatives (barbiturates/benzodiazepines)
- Volatile inhalants
- Cannabis
- Other substances
- None of the above

6. How would you rate your own wellness?

- Excellent
- Great
- Good
- Fair
- Not so good

Poor

7. What is your specific training for the work?
8. What training opportunities are you currently engaged with?
9. What is your hourly salary?
 - less than 10.00 per hour
 - 10-12\$ per hour
 - 12.01-14.50 per hour
 - 14.51-17.00 per hour
 - 17.01-19.50 per hour
 - 19.51-22.00 per hour
 - 22.01-24.50 per hour
 - 24.51 per hour or more

10. How long have you been in this position?
 - less than 6 months
 - 6 months to a year
 - 1-2 years
 - 2-4 years
 - 4-6 years
 - 6-8 years
 - 8-10 years
 - 10-12 years
 - 12-15 years
 - 15 years +

Section II

1. What are your hours of operation?
2. Are there any additional supports available after program hours such as a helpline or answering service?
3. What other programs in the community exist that address addiction-related needs (e.g., support groups, school programs, 12-step meetings, etc.)?
4. Do you have a wait list?
 - Yes
 - No
 - N/A

If yes: NNADAP Section: waitlists

1. If you said yes, how long is your waitlist?
2. What support, if any, is available while clients are waiting to see you?

Section III

1. Where do you/can you refer people who are not stabilized?
2. Where do you send your clients for treatment?
3. Where would you prefer to send your clients for treatment?
4. What after care programs exist in your area?
5. Describe what a good aftercare program would look like (in a perfect world)?
6. Do you have (or run) any land-based programs? And if so, please tell us about them.

Section IV

1. Do you offer programs for:

	Yes	No	Have in the past	Plan to in the near future
women				
pregnant women				
women and children				
men				
men and children				
youth				
FASD victims				
sex offenders				
people with mental health challenges				
people with brain injuries				

2. On average, how long do clients stay with the service?
3. What are their reasons for leaving? (choose all that apply)
 - drop out
 - referral to treatment
 - referral to detox
 - referral to other agency
 - they no longer need support
 - they move
 - they choose to not get clean and sober
 - they are unhappy with their service
 - they choose to see a different counsellor
 - they find work
 - they are spending more time recreating
 - other

Section V

1. How are traditional teachings from your territory shared in your community?

2. Are they shared: (choose as many as you like)

- Openly to everyone
- All the time
- At funerals
- At community gatherings
- from the addictions counsellor
- At potlatches, feasts, winterdances, or pow wows
- In schools
- Within Families
- Only to people who belong to certain families
- Rarely
- When people are drinking

3. Where do you seek help and support yourself?

- Elder
- Other Drug and Alcohol Counsellor in the community
- Men's Treatment Centre
- Spiritual Healer
- CHR
- Colleagues
- Traditional Healer
- Referral Worker or Colleague
- Other NADAAP workers programs at Treatment Centres
- Art Therapist
- Counsellor outside the community
- Doctor
- Psychologist
- First Nation's Treatment Centre
- Psychiatrist
- Women's Treatment Centre
- Other

4. If you said 'other', what kind of helper would the helper be?

5. What do you see as the most immediate needs in your community in regards to substance use/addiction?

Section VI

1. Tell us the success story that you find most significant.

Appendix IV: Questions asked of Treatment Centres

A) To ask of Treatment Centre *Directors*:

Do you take clients who are on methadone? Why or why not?

Where **can** you refer people who are not stabilized?

Where **do** you refer people who are not stabilized?

What after care programs exist? Should treatment centres be involved in aftercare programs?

What do you feel a good after care program includes?

Tell me about travel costs.

Who funds your programs?

What mix of treatment models are presently offered at the centre (e.g., Biopsychosocial, Disease-based, Cultural model, etc.)?

What modalities are utilized within these models (psychosocial counselling, group therapy, etc.)? [

Are the services accredited? If so, who are they accredited by? How long is the accreditation for? If not, are there plans to become accredited?

What relationships exist with off-reserve programs or service providers?

To what extent are there linkages among NNADAP services and provincial/regional addictions and mental health services?

What is the worker to client ratio?

How many full-time staff do you have?

What are the training levels of staff? How many of the staff are certified?

What training opportunities are employees currently engaged with?

What are the retention rates of qualified personnel?

What access is there to addictions/mental health-related training for workers?

What are the employee retention rates for Aboriginal and non-Aboriginal staff?

What are the average employee pay rates?

In what ways is culture used as part of your program?

Are there any questions we didn't ask, that you wanted us to ask?

B) Questions to be asked of Treatment Centre *Intake Workers* as key informants:

Where do you receive referrals from?

What range of clients does you cater to — in terms of age, gender, drug of abuse, geographical distribution, etc.?

Do you provide day-care or schooling for children?

Do you have specific programs for families, youth, women, pregnant women, and people with concurrent disorders?

What is the number of beds available?

What is the length of the program?

What is the intake frequency?

What relationships exist with off-reserve programs or service providers?

Does the program offer regular access to professional mental health services (e.g., counsellors, psychologists, psychiatrists, community physicians, nurses)?

Does the program have access to pharmacological treatments?

How accessible is the service? How do existing clients access the service — on foot, by car, by public transportation, NIHB transportation?

What specialized programming is offered to clients? Are their accommodations for clients with FASD, learning disabilities, and/or brain injuries? Are clients on probation served? Are sex offenders served?

Do you have a waiting list? If so, how long?

What support, if any, is provided while waiting? What follow-up support is provided?

What culturally appropriate/specific services are offered?

Is there an integration of First Nations spiritual practices?

How are elders accessed by programs?

Are traditional ceremonies or practices used as part of programs?

Are traditional medicines and teachings integrated into services?

What do you see as the most immediate needs in regards to substance use/addiction?

Appendix V: ABCFNTP Chart

Stehiyah Healing and Wellness Centre
 18 Kimsa / 18 Kimsa Healing and Wellness Village
 Mission Statement: The Stehiyah Healing and Wellness Village
 through the use of ceremony and traditional healing arts
 will assist the healing and wellness needs of Aboriginal People
 through the use of ceremony and traditional healing arts.
 All centres are autonomous, maintaining separate and
 independent funding contributions, human resources,
 program curriculums, policies and procedures, referral
 processes, admission requirements, and accreditation.
 ABCFNTP is affiliated with the First Nations Wellness
 Addictions Counsellor Certification Board and National
 Native Addictions Partnership Foundation

Three Voices of Healing Society
 250-428-5316 / Fax: 250-428-5325
 Email: address@threevoices.org
 Website: www.threevoices.org
 Mission Statement: The primary Mission of Three Voices of
 Healing Society treatment program is to prevent and manage
 addiction to alcohol and other substances
 and to provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Gya' Wa' Taab Healing Centre
 P.O. Box 1018, Kimsa Village, BC V0X 2H0
 Phone: 250-679-2117 / Fax: 250-679-9815
 Email: gya@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Nganqini Wellness Centre
 P.O. Box 2529, Williams Lake, BC V2C 4P2
 Phone: 250-898-0001 / Fax: 250-898-0007
 Email: nganqini@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

North Wind Healing Centre
 P.O. Box 2480, Salmon A. Dawson Creek, BC V1C 4T5
 Phone: 250-848-6977 / Fax: 250-848-6978
 Email: nwhc@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Round Lake Treatment Centre
 2000 Elmer, Louis Road, Armstrong, BC V0E 1S5
 Phone: 250-548-2077 / Fax: 250-548-2237
 Email: roundlake@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Kakawa's Family Development Centre
 Box 17, Mekeas Island, Temo, BC V0R 2Z0
 Phone: 250-725-3951 / Fax: 250-725-4285
 Email: kakawa@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Hey-way-nogw' Healing Circle
 4401, 1628 Bonanza, Williams Lake, BC V2N 1W1
 Phone: 604-874-1411 / Fax: 604-874-5235
 Email: heywaynogw@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Carrie Sekani Family Services
 P.O. Box 1219, Vanderhoop, BC V0C 3A0
 Phone: 250-567-2900 / Fax: 250-567-2975
 Email: sekani@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Nganqini Treatment Centre
 P.O. Box 290, Allen Hwy, BC V0R 1A8
 Phone: 250-974-5722 / Fax: 250-974-2257
 Email: nganqini@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

North Wind Healing Centre
 P.O. Box 2480, Salmon A. Dawson Creek, BC V1C 4T5
 Phone: 250-848-6977 / Fax: 250-848-6978
 Email: nwhc@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Round Lake Treatment Centre
 2000 Elmer, Louis Road, Armstrong, BC V0E 1S5
 Phone: 250-548-2077 / Fax: 250-548-2237
 Email: roundlake@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Kakawa's Family Development Centre
 Box 17, Mekeas Island, Temo, BC V0R 2Z0
 Phone: 250-725-3951 / Fax: 250-725-4285
 Email: kakawa@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Hey-way-nogw' Healing Circle
 4401, 1628 Bonanza, Williams Lake, BC V2N 1W1
 Phone: 604-874-1411 / Fax: 604-874-5235
 Email: heywaynogw@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Carrie Sekani Family Services
 P.O. Box 1219, Vanderhoop, BC V0C 3A0
 Phone: 250-567-2900 / Fax: 250-567-2975
 Email: sekani@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Stehiyah Healing and Wellness Village
 60550 Climbuck Lake Road, Climbuck, BC V4Z 1A7
 Phone: 604-878-6088 / Fax: 604-878-6088
 Email: stehiyah@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Information & Referral Service
 13, Road 1, Cowichan Valley, BC
 Phone: 250-725-3951 / Fax: 250-725-4285
 Email: info@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Three Voices of Healing Society
 250-428-5316 / Fax: 250-428-5325
 Email: address@threevoices.org
 Website: www.threevoices.org
 Mission Statement: The primary Mission of Three Voices of
 Healing Society treatment program is to prevent and manage
 addiction to alcohol and other substances
 and to provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Gya' Wa' Taab Healing Centre
 P.O. Box 1018, Kimsa Village, BC V0X 2H0
 Phone: 250-679-2117 / Fax: 250-679-9815
 Email: gya@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Nganqini Wellness Centre
 P.O. Box 2529, Williams Lake, BC V2C 4P2
 Phone: 250-898-0001 / Fax: 250-898-0007
 Email: nganqini@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

North Wind Healing Centre
 P.O. Box 2480, Salmon A. Dawson Creek, BC V1C 4T5
 Phone: 250-848-6977 / Fax: 250-848-6978
 Email: nwhc@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Round Lake Treatment Centre
 2000 Elmer, Louis Road, Armstrong, BC V0E 1S5
 Phone: 250-548-2077 / Fax: 250-548-2237
 Email: roundlake@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Kakawa's Family Development Centre
 Box 17, Mekeas Island, Temo, BC V0R 2Z0
 Phone: 250-725-3951 / Fax: 250-725-4285
 Email: kakawa@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Hey-way-nogw' Healing Circle
 4401, 1628 Bonanza, Williams Lake, BC V2N 1W1
 Phone: 604-874-1411 / Fax: 604-874-5235
 Email: heywaynogw@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

Carrie Sekani Family Services
 P.O. Box 1219, Vanderhoop, BC V0C 3A0
 Phone: 250-567-2900 / Fax: 250-567-2975
 Email: sekani@threevoices.org
 Website: www.threevoices.org
 Mission Statement: To provide a safe and healthy happy
 environment for the people of the
 program. The primary mission of the program is to
 provide a safe and healthy happy
 environment for the people of the
 program.

MEMBERS
 Executive Directors:
 Carrie Sekani Family Services
 Gya' Wa' Taab Healing Centre
 Hey-way-nogw' Healing Circle for Addictions Society
 Kakawa's Family Development Centre
 Nangini Treatment Centre
 Nganqini Wellness Centre
 North Wind Healing Centre
 Round Lake Treatment Centre
 Stehiyah Healing & Wellness Village
 Three Voices of Healing Society
 Taow Tun Le Lum Treatment Centre
 Wily-Si-Saw House of Purification

PRESIDENT
 Marie Anderson
 Hey-way-nogw' Healing Circle for Addictions Society

EXECUTIVE DIRECTOR
 Valerik Genaille

MEMBERSHIP / AFFILIATION
 The Association of BC First Nations Treatment Programs (ABCFNTP) is a network of non-political, not-for-profit residential addictions treatment facilities. Each treatment centre is independently managed and operated under the authority of a Board of Directors. All centres are autonomous, maintaining separate and independent funding contributions, human resources, program curriculums, policies and procedures, referral processes, admission requirements, and accreditation. ABCFNTP is affiliated with the First Nations Wellness Addictions Counsellor Certification Board and National Native Addictions Partnership Foundation

CONTINUUM OF CARE / NETWORK
 The continuum of care for recovery from addictions is comprised of independent services offered by a network of Addictions Specialists through residential treatment, front-line and community resources.
 From-line addictions counsellors are requested to keep contact information up-to-date with the ABCFNTP

MISSION STATEMENT
 To provide a First Nations forum that promotes culturally relevant best practices to enhance, extend and advance the continuum of care in addressing addictions.

VISION STATEMENT
 To enhance First Nations traditions of healing, wellness, balance and harmony

- where addictions programming exists in each community as an integrated, holistic approach towards health and wellness;
- where there is an openness to addictions programming as a prominent part of the healing process for individuals, families and communities.

PROGRAM MANDATE


- To assist in promoting excellence in programming in primary and/or secondary treatment for alcohol and drug addiction.
- To encourage high quality services by the development of resources, information networking and by working co-operatively.
- To co-ordinate regular meetings of the First Nations Treatment Programs for the purpose of sharing information, developing resources, discussing current treatment and training issues and identifying needs.
- To provide a supportive environment that will encourage the development of suitable training programs for the staff of the treatment programs.
- To assist treatment centres in the provision of high quality services.
- To advocate on behalf of BC First Nations Treatment Programs and those serviced through those organizations.
- To participate in the decision-making process related to treatment and act as a resource to the decision-making bodies.



Association of BC First Nations Treatment Programs

Satellite Office
 #2, 3005 - 29th Avenue
 Vernon, BC V1T 1Y9
 Telephone: (250) 503-1135
 Fax: (250) 503-2473
 Email: execdir@firstnations-treatment.org

For details on individual Treatment Centres
 Website: www.firstnations-treatment.org

Program funded by First Nations & Inuit Health

 Brochure Print funded by
 First Nations Health Council

Treatment Centres	Program Types	Accessibility	Recovery Stage	Substance / Addiction Type	Program Components	Aftercare
ADMISSION • First Nations individuals and their families • Referral by an Alcohol and Drug Counsellor • Submission of a fully completed application including: current medical / TB test • Each Centre provides referral packages & intake schedules. • Accessibility and admission criteria vary with each program and Centre * Provided as required by individual treatment needs	Accredited by Accreditation Canada or CARF (IP = In Process) • Adult / Individual / Coeducation Program • Elders' Program • Family Program • Men's Only Program • Women's Only Program • Youth Program • Long-term Rehabilitation Program • Out Patient Program • Residential School Program • Trauma Program • Walk-in & Crisis Services (Local) • Spousal Support Program • Refresher Program • Referral / Helper Program • Corrections: Parole / Probation (Criteria varies by program) • Developmental Disability (Minor Severity) • FASD (Minor Severity) • FASD (Moderate Severity) • Mental Illness Stabilized/Managed by Psychotropic Medication • Hearing Impairment (Minor Severity) • Learning Disability (Minor Severity) • Literacy Assistance • Methadone Maintenance Therapy (Carries) • Visual Impairment • Physical Disability (Minor Severity) • Wheelchair Access • Sex Offenders • Non-Medical Detox • Early Recovery / Stabilization • Middle Recovery • Late Recovery • Alcohol • Co Occurring Disorders • Crystal Meth • Hallucinogens • Marijuana • Narcotics / Opioids • Polydrug Use • Process Addictions • Solvent Abuse • Tobacco • Sweatlodge Ceremonies • Elder Resources • First Nations Identity and Self-Esteem • Cultural Activities / Resources • Intake Screening • Orientation and Assessment • Mental Health Services (Psychologist Resources) * • Crisis Intervention * • Alcohol / Other Drug Education • Case Management and Individual Treatment Planning • Individual Counselling / One-to-One • Group Counselling • Gender Specific Group Sessions • Youth Counselling / Group Sessions • Couples Counselling Sessions (Behavioural/Coaching) * • Family Violence Counselling * • Parenting Skills • Social Development / Interpersonal Skills / Healthy LifeSkills • Problem Solving Training and Goal Setting • Stress Management Training / Healthier Choices • Anger Management / Conflict Resolution • Coping Skills Training (Urges and Cravings) • Harm Reduction • HIV Education (Testing *) • Recreational Therapy • Trauma Counselling Support * • Residential School Counselling Support * • Suicide Ideation Counselling Support (Stabilized) * • AA / NA / Self-help Groups • 12 Step Work • Case Conferences with Referral • Referral Services • Relapse Prevent on Training (Cognitive Behavioural) • Follow-up & Individual Aftercare Planning	• First Nations individuals and their families • Referral by an Alcohol and Drug Counsellor • Submission of a fully completed application including: current medical / TB test • Each Centre provides referral packages & intake schedules. • Accessibility and admission criteria vary with each program and Centre * Provided as required by individual treatment needs	Accredited by Accreditation Canada or CARF (IP = In Process) • Adult / Individual / Coeducation Program • Elders' Program • Family Program • Men's Only Program • Women's Only Program • Youth Program • Long-term Rehabilitation Program • Out Patient Program • Residential School Program • Trauma Program • Walk-in & Crisis Services (Local) • Spousal Support Program • Refresher Program • Referral / Helper Program • Corrections: Parole / Probation (Criteria varies by program) • Developmental Disability (Minor Severity) • FASD (Minor Severity) • FASD (Moderate Severity) • Mental Illness Stabilized/Managed by Psychotropic Medication • Hearing Impairment (Minor Severity) • Learning Disability (Minor Severity) • Literacy Assistance • Methadone Maintenance Therapy (Carries) • Visual Impairment • Physical Disability (Minor Severity) • Wheelchair Access • Sex Offenders • Non-Medical Detox • Early Recovery / Stabilization • Middle Recovery • Late Recovery • Alcohol • Co Occurring Disorders • Crystal Meth • Hallucinogens • Marijuana • Narcotics / Opioids • Polydrug Use • Process Addictions • Solvent Abuse • Tobacco • Sweatlodge Ceremonies • Elder Resources • First Nations Identity and Self-Esteem • Cultural Activities / Resources • Intake Screening • Orientation and Assessment • Mental Health Services (Psychologist Resources) * • Crisis Intervention * • Alcohol / Other Drug Education • Case Management and Individual Treatment Planning • Individual Counselling / One-to-One • Group Counselling • Gender Specific Group Sessions • Youth Counselling / Group Sessions • Couples Counselling Sessions (Behavioural/Coaching) * • Family Violence Counselling * • Parenting Skills • Social Development / Interpersonal Skills / Healthy LifeSkills • Problem Solving Training and Goal Setting • Stress Management Training / Healthier Choices • Anger Management / Conflict Resolution • Coping Skills Training (Urges and Cravings) • Harm Reduction • HIV Education (Testing *) • Recreational Therapy • Trauma Counselling Support * • Residential School Counselling Support * • Suicide Ideation Counselling Support (Stabilized) * • AA / NA / Self-help Groups • 12 Step Work • Case Conferences with Referral • Referral Services • Relapse Prevent on Training (Cognitive Behavioural) • Follow-up & Individual Aftercare Planning	• First Nations individuals and their families • Referral by an Alcohol and Drug Counsellor • Submission of a fully completed application including: current medical / TB test • Each Centre provides referral packages & intake schedules. • Accessibility and admission criteria vary with each program and Centre * Provided as required by individual treatment needs	Accredited by Accreditation Canada or CARF (IP = In Process) • Adult / Individual / Coeducation Program • Elders' Program • Family Program • Men's Only Program • Women's Only Program • Youth Program • Long-term Rehabilitation Program • Out Patient Program • Residential School Program • Trauma Program • Walk-in & Crisis Services (Local) • Spousal Support Program • Refresher Program • Referral / Helper Program • Corrections: Parole / Probation (Criteria varies by program) • Developmental Disability (Minor Severity) • FASD (Minor Severity) • FASD (Moderate Severity) • Mental Illness Stabilized/Managed by Psychotropic Medication • Hearing Impairment (Minor Severity) • Learning Disability (Minor Severity) • Literacy Assistance • Methadone Maintenance Therapy (Carries) • Visual Impairment • Physical Disability (Minor Severity) • Wheelchair Access • Sex Offenders • Non-Medical Detox • Early Recovery / Stabilization • Middle Recovery • Late Recovery • Alcohol • Co Occurring Disorders • Crystal Meth • Hallucinogens • Marijuana • Narcotics / Opioids • Polydrug Use • Process Addictions • Solvent Abuse • Tobacco • Sweatlodge Ceremonies • Elder Resources • First Nations Identity and Self-Esteem • Cultural Activities / Resources • Intake Screening • Orientation and Assessment • Mental Health Services (Psychologist Resources) * • Crisis Intervention * • Alcohol / Other Drug Education • Case Management and Individual Treatment Planning • Individual Counselling / One-to-One • Group Counselling • Gender Specific Group Sessions • Youth Counselling / Group Sessions • Couples Counselling Sessions (Behavioural/Coaching) * • Family Violence Counselling * • Parenting Skills • Social Development / Interpersonal Skills / Healthy LifeSkills • Problem Solving Training and Goal Setting • Stress Management Training / Healthier Choices • Anger Management / Conflict Resolution • Coping Skills Training (Urges and Cravings) • Harm Reduction • HIV Education (Testing *) • Recreational Therapy • Trauma Counselling Support * • Residential School Counselling Support * • Suicide Ideation Counselling Support (Stabilized) * • AA / NA / Self-help Groups • 12 Step Work • Case Conferences with Referral • Referral Services • Relapse Prevent on Training (Cognitive Behavioural) • Follow-up & Individual Aftercare Planning	• First Nations individuals and their families • Referral by an Alcohol and Drug Counsellor • Submission of a fully completed application including: current medical / TB test • Each Centre provides referral packages & intake schedules. • Accessibility and admission criteria vary with each program and Centre * Provided as required by individual treatment needs

© Association of BC First Nations Treatment Programs

WHAT DOES "TREATMENT READY" MEAN?

The client is informed of the treatment process, is ready and committed to be present and able to participate in a highly structured and controlled program. The client is informed of the program and the program prepared day—seven days a week, 10–12 hours per day. The client is prepared for an intense experience that requires full attendance, free of any legal or outside commitments for the program duration. The client application and referral process is fully completed including a minimum of 6 counselling sessions, current medical exam and TB test, finances in place, solid travel plans in place (to and from) and meet the sobriety requirement on arrival.

PROGRAM DESCRIPTION

All Centres provide the fundamental components for substance abuse treatment. The design, titles and curriculum modules of the programs at all Centres are unique. Each Centre establishes policies and guidelines to determine referral and intake processes, admission criteria, sobriety

requirements and accessibility criteria. Accessibility Note: Clients with a mental illness must have a diagnosis and assessment from a psychiatrist.

All programs use multi-disciplinary, addiction specialist teams that may include a variety of personnel, including: addictions counsellors, social workers, clinical supervisors, Elders, cultural resources, psychologists, life skill educators, intake coordinators and support staff. All treatment models use an integrated and holistic approach utilizing a variety of cultural, abstinence and evidence-based therapies for sobriety and long-term recovery. The treatment objectives are abstinence from alcohol, other drugs and process addictions to reduce or eliminate the related harms.

CULTURAL COMPONENTS

Addictions are the focus in all treatment programs; the cultural/spiritual components are important tools in recovery from alcohol and other drugs. All Centres offer culturally relevant programs intended to build a positive identity and Aboriginal world view while respecting the cultural diversity

in BC. Centres accept clients from all regions, and the programs are intended to introduce, reinforce, values, beliefs and activities common to First Nations peoples. While all beliefs are respected, Centres ask clients to participate in the cultural and spiritual components as delivered with the purpose to learn, understand, solidify and enhance their cultural or spiritual practices. The program components do not replace or negate the practices of any nation. Clients are advised to learn the specific practices of their nation from Elders and cultural resources where possible.

MEDICAL DETOX

Detoxification is withdrawal management supervised by medical and therapeutic staff that assists persons with symptoms of withdrawal from substances to safely withdraw. A doctor completes an assessment, including blood work to check for liver damage or other drug-induced complications. Personnel supervising a medical detox are trained to handle emergency situations like seizures or convulsions. Substances such as alcohol, opiates and Benzodiazepines, when stopped abruptly, can produce withdrawal

symptoms so severe the person may believe it easier to return to the substance(s) rather than complete detox. A complete physical check-up by a doctor is recommended when a person is considering detoxing from substance addiction. Considerations for detox include age, physical condition, length of substance addiction and amount, regularity, consumed. Some individuals have health conditions that can cause complications or even be fatal during detox, and they should not detox non-medically. Seek a facility for medical detox if there is a history of heart, liver or kidney problems, as well as diabetes or high blood pressure.

NON-MEDICAL DETOX

Medically supported detox from substances may not be necessary; if the person is otherwise in good health. Rest and good nourishment in a safe and comfortable environment at home with community support or non-medical detox center may be all that is required, as long as there is round-the-clock individuals trained in CPR, First Aid and basic medical emergency procedures should a complication develop.

Appendix VI: Community Member Survey

1. What Region of the province do you live in?

- Vancouver Coastal
- Interior
- Fraser Valley
- Vancouver Island
- Northern

2. What type of area do you live in?

- Rural
- Urban
- Isolated
- Other

3. Do you live on or off reserve?

- On
- Off

4. What is your age?

- Under 18
- 18-25
- 25-35
- 35-45
- 45-60
- 61+

5. Gender?

- Male
- Female
- Other

6. Do you use any of these substances yourself:

- Alcohol
- Opioids (heroin/methadone/)
- Cocaine (cocaine/crack)
- Stimulants (amphetamines/crystal meth/MDMA)
- Hallucinogens (LSD/others)
- Hypnotics and sedatives (barbiturates/benzodiazepines)
- Volatile inhalants
- Cannabis
- Other substances

7. How would you rate your own wellness?

- Excellent

Great
Good
Fair
Not so good
Poor

8. Do you take prescription medication for:

pain
anxiety
depression
hyperactivity
other
I don't take prescription medication

9. How strong is the traditional language in your community? (Choose the closest answer)

90-100%
70-80%
50-60%
30-40%
10-20%
Less than 10%
Gone

10. What cultural activities do you participate in?

11. Other than funerals, how often do you participate in cultural activities?

10 or more times per month
Once a week
Twice a month
Once a month
Less than Once a Month
Never

12. Is there a word or phrase in your language that might be the equivalent of what mainstream calls 'mental health'? If you know, can you tell us? (And tell us the language?)

13. Why do you think so many First Nations people think drinking is not a good idea?

14. Why do you think people drink or take drugs?

15. How are traditional teachings shared in your community?

16. How are they shared? (choose as many as you like)

Openly to everyone
All the time
At funerals

At community gatherings
At potlatches, feasts, winterdances, or pow wows
In schools
Within Families
Only to people who belong to certain families
Rarely
When people are drinking

17. If you yourself were going to see a helper, what kind of helper would you like to see? (choose as many as you like)

Elder
Psychiatrist
Men's Treatment Centre
Women's Treatment Centre
Spiritual Healer
Drug and Alcohol Counsellor in the community
CHR
Traditional Healer
NNADAP Worker
Counsellor outside the community
Art Therapist
Doctor
First Nation's Treatment Centre
Psychologist
Other

18. If you said 'other', what kind of helper would the helper be?

19. What do you see as the most immediate needs in your community in regards to substance use/addiction?

Appendix VII: Why do so many First Nations people think it's not a good idea to drink? Clustered Community Member Responses

It's not our way (29)

Historic Negative Impact (16)

Robbed/Robs us of our culture (10)

Alcohol and culture do not mix (2)

We weren't meant to drink (2)

Because of spiritual beliefs (1)

Disconnects young and old (1)

It's destructive (8)

It causes pain and suffering (4)

Tragedies (2)

It ruins lives (3)

Takes away quality of life (2)

Bad things happen (3)

Loss of self (10)

Loss of spirit/soul (11)

Impact on mind (7)

Impact on body (3)

Impact on emotions (8)

It changes who you are (2)

Loss of pride, self esteem, dishonour, self respect (4)

Financial impact (7)

Employment (2)

Social problems (3)

Abuse (4)

Sexual abuse (3)

Spousal abuse (3)

Violence (9)

Physical abuse (1)

Verbal abuse (1)

Trauma (4)

Deaths (9)

Suicides (2)

It's a depressant (6)

Affects children (8)

Affects families (36)

Affects communities (7)
Impacts generations (10)

Creates problems/troubles/difficulties (10)
Impacts friendships and relationships (3)
Impairs judgement and decision making (3)
Is used as an excuse/crutch (2)
Creates a loss of control (5)

It's frowned upon by non-First Nations people (2)
It makes out people look bad (9)
It inhibits our role in society (1)

Out people don't know how to drink in moderation (9)
People drink unmanageably (2)
People binge drink (3)

Not enough people think it is bad idea (2)
Drinking is a good idea (4)
People don't think it is bad (5)

Because First Nations are healing (4)
Because of individuals' personal experiences (17)
Because they know more/better now (2)

Legal issues (2)
It's a gateway drug (3)

Not good for health (25)
It's addictive (24)
It's a disease (2)
First Nations people are more susceptible (7)
Genetics of cellular memories (7)
It makes you throw up (1)

Stupid (1)
Bad (1)
Evil (1)
Because (1)
AA (1)
Imprisons us (1)
Badness (1)
Symptomatic of other things (1)
Symptom of something greater (1)
Impacts perception of a good time (1)
Puts them in a bad way (1)

Appendix VIII: First Nations W Addictions Certification...

REQUIREMENTS FOR CERTIFICATION

Specific Qualifications

An Indigenous Certified Addictions Specialist I will possess the following qualifications.

Indigenous Certified Addictions Specialist I:

EDUCATION: High School Diploma or GED.

240 hours of Alcohol and Drug Specific education, including the 12 Core functions.

EXPERIENCE: One-year full time work experience fulfilled by:

One-year (2,000 hours) full time paid employment in an alcohol program. Training includes supervised on the job training, with workshops or formal education focusing on Counselling the chemically dependent individual and family.

Indigenous Certified Addictions Specialist II

EDUCATION: Associate of Arts (AA) Degree in Human Services Field from an accredited college, e.g. we include Addictions/Wellness Counsellors, Social Workers, Wellness Worker, Psychiatrist, Community Health Associates, Day Care Workers, etc.

270 hours of Alcohol and Drug Specific education.

A minimum of 6 hours of Specific Ethics training.

A minimum of 6 hours of Specific HIV training is recommended but not mandatory.

EXPERIENCE: Three years (6,000 hours) full time work experience fulfilled by:

1. Three years full time paid employment in an alcohol program.
- a. An Associate of Arts (AA) degree in Chemical dependency will reduce the work requirement by 1000 hours.
- b. A Bachelors degree with 30 semester hours or 40-quarter hours in Counselling courses will reduce work requirement by 2000 hours.
- c. A Masters or higher degree with 30 semester or 40-quarter hours in Counselling courses will reduce the work requirement by 4000 hours.

PRACTICUM: Supervised 300-hour practicum with a minimum of 10 hours in each of 12-Core Functions.

Indigenous Certified Addictions Specialist III

EDUCATION: Four year degree B.Sc./B.A. in Human Services Field from an accredited college.

270 hours of Alcohol and Drug Specific education.

A minimum of 6 hours of Specific Ethics training.

A minimum of 6 hours of Specific HIV training is recommended but not mandatory.

EXPERIENCE: Four years (8,000 hours) full time work experience fulfilled by:

1. Four years full time paid employment in an alcohol program.
- a. An Associate of Arts (AA) degree in Chemical dependency will reduce the work requirement by 1000 hours.
- b. A Bachelors degree with 30 semester hours or 40-quarter hours in Counselling courses will reduce work requirement by 2000 hours.
- c. A Masters or higher degree with 30 semester or 40-quarter hours in Counselling courses will reduce the work requirement by 4000 hours.

PRACTICUM

Supervised 300-hour practicum with a minimum of 10 hours in each of 12-Core Functions. Anyone applying for Indigenous Certified Addictions Specialist I must have completed a minimum of twenty (20) semester credits or 300 contact hours in an accredited institution of higher learning (college or university) or training program in specialized alcohol/drug courses. Those credits must include courses in the following:

- a. Introduction to Chemical Dependency
- b. Bio/systems and Pharmacology
- c. Counselling the Chemically Dependent
- d. Case Report Writing
- e. Ethics in Chemical Dependency Counselling
- f. HIV/AIDS is highly recommended.
- g. Group Facilitation Skills
- h. Relapse Prevention

Indigenous Certified Addictions Specialist II and III must have completed 8 credit hours or 120 contact hours in addition to the 20 credit hours required for Level I, which have a specific alcohol/drug oriented focus in the areas of the 12-Core Functions.

- a. Screening Case Management
- b. Intake Crisis Intervention
- c. Orientation Client Education
- d. Assessment Referral
- e. Treatment Planning Reports and Record Keeping
- f. Counselling Consultation

Specific Qualifications – Indigenous Certified Addictions Specialist II and III.

An Indigenous Certified Addictions Specialist II and III should possess the following qualifications in addition to those general qualifications and competencies already enumerated.

- a. Ability to speak knowledgeably on First Nations alcohol/drug problems.

 - b. Knowledge of different Counselling philosophies and theories related to First Nations healing and recovery practices.
 - c. Ability to coordinate, manage and facilitate continuance of treatment within the Treatment Center delivery system.
 - d. Ability to assess the effectiveness of various treatment and program modalities as they apply to First Nations clients and their families.
 - e. Successful completion of the ICRC Oral Case Presentation Method Exam process.
-
- b. Knowledge of different Counselling philosophies and theories related to First Nations healing and recovery practices.
 - c. Ability to coordinate, manage and facilitate continuance of treatment within the Treatment Center delivery system.
 - d. Ability to assess the effectiveness of various treatment and program modalities as they apply to First Nations clients and their families.
 - e. Successful completion of the ICRC Oral Case Presentation Method Exam process.

Appendix IX: ABCFNTF Discussion Paper on Patient Travel

Introduction

All operational funds provided in the Treatment Centres' Contribution Agreements are dedicated to treatment activities, and patient travel is funded by NIHB. Contribution Agreements provide travel funds for treatment / program activities; patient travel is under the jurisdiction of NIHB. Many treatment centres have not accessed NIHB patient medical travel funds and have absorbed the cost of patient travel to medical support services, and in some cases expenses for return travel for clients who do not complete treatment. Patient medical travel requires vehicle, fuel, staffing costs and taxi fares. Increasing operating costs no longer allow this absorption. Budgets are falling short to meet operation and capital needs, and contingency funds depleted. Invoices submitted to First Nations Bands for patient medical travel and return travel expenses often remain unpaid.

Issues

1. Patient Medical Travel

The admission criteria for Treatment Centres requires that applicants be medically fit to attend treatment programs. Due to the nature of addiction and the resulting physiological and life-style harms, clients often arrive with medical and dental conditions that are chronic, untreated, or undiagnosed. New substances and polydrug use increases the complexity of health issues in the client body. The incidences where clients are admitted to treatment and require access to medical or dental treatment occur in every intake. Considerations for the clients' participation and treatment decisions by staff include the ability to participate in the program, severity of health issues, projected absences from treatment, and bed occupancy rates. The medical treatment and support that is required necessitates patient travel to medical services has a financial impact.

2. Addiction and Medical Impacts

- Chronic/severe medical conditions can be left unattended for long lengths of time because of an active addiction.
- Medical and dental problems are undiagnosed or ignored while the client is using; the drug of choice can mask painful conditions.
- Active addictions interfere with the client's ability to access to medical services and adhere to medical treatment.
- Recent studies have been conducted that suggest persons with active addictions have poor access to medical services because of attitudes and treatment by medical service providers.
- Medical conditions may not be resolved without the intervention of addictions treatment.
- The client may not access addictions treatment if they must wait until medical condition are resolved.
- Drugs of choice such as crystal meth, crack cocaine, ecstasy, heroin, alcohol and tobacco are hard on the organs; clients maybe capable of attending treatment but compromised health with conditions such as Hep C, HIV/AIDS, diabetes, rotting teeth that may require increased medical services.
- Poly drug use and medical conditions may require ongoing medical care, i.e. clients with diabetes using methadone/crack.

- Dental problems can appear suddenly and painful conditions necessitate immediate care.
- Increased meth use has increased the need for dental care.
- Medical and dental problems may not present until after the client has been admitted for treatment.
- Addictions treatment often sparks motivation for self and health care after admission to treatment.

3. Referral

- Treatment centres rely on the assessment of referral workers and medical professionals to assess a clients' readiness and health prior to admission.
- Referral workers / medical professionals rely on information provided by clients.
- Some medical services are not available in the clients' home area because of remoteness or shortages of medical professional.

4. Patient Return Travel

In the case of return travel, the NIHB patient travel policy (2005) stipulates that return travel will be paid if the client completes treatment and will not be paid if ***“the client leaves against the advice of the counsellor.”*** While NIHB states that return travel will be provided or reimbursed where the client has left for other reasons, there is inconsistency in the interpretation of the policy by the multiple organizations involved in administering patient travel funds, namely NIHB, Bands with Contribution Agreements and Bands with Transfer Agreements. Return travel expenses that are not reimbursed have a financial impact. It must be clearly defined for all parties when the ***clients leave against the advice of the counsellor and when the clients leave for other circumstances.***

a. Voluntary Treatment

All treatment programs are voluntary because mandatory treatment is considered ineffective. Placing the condition of treatment completion on access to return travel is reminiscent of mandatory treatment. With a one-way trip, the principle of voluntary participation is hollow. When clients come to the treatment centre, they are told they are in safe, non-judgmental place. By making return travel conditional, the principles of non-judgment and safety are compromised. We must remain consistent with a safe, non-judgmental therapeutic environment throughout all aspects of the treatment process.

b. Guaranteed Return Travel

A client who completes treatment is guaranteed return travel; therefore if all clients completed treatment, FNIHB would have to be prepared to pay 100% of the return travel. Considering this, payment for the return travel of clients who do not complete treatment is not an added cost.

c. Termination of Treatment

Clients' treatment may be terminated with the care and support of the counsellor because of unforeseen circumstances or circumstances beyond the client's control. In these cases, the patient medical travel policy should not be punitive.

- Illness, including medivac during emergencies
- Death in the family
- Clients with FAS/D who are unable to complete a treatment program. Some clients with FAS/D may be unable to manage return travel without the support of service providers. Clients with

FAS/D may have different issues in withdrawal or detox, and it's not always known how FAS/D clients will experience treatment until they are in treatment.

- Clients with mental health problems beyond the capacity of the facility and treatment staff, i.e. requiring 24-hour medical supervision or psychiatric intervention. Mental illness doesn't always present in the referral package.
- Clients admitted to the same intake as a client whom they allege as their abuser.
- Treatment is terminated because the client is not ready for treatment or is inappropriately referred.

d. Risks for therapeutic environment / safe travel related to clients without return travel

- Treatment terminations for volatile clients where the reaction disrupts the therapeutic environment, impacting the physical and/or emotional safety of other clients. The timing between termination of treatment and start of travel home must be short and client cannot be held 24-48 hours waiting for travel funds.
- Limited community resources, such as a lack of hostels, halfway houses, shelters or food banks, to offer referrals.
- Isolated areas pose a high risk or other travel blocks when a client is without funds, e.g. along Highway 16 a.k.a. Highway of Tears or being situated on an island.

5. Policy Recommendations

- a. Choice in method of travel when costs are similar for air and ground (within \$50.00), or to include a provision where clients may pay the difference between the cost of preferred method of travel. For extended travel from isolated areas, clients arrive exhausted and hungry from extended travel time. Some, particularly Elders, are upset and arrive with no idea where they are. Choice in travel methods would reduce these concerns.
- b. Unconditional and full funding for return travel and related travel costs for youth. Youth (13-17) attending family treatment are considered teens-at-risk, cannot travel home alone and must be escorted home. There is a legal obligation regardless of the reason for termination of treatment.
- c. Financial costs related to escorts for youth return travel, including salary, meals and return travel.
- d. Travel for Status Indians living off-reserve sometimes cannot access any travel or comfort allowance from their Band, and cannot access these funds from provincial sources because they are Status Indians.
- e. Return travel for addictions treatment programs that are related to residential school or trauma issues. Travel is sometimes not covered because it is not considered alcohol and drug treatment. Some Bands categorize it as different, possibly as per contribution agreement.
- f. The policy should include travel for a refresher or secondary stage recovery treatment programs.

Future Directions

The NIHB Patient Travel Policy is a national policy. There is a need for input from all regions to develop recommendations for policy change and clarity to ensure consistent interpretation of the policy by all the organizations administering patient travel funds, including NIHB, Bands with Contribution Agreements and Bands with Transfer Agreements. There is opportunity to reduce the financial impacts and improve client travel if we lobby for change collectively.

Bibliographic Material

Abel, Ernest L. And John H. Hannigan : Maternal risk factors in fetal alcohol syndrome: Provocative and permissive influences (1995) Published by Elsevier Science Inc. Neurotoxicol Teratology, 1995

Aboriginal Healing Foundation (2008) Aboriginal Healing in Canada: Studies in Therapeutic Meaning and Practice.

Aboriginal Healing Foundation. (2007) Addictive Behaviours among Aboriginal People in Canada. Author: Deborah Chansonneuve

Aboriginal Healing Foundation (2003). Fetal Alcohol Syndrome Among Aboriginal People in Canada: Review and Analysis of the Intergenerational Links to Residential Schools. Author, Caroline Tait.

Asante, K.O. and G. Robinson (1990). Pregnancy Outreach Program in British Columbia: The Prevention of Alcohol-Related Birth Defects. Canadian Journal of Public Health 81(1): 76-77.

Assembly of First Nations (2007). RHS: Our Voice, Our Survey, Our Reality, Selected Results from RHS Phase 1 (2002/2003)

Ajunnginiq Centre. National Aboriginal Health Organization (NAHO). (2004) Alcohol Problems and Approaches: Theories, Evidence and Northern Practice.

Alberta Alcohol and Drug Abuse Commission, CCSA and the National Policy Working Group (2003) Strengthening Evidence-Based Addictions Programs: A Policy Discussion Paper.

Archibald, Jo-Ann. (2008). Indigenous Storywork: Educating the Heart, Mind, Body, and Spirit. UBC Press: Vancouver

Atleo, Marlene R. (2001) Learning models in the Umeek narratives. Thesis (Ph.D.) The University of British Columbia, 2001.

Brisch, Karl Heinz. (2002) Treating Attachment Disorders: From Theory to Therapy. Guilford Press, New York.

BC Coroner's Office (2008) Something to Look Forward To: A 5 year retrospective review on child and youth suicide in BC

BC Ministry of Education (2001). The Current Position of Aboriginal Support Workers in the BC Education System. Author: Mostly Salish Consulting. Accessed March 3, 2009 at http://www.bced.gov.bc.ca/abed/aboriginal_support_workers.pdf

BC Ministry of Health Services (2004) Every Door is the Right Door: A British Columbia Planning Framework to address problematic substance abuse and addiction.

BC Office of the Provincial Health Officer (2008) Public Health Approach to Alcohol Policy: An Updated Report from the Provincial Health Officer, P.R.W. Kendall, OBC, MBBS, MSc, FRCPC

BC Office of the Provincial Health Officer (2007). The Health and Well-being of the Aboriginal Population in British Columbia Interim Update.

CAMH (2007) Responding to the Risks and Harms of Problematic Substance Use: Re-thinking the Continuum of Care— a background paper for the National Treatment Strategy Working Group.

CAMH (2006) Towards a Model System of Services and Supports for Addictions— a background paper for the National Treatment Strategy Working Group.

Camille, Carol. (unpublished) Living with Tradition (Cultural Life Skills model designed for youth and families.)

Canadian Centre on Substance Abuse (2008) Drinking after Driving in Canada: Analysis drawn from the 2004 Canadian Addiction Survey

Canadian Centre on Substance Abuse, (2006) Evidence-based Treatment: Information for the Service Provider.

Canadian Centre on Substance Abuse (2007). Harm Reduction Policies and Programs for persons of Aboriginal descent.

Canadian Centre on Substance Abuse (2006) Harm Reduction Policies and Programs for Youth.

Canadian Centre on Substance Abuse. (2005) Substance Abuse in Canada: Current Challenges and Choices.

Canadian Centre on Substance Abuse. (2007) Substance Abuse in Canada: Youth in Focus.

CARBC. (2008) Regional Variations and Trends in Substance Use & Related Harm in BC, Bulletin 4 - Nov 2008.

Centre for Addictions and Research BC. 2009. Alcohol and Other Drug Monitoring program accessed June 12, 2009 at <http://carbc.ca/MonitoringProject/HighRiskPopulations/tabid/424/Default.aspx>

Chandler, Michael J. and Lalonde, Christopher (1998) Cultural Continuity as a Hedge Against Suicide in Canada's First Nations. *The University of British Columbia*.

Chudley, Albert E., Julianne Conry, Jocelynn L. Cook, Christine Loock, Ted Rosales, Nicole LeBlanc. (2005). Fetal Alcohol Spectrum Disorder: Canadian Guidelines for diagnosis. Produced by the Public Health Agency of Canada, National Advisory Committee on Fetal Alcohol Spectrum Disorder.

The Centre for Addiction and Mental Health (2005). Mental Health and Addiction Services in Regionalized Health Governance Structures: A Review.

College of Pharmacists of BC. 2007. Pharmacy Methadone Maintenance Guide.
Collie, Kate and Cubranic, Davor. Internet Art Therapy, UBC, accessed May 21, 2009 at <http://www.youtube.com/watch?v=pYfiRfeXTxw>.

Correctional Service Canada, Mother Child Program, accessed May 21, 2009: <http://www.csc-scc.gc.ca/text/prgrm/fsw/pro02-5-eng.shtml>

Craib, Kevin J.P.; Spittal Patricia M.; Wood, Evan; Laliberte, Nancy; Hogg, Robert S.; Li, Kathy; Heath, Katherine; Tyndall, Mark W.; O'Shaughnessy, Michael V.; Schechter, Martin T. (2003) Risk factors for elevated HIV incidence among Aboriginal injection drug users in Vancouver. *Canadian Medical Association Journal*, January 7, 2003; 168 (1)

FAS/E Support Network of BC. A Manual for Community Caring-FASD- Vol. 3-Interventions. (2002)
Flores, Philip J. (2004) *Addiction as an Attachment Disorder*. Jason Aronson: Oxford.

Grande, Sandy. (2004). *Red Pedagogy: Native American Social and Political Thought: Native American* Rowman & Littlefield;

Health Canada (1999). Literature Review: Evaluation Strategies in Aboriginal Substance Abuse Programs: A Discussion. First Nations and Inuit Health Branch.

Health Canada (2002) *Best Practices: Concurrent Mental Health and Substance Abuse Disorders*.

Health Canada (2005) *Interventions Supported by Scientific Evidence for Substance Abuse Treatment, Harm Reduction and Prevention*. First Nations and Inuit Health Branch.

Health Canada (2006). *Best Practices: Early Interventions, Outreach, and Community Linkages for Women with Substance Abuse Problems*.

Health Canada (2001) Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems.

Health Canada (2001) Best Practices: Treatment and Rehabilitation for Youth with Substance Use Problems.

Health Canada (2001) Prevention of Substance Use Problems among Young People – A Compendium of Best Practices.

Health Canada. 2009. Ministerial message accessed June 18, 2009 at <http://www.tbs-sct.gc.ca/rpp/2008-2009/inst/shc/shctb-eng.asp> .

Health Canada. 2002. Methadone Maintenance Treatment. Ottawa.

Hughes, Honourable Ted OC, QC, LL.D. (Hon). (2006) *BC Children and Youth Review: An Independent Review of BC's Child Protection System. April 7, 2006*

INAC, Royal Commission on Aboriginal People (1996)

Kinzel, A. and Nanson, J. (2000). Education and debriefing: Strategies for preventing crises in crisis-line volunteers. *Crisis*. 21(3):126-34.

Levy, Terry M. and Orlans, Michael. (1998) *Attachment, Trauma, and Healing: Understanding and Treating Attachment Disorder in Children and Families*. CWLA Press, Washington DC.

Mate, Gabor. (2008) *In the Realm of Hungry Ghosts: Close Encounters with Addiction*. Alfred A Knopff, Toronto.

McCreary Centre Society (2008) *A Picture of Health: Highlights from the 2008 BC Adolescent Health Survey*.

McCreary Centre Society (2007). *Moving Upstream: Aboriginal Marginalized and Street-Involved Youth in B.C.*

National Native Addictions Partnership Foundation. 2006. *National Workforce Development Strategy*

National Treatment Agency for Substance Misuse UK. (2006) *Models of Care for the treatment of adult substance misusers: Update 2006*.

O'Malley, Kieran; Huggins, Janet. 2005. *Suicidality in Adolescents and Adults With Fetal Alcohol Spectrum Disorders*. *The Canadian Journal of Psychiatry*, Vol 50, No 2, February 2005. Page 125.

O'Neill, Linda Kay. (2008). *The Experience of Northern Helping Practitioners*. A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy in the Department of Educational Psychology and Leadership Studies University of Victoria.

Palmer, G. Jr. (2003) *Telling Stories the Kiowa Way*. Tucson: University of Arizona Press

Pearlman, L.A., & Saakvitne, K.W. (1995). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors. New York: W.W. Norton.

Poulin, Christiane, Stein, Jonathan and Butt, John. (2000) Surveillance of Drug Overdose Deaths Using Medical Examiner Data. Public Health Agency of Canada. Vol 19. No.4.

Proulx, Lucille. (2002) *Strengthening Emotional Ties through Parent-Child-Dyad Art Therapy: Interventions with Infants and Preschoolers*. Jessica Kingsley Publishers, London.

Roleau, Maud; Levichek, Zina Levichek; Koren, Gideon., Are Mothers Who Drink Heavily In Pregnancy Victims Of FAS? Page 3., 2001

Smye, V. (2004). *The nature of the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system*. Doctoral dissertation, University of British Columbia.

Sproule, B; Brands, B; Li, S.; Catz-Biro, L. (2009) Changing patterns in opioid addiction: characterizing users of oxycodone and other opioids. *Canadian Family Physician*.: 2009 Jan;55(1):68-9, 69.e1-5.

Stevenson, Tracey-Lee. (2001) *Methadone Maintenance: From a Woman's Perspective*. A thesis submitted to the School of Nursing in conformity with the requirements for the degree of Master of Science Queen's University Kingston. Ontario.

Thatcher, Richard W. (2004). *Fighting Firewater Fictions: Moving beyond the Disease Model of Alcoholism in First Nations*. University of Toronto Press: Toronto.

Tsow Tun Lelum Treatment Society (2006) *How Does Treatment Affect the Quality of Life?*

United Nations Office on Drugs and Crime. (2002) *Contemporary Drug Abuse Treatment: A Review of the Evidence Base* United Nations, New York.

Van der Woerd, Kim. (2005) *From Theory to Practice: Methodological and Ethical Issues for Research with First Nations Communities*. Simon Fraser University

Wardmen, Dennis; Quantz, Darryl. 2006. Harm reduction services for British Columbia's First Nation population: a qualitative inquiry into opportunities and barriers for injection drug users. *Harm Reduction Journal* 3:30. Published online 2006 October 11.

Wilson, Shawn. 2008. *Research is Ceremony: Indigenous Research Methods*. Fernwood Publishing: Black Point, N.S.

Wood, Evan; Montaner, Julio S.; Li, Kathy; Barney, Lucy; Tyndall, Mark W.; Kerr, Thomas. (2007) Rate of methadone use among Aboriginal opioid injection drug users. From the British Columbia Centre for Excellence in HIV/AIDS, St. Paul's Hospital; the Department of Medicine, University of British Columbia; and the British Columbia Centre for Disease Control, Vancouver, BC

