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Ontario Region First Nations Addictions Service Needs Assessment

Final Report

June 8, 2009

Executive Summary

INTRODUCTION TO THE STUDY

As part of the Addictions Evidence-Based process occurring within the First Nations and Inuit Health Branch (FNIHB) of Health Canada, Ontario Region First Nations and Inuit Health (FNIH) together with the Chiefs of Ontario (COO) undertook a needs assessment of the Region's addictions services. The purpose of the needs assessment was to identify gaps, overlaps, strengths of the addictions prevention and treatment services accessed by the Region's First Nations population. Based upon this assessment, FNIH Ontario Region and COO, in consultation with First Nations communities and representative organizations, have worked together to produce this report that establishes a strategic plan for enhancing and renewing Ontario First Nations addictions prevention and treatment services.

Ontario First Nations have shown increasing concern regarding addictions and substance abuse experienced by their population. For example, COO passed a resolution in December 2008 to develop a Prescription Drugs Abuse Policy; the Union of Ontario Indians (UOI) introduced the War on Drugs Strategy in 2008/09, and in February 2009, the Sioux Lookout First Nations Health Authority held the *Chiefs Forum: Answering the call for Help Reducing Prescription Drug Abuse in our Communities*.

The aim of the regional needs assessment process coincides with First Nations concerns and is intended to ensure that the region's First Nations communities have access to an effective, sustainable and culturally-appropriate continuum of addictions prevention and treatment services. The goal of the National Native Alcohol and Drug Program (NNADAP) has been to provide culturally-based addiction prevention and treatment services to First Nations and Inuit peoples. Since its inception as a pilot project in the 1970's, hundreds of community-based alcohol prevention and community treatment projects have been created across Canada. Many First Nations and Aboriginal service providers are increasing their efforts to integrate and coordinate their addiction treatment and prevention services based upon population need and best/promising practices. To ensure responsiveness to emerging needs and trends, it was felt that FNIH Regions would benefit from a comprehensive review of the NNADAP system to ensure the best allocation of existing and potential resources, and the optimal configuration of services.

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METHODOLOGY

The needs assessment used multiple data collection activities to provide an analysis of addiction treatment and prevention needs as well as services currently available to Ontario First Nations. This approach also explored innovative and promising practices as well as models of service delivery. The project included key informant interviews, focus groups, surveys, case studies and a document/literature review to respond to the main study questions.

During this three month process of data collection, input was received from at least 95 First Nations communities in Ontario as well as other stakeholders involved in addictions and substance abuse prevention and treatment.

1. Face to face meetings were held with more than 230 people individually in communities including workers, former and current clients, Elders, Board Members, physicians, police, community members, Chiefs and band councillors, youth and other stakeholders during twelve site visits.
2. 40 key informant interviews were completed.
3. More than 150 documents or literature were reviewed as part of this study.
4. 123 surveys were distributed to NNADAP workers/Health Directors and 38 completed responses were received.
5. Focus groups obtaining specific information on the main research questions were held with 83 participants at the NNADAP conference.

FINDINGS

Participant and document findings were presented within four general theme areas in the report:

1. Current Situation regarding addictions and substance abuse
2. Challenges and Gaps
3. Innovative Approaches and Promising Practices
4. Priorities for enhanced service delivery

The combined study findings from all lines of enquiry confirm that alcohol is still the highest ranked substance abused in Ontario First Nations communities followed closely by cannabis (in the form of marijuana and hash), cocaine and oxycondone, (including Oxycontin and Percocet). However, the study findings firmly indicate that poly-substance abuse is rampant with Ontario First Nations people, such as alcohol and oxycondone.

Participants identified that addictions and substance abuse problems are starting at ages as young as nine among First Nations children. Participants note that substances abused by the youth include tobacco, alcohol, cannabis and prescription drugs.

Study participants indicated that they believe 80% of their clients are seeing symptoms of possible mental health issues. The vast majority of survey

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respondents indicated that clients had difficulty accessing addiction services if they also have concurrent mental health issues.

The combined study findings confirm that many social and economic determinants of health, as well as the historical burden described in this report influence addictions and substance abuse in Ontario First Nations communities.

Respondents indicated that there are many education, promotion and prevention resources available within their communities. However, participants identified the lack of programs and services for drug-addicted expectant mothers and youths. As well, an overwhelming challenge mentioned by many participants is the lack of family treatment centres.

Another challenge mentioned by participants was the overall location of the community and what resources are available to it. Specifically this relates to resources available, transportation back and forth from treatment, and keeping people within the community.

Participants discussed the necessity of including culture at every step throughout the treatment process. Many stated that including culture in a piecemeal way is a very surface approach and not indicative of holism. Culture needs to be included continually in order for it to have an impact on treatment.

One of the pressing challenges for the participants is the need for training in current realities concerning addictions. Participants spoke of a broad range of training that needs to occur to ensure effectiveness of service and the safety of the workers in treatment centres.

DISCUSSION

An overall conclusion from the Ontario Region First Nations Addictions Service Needs Assessment is the need for the establishment of a collaborative and integrated continuum of care for addictions prevention and treatment services. Furthermore, to maximize positive health outcomes in the area of addictions, it is important that this continuum of care include health, mental health and social services sectors as well as the community. It might further be argued that the justice sector should be included in the continuum of care.

Health Canada's work in the field of addiction has determined that people with untreated concurrent disorders or multiple diagnoses are more likely to continue using substances and to experience poorer outcomes from stand-alone addictions treatment services. They suggest that integrated approaches addressing substance use and mental disorders have proven to be more effective in helping people with concurrent disorders (Health Canada, 2002).

Overall, this study confirms that the most effective integrated approaches should be based on First Nations cultural knowledge, approaches and values. A sample

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model was provided based on motivational and encouragement values. This model recognizes that it takes time to move towards living a healthy life when dealing with the social economic challenges faced by First Nation community members who are struggling with addiction. It reinforces what was confirmed in the literature and the findings from participants that improving confidence and understanding of identity and improving self-esteem will lead to improved health outcomes.

The needs assessment findings indicate that different approaches are required depending on what stage an individual is at regarding addiction or substance abuse. For example, there is a strong need for prevention activities for young people or new users of substances. This can involve an education and counseling component. This is important due to reports from the young people that they are turning to opiate use, primarily prescription drugs. It is worrisome in that they not only inhale the substance but are beginning to inject the opiate. This could lead to an increase in transmitting communicable diseases.

The literature and study participants indicate that once individuals have passed the experimental or early use stage and become addicted to substances, then the focus needs to shift to early recognition and direct intervention.

There is a need to increase education and awareness with people who have a legitimate need for narcotics to address their related ailments. Care must be taken that their rights are not affected by anti-drug efforts. At the same time, they must be educated about how their prescriptions must be safe guarded so that they are not abused and use inappropriately by others. In particular, seniors in our First Nations communities need to be educated or provided support as they are often bullied by younger people who take their prescriptions from them. As a result of colonization, it is difficult for many First Nation people to say no to the young people for fear of losing them (particularly through suicide), so it is a delicate balance.

It is important to remain non-judgmental and offer ongoing support. Many studies suggest that the earlier an individual becomes involved with an individual struggling with addiction, such as an elder community member or close friend, then the quicker the healing process will be expedited.

As mentioned earlier in this discussion, the cornerstone to addressing addiction and wellness issues is the provision of a continuum of care. It is possible to develop multi-disciplinary teams, not only in geographical clusters but also at the community level. Although resources may be limited, they are still present in First Nations communities. This shift requires a change management strategy. It also involves re-awakening the natural volunteers and helpers in the community to enhance sustainability of community programs. Numerous treatment centres are currently accredited and others are undergoing accreditation.

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STRATEGIC PRIORITIES

The primary objectives of the regional needs assessment is to provide a comprehensive examination of addiction treatment and prevention services within the FNIH (Ontario) Region; and, based upon these findings, to develop a comprehensive report that identifies strategic areas for action for optimizing services within the region. The steering committee has identified four strategic priority areas and will be working with the representative groups to develop a detailed action plan. The four strategic priority areas are:

Strategic Priority #1: Training and Supporting Resources

- An appropriately trained accredited workforce who are financially compensated in accordance with provincial equivalents.
- Effective coordination and collaboration with other service providers.
- Reduction in individual use and harms associated with drug and alcohol use
- First Nation culturally based healing program is in place to support client recovery.

Strategic Priority #2: Education and Prevention

- Reduction in the prevalence of fetal effects of drug and alcohol use.
- Reduction in the prevalence of prescription drug abuse.
- Reduction in the prevalence of youth drug and alcohol abuse.
- Traditional First Nation healing approaches in place to support client recovery.
- Reduction in individual use and harms associated with drug and alcohol abuse.
- More prevention services and supports in place for First Nation people.

Strategic Priority #3: Continuum of Care

- Enhanced development of a coordinated continuum of addiction prevention and treatment services for and by First Nations that includes traditional, cultural and mainstream approaches.
- Reduction in individual use and harms associated with drug and alcohol use.
- First Nation communities are recognized and supported as important resources by developing capacity to address alcohol and drug abuse.
- First Nation promising practices and community based research is supported.
- Community based research initiatives are funded.
- Promising practices are documented and disseminated at the community level.

Strategic Priority #4: Promotion of Stability

- Clarified and strengthened roles and responsibilities between addictions, mental health, and related human and health services among federal, provincial, and First Nation delivered programs and services.
- A culturally safe and effective multidisciplinary and comprehensive continuum of addiction prevention and treatment services for Ontario First Nations people.
- Culturally appropriate services and strategies are First Nation developed, implemented and evaluated in collaboration with local and regional service providers.

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In conclusion, the literature and the study participants confirm that many First Nation individuals will require four or five efforts at addiction treatment before they achieve success. As such, community members, front line workers and leaders need to be relentless in the provision of service. The door can never be shut to addressing addictions and mental health issues with First Nation members. First Nations have a responsibility to protect, nourish and encourage growth and wholeness for each of their community members..

Acknowledgements

The study team and advisory committee wishes to acknowledge the contributions of Elders, community members, front-line workers, service providers and stakeholders who shared their knowledge, passion and respect of First Nations people throughout the needs assessment process. It is their wisdom and knowledge that is shared in this report and will inform decision-makers within First Nations communities, the First Nation and Inuit Health Branch and First Nation and Inuit Health Ontario Region, First Nation leaders, the government of Ontario and service providers regarding improving addiction prevention and treatment services for First Nations people in Ontario.

Gratitude is extended to the staff at each case study site for their support and helpfulness in coordinating the focus groups. Appreciation is also offered to the interview, survey and conference respondents who took time from their busy schedules to offer insight and assistance with the study.

Acronyms

AHF	Aboriginal Healing Foundation
ABOC	Aboriginal-Based Organized Crime
AIDS	Acquired Immune Deficiency Syndrome
ADAT	Admission and Discharge Criteria and Assessment Tools
ARTC	Adult Residential Treatment Centre
AA	Alcoholics Anonymous
AFN	Assembly of First Nations
BRC	Band Council Resolution
BPS	Biopsychosocial
CCSA	Canadian Centre on Substance Abuse
CAMH	Centre for Addiction and Mental Health
DSM	Diagnostic and Statistical Manual of Mental Disorders
DARE	Drug Abuse Resistance Education
FNAAP	First Nations Addictions Advisory Panel
FNIH	First Nations and Inuit Health
FNIHB	First Nations and Inuit Health Branch
FDA	Food and Drugs Association
HTT	Historical Trauma Transmission
HIV	Human Immunodeficiency Virus
INAC	Indian and Northern Affairs Canada
IV	Intravenous
K-NET	Kuhkenah Network
LHIN	Local Health Integration Networks
MWAC	Mental Wellness Advisory Committee
MET	Motivational Enhancement Therapy
NAMA	National Alliance of Methadone Advocates
NIDA	National Institute on Drug Abuse
NNADAP	National Native Alcohol and Drug Abuse Program
NIHB	Non-Insured Health Benefits
OPP	Ontario Provincial Police
ORAPC	Ontario Regional Addictions Partnership Committee
OTN	Ontario Telemedicine Network
PTSD	Post Traumatic Stress Disorder
PTO	Provincial Territorial Organization
RCMP	Royal Canadian Mounted Police
TFR	Total Fertility Rate
TB	Tuberculosis
UOI	Union of Ontario Indians
UN	United Nations
WHO	World Health Organization

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Chapter One: Introduction

The knowledge that will support our survival in the future will not be an artifact from the past. It will be a living fire rekindled from surviving embers and fueled with materials of the 21st century. – Marlene Brant Castellano

The strength of Ontario First Nations people rests in their resiliency, diversity and cultural worldviews. First Nations family and community values have withstood the test of time and a challenging onslaught of assimilation policies targeted at eroding their language, culture, family and community ties. Ontario First Nation people still proudly exist in 133 First Nations communities in this province, as well as off-reserve. The on-reserve population ranges from small communities of 150 members to some of the largest communities in Canada of 20,000 members for a total exceeding 175,000 First Nations people. Languages such as Ojibway, Cree, Oji-Cree, and Haudenasaunee dialects are not extinct and are expected to survive for many generations to come. While the cultural worldviews are diverse in First Nations across this vast province, they all include distinct values systems, belief systems, traditional governance systems, ways of learning and knowing, and ceremonies continue to thrive in many First Nations. Ontario First Nations are politically organized at the First Nation level, tribal level, territorial level as well as at the provincial level (political confederacy) and the national level (Assembly of First Nations). These strengths provide a solid foundation not only for supporting the survival of Ontario First Nations people in the future but also for building healthier communities.

Nature of Study

As part of the Addictions Evidence-Based process occurring within the First Nations and Inuit Health Branch (FNIHB) of Health Canada, Ontario Region First Nations and Inuit Health (FNIH) together with the Chiefs of Ontario (COO) undertook a needs assessment of the Region's addictions services. The purpose of the needs assessment is to identify gaps, overlaps, strengths of the addictions prevention and treatment services accessed by the Region's First Nations population. Based upon this assessment, FNIH Ontario Region and COO, in consultation with First Nations communities and representative organizations, have worked together to produce the report that establishes a strategic plan for enhancing and renewing Ontario First Nations addictions prevention and treatment services.

Ontario First Nations have shown increasing concern regarding addictions and substance abuse experienced by their population. For example:

1. COO passed a resolution in December 2008 to develop a Prescription Drugs Abuse Policy. Resolution 68/8 states that the policy will be developed under the direction of the Ontario Regional Chief and Ontario Chiefs Committee on Health

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and working with First Nations communities and FNIHB (First Nations and Inuit Health Branch). The Chiefs on Ontario Health Coordination Unit is directed to coordinate the development of the policy. The policy will emphasize on awareness, prevention and treatment options.

2. The Union of Ontario Indians (UOI) recently introduced the War on Drugs Strategy. Partners of this strategy include the Government of Canada, Government of Ontario, Ontario Provincial Police (OPP), Anishinabek Police Service and community and tribal police services. The strategy is aimed at eliminating illicit drug abuse, trafficking and associated organized crime in Anishinabek Nations across Ontario. The War on Drugs is encompassed by four pillars: prevention, treatment, ogitchidaawin (protecting our own) and enforcement. A conference was held in late February 2009 on this Strategy and a report and next steps are expected shortly.
3. In February 2009, the Sioux Lookout First Nations Health Authority held the *Chiefs Forum: Answering the call for Help Reducing Prescription Drug Abuse in our Communities*. Chiefs, Health Directors and frontline workers from all across Ontario attended this three day meeting to develop resolutions, strategies and consensus on matters related to prescription drugs abuse. Participants in all groups promoted raising education awareness levels, working together as a community and taking responsibility at the community level to combat prescription drug abuse problems. Participants also noted that solutions to prescription drug abuse must be a collective effort of community members, leaders, professionals and must be supported by both federal and provincial governments.

The aim of the regional needs assessment process coincides with First Nations concerns and is intended to ensure that the region's First Nations communities have access to an effective, sustainable and culturally-appropriate continuum of addictions prevention and treatment services. The goal of the National Native Alcohol and Drug Program (NNADAP) has been to provide culturally-based addiction prevention and treatment services to First Nations and Inuit peoples. Since its inception as a pilot project in the 1970's, hundreds of community-based alcohol prevention and community treatment projects have been created across Canada. Many First Nations and Aboriginal service providers are increasing their efforts to integrate and coordinate their addiction treatment and prevention services based upon population need and best/promising practices. To ensure responsiveness to emerging needs and trends, it was felt that FNIH Regions would benefit from a comprehensive review of the NNADAP system to ensure the best allocation of existing and potential resources, and the optimal configuration of services.

Historical issues and Context

To gain a better understanding of the current situation of First Nations people in Ontario, it is imperative to consider events of the past. This is particularly important for those working in the health, justice, and social service sectors (Chansonneuve, 2007). Historical traumas such as colonization, the erosion of

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traditional lifestyles and land, the residential school system, the sixties scoop, and racist, sexist legislation were all deliberate attempts by the Government of Canada to eradicate First Nations culture, language, beliefs and customs (Chansonneuve, 2007).

As part of the colonization process, a policy of assimilation was instituted to extinguish Aboriginal title to the land. The *Indian Act* ("An Act respecting Indians"), R.S., 1985, c. I-5, is a Canadian statute that concerns registered Indians (i.e., First Nations peoples of Canada), their bands, and the system of Indian reserves. The Act became official legislation in 1876 and gives the federal government, via the Minister of Indian Affairs and Northern Development, unprecedented authority to control the lives and lands of First Nations people.

The *Indian Act* denied Status Indians the right to vote, enlist in the war or own land, unless they gave up their status and "enfranchised" into mainstream Canadian society. In addition, the Act outlawed cultural practices and imposed severe penalties for the possession of liquor. Following the Indian Act, women and their children were forcibly enfranchised if they married non-status men. Status Indian children were also removed from their homes, under the Minister's authority to educate them, and sent to residential schools. The residential schools (1892 – 1996) were designed to eliminate the languages, values and cultures of Aboriginal people. The physical and sexual abuse which occurred in these schools as well as the neglect and absence of parental role models have significantly contributed to the cycle of social and economic issues that still reverberates today. Starting in 1951 – during what has become known as the 'Sixties Scoop' – provincial child care agencies received payments by the federal government for each "Indian" child they apprehended. By the end of the 1960's, up to 40% of all legal wards were First Nations children, even though they formed less than 3% of the national population (Fournier and Grey 1997).

Notwithstanding these provincial government interventions, history did not unfold as anticipated. First Nations did not give up their identity and disappear. The rights of First Nations peoples to maintain their identity within Canada have been recognized in the highest law of the land with entrenchment of Aboriginal rights into the Canadian Constitution and self government negotiations. Very complex, yet meaningful, relationships have been established between First Nations people and the Government of Canada through both Supreme Court decisions and political accommodations, such as the Statement of Apology to former students of Indian Residential Schools on behalf of the Government of Canada and the Indian Residential Schools Truth and Reconciliation Commission (Dickason 1992). In addition, meaningful relationships have been established between the province and Ontario First Nations including the 1965 Child Welfare Agreement, the Aboriginal Healing and Wellness Strategy, Health Promotions Strategy and an Injury Prevention Initiative. Tripartite relationships are currently underway in Ontario between the Federal, Provincial and First Nations governments such as the First Nations Public Health Framework.

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Ontario First Nations have paid a heavy cost for two hundred years of the colonization efforts. Social and economic marginalization, poverty, abuse, and racism have had multigenerational adverse impacts. Twenty-nine First Nations from Ontario participated in the Assembly of First Nations' First Nations Regional Longitudinal Health Survey 2002/2003 (Assembly of First Nations 2007a). This report indicates that there are serious issues facing the health status of Ontario First Nations. The Ontario First Nations 2003 First Nations Regional Longitudinal Health Survey (RHS) highlights many important differences in living conditions and health between Ontario First Nations communities and Canada as a whole.

The survey finds that Ontario First Nations adults have significantly higher rates of hypertension, arthritis/rheumatism, diabetes and obesity than Canadian adults. For all age groups and genders, smoking is approximately twice that found in the Canadian population. The proportion of heavy drinkers in Ontario First Nations adults is higher than the general Canadian population.

Almost thirty percent of Ontario First Nations adults report having suicidal thoughts and 50% of those people reported at least one suicide attempt over their lifetime. A majority of Ontario First Nations people who participated in the RHS either attended residential school or had a parent or grandparent who attended residential school. The intergenerational impacts of residential schools and other assimilation policies, such as increased prevalence rates of substance abuse, alcoholism, family dysfunction, violence, lower social and economic status and suicide, have been well documented (RCAP, Tait, Chassoneuve).

In a 2007 report for the Aboriginal Healing Foundation, Chansonneuve discusses the Historic Trauma Transmission (HTT) model, developed by Maria Braveheart. Historic trauma refers to "a series of traumatic events occurring over time with no opportunity for recovery and rebalance between these events" (Chansonneuve 2007, pg. 2), and is transmitted across generations through biological, cultural, social and psychological channels.

With this increased understanding of the underlying causes of many of the social, health and economic challenges faced by First Nations people in Ontario, a new approach is required to more successfully and effectively strengthen Ontario First Nations. First Nations people in Ontario insist upon a partnership approach to all social, economic, environmental and governance policies affecting them. Reports, such as the Royal Commission on Aboriginal Peoples (1996) and the more recent, Strengthening the Relationship, Report on the Canada-Aboriginal People Roundtable (2004), concur that new and innovative directions must be adopted by government agents to build a strong and sustainable partnership with Aboriginal Peoples. Historically, Ontario First Nations have been quite successful in developing such partnerships, particularly with the First Nations and Inuit Heath Ontario Region. This project serves as evidence that there is political will for ongoing collaboration in the development, delivery and management of First Nations programs and services to address pressing community needs.

Methodology

This needs assessment is being guided by an Advisory Committee composed of representatives of Ontario First Nations, the Ontario Regional Addictions Partnership Committee (ORAPC), and First Nations and Inuit Health Ontario Region (FNIH). The Advisory Committee will present findings to the Chiefs in Assembly as well as to the First Nations Addictions Advisory Panel (FNAAP) to articulate a regional and national program framework. It provides opportunities for input into changes considered necessary to modernize the system and improve the health status of First Nations members struggling with addictions and substance abuse.

The needs assessment used multiple data collection activities to provide an analysis of addiction treatment and prevention needs as well as services currently available to Ontario First Nations. This approach also explored innovative and promising practices and models of service delivery. The project included key informant interviews, focus groups, surveys, case studies and a document/literature review to respond to the following main study questions:

1. What are the current addictions and substance abuse problems faced by Ontario First Nations?
2. What services or resources are available to address these needs?
3. What treatment modalities are currently being used?
4. What challenges are faced in meeting identified needs? Are there gaps in services?
5. What innovative approaches, structures or promising practices have been developed at the community, tribal, or regional level to address First Nation addictions prevention and treatment needs?
6. What relationships have been developed to effectively meet current Ontario First Nations addictions prevention and treatment needs?
7. How are Aboriginal values, culture and/or language incorporated into community approaches?
8. Have policies been developed to better address First Nations addictions prevention and treatment needs?
9. What are the priorities for enhancing and improving addictions prevention and treatment services for Ontario First Nations?

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During this three month process of data collection, input was received from at least 95 First Nations communities as well as other stakeholders involved in addictions and substance abuse prevention and treatment.

1. Face to face meetings were held with more than 230 people individually in communities including workers, former and current clients, Elders, Board Members, physicians, police, community members, Chiefs and band councillors, youth and other stakeholders during twelve site visits.
2. 40 key informant interviews were completed.
3. More than 150 documents or literature were reviewed as part of this study.
4. 123 surveys were distributed to NNADAP workers/Health Directors and 38 completed responses were received.
5. Focus groups obtaining specific information on the main research questions were held with 83 participants at the NNADAP conference.

Structure of this report

This report provides a description of addictions and substance abuse treatment and prevention needs as well as services currently available to Ontario First Nations. Innovative and promising practices are also highlighted. This report provides:

1. A contextual assessment of the structural, social and cultural factors that may influence the overall addictions and substance abuse situation;
2. Drug use assessment to arrive at a comprehensive description of the addictions and substance use situation and associated problems;
3. Resource assessment identifying existing resources and gaps to address these issues; and,
4. Intervention and policy assessment which examines the type of interventions and policies used to address the addictions and substance abuse situation and where improvements may be made.

Chapter 1: provides an introduction to the study and general contextual information.

Chapter 2: presents participant and document findings within four general theme areas:

1. Current Situation regarding addictions and substance abuse
2. Challenges and Gaps
3. Innovative Approaches and Promising Practices
4. Priorities for enhanced service delivery

Chapter 3: provides summary analysis of the findings.

Chapter 4: contains a strategic plan for enhancing and renewing the addictions prevention and treatment services.

CHAPTER TWO: FINDINGS

This chapter presents participant and document findings within four general theme areas:

1. Current Situation regarding addictions and substance abuse
2. Challenges and Gaps
3. Innovative Approaches and Promising Practices
4. Priorities for enhanced service delivery

In this section, findings are discussed from focus groups and key informant interviews during the twelve site visits, key informant interviews as well as survey findings from 38 First Nations communities and eighty nine participants at the NNADAP conference on November 28, 2008. This section of the report provides quantitative and qualitative information from the participants. The discussion of participant findings is followed by a summary of what the relevant literature has to add regarding the findings.

The following twelve site visits were completed for a total of 198 focus group participants and 29 key informant interviews:

1. Ngwaagan Gamig Recovery Centre (Rainbow Lodge), Wikwemikong.
2. Anishnabie Naadmaagi Gamig Treatment Centre, Blind River.
3. Sagashtawao Healing Lodge, Moosonee.
4. Dilico Anishinabek Family Care, Thunder Bay.
5. Sioux Lookout First Nations Health Authority, Sioux Lookout.
6. Eagle Lake Health Centre, Eagle Lake.
7. Migisi Alcohol and Drug Treatment Centre, Kenora.
8. Native Horizons Treatment Centre, Hagersville.
9. Nimkee NupiGawagan Healing Centre, Muncey.
10. New Directions, Six Nations of the Grand Territory.
11. Reverend Tommy Beardy Memorial Family Treatment Centre, Muskrat Dam.
12. Curve Lake First Nation.

Key Informants were held with forty individuals including representatives of:

1. First Nations and Inuit Health Ontario Region.
2. Provincial Territorial Organizations (PTO's).
3. Ontario Regional Addictions Partnership Committee (ORAPC).
4. Treatment Centre Directors.
5. Chiefs and other First Nations representatives.

There were quantitative findings from 37 surveyed communities, including 13 from the northwest, four from the northeast, seven from the central and 13 from the southern regions.

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In addition to participation from NNADAP workers during site visits, this study held focus groups with 87 NNADAP workers from the following geographical areas.

1. 15 participants from the Kenora, Rainy River, Fort Francis Corridor region.
2. 27 participants from the South region.
3. 18 participants from the Central region.
4. 27 participants from the North region.

2.1 Current Situation

Introduction

The following section will highlight study participant discussion regarding the current landscape of addictions and substance abuse prevention, treatment and services in Ontario First Nations. Themes have been organized under the following categories:

1. Current addictions and substance abuse issues;
2. Underlying factors;
3. What resources are available to address these needs;
4. Treatment modalities currently being utilized; and
5. Integration of First Nation values, culture and language into addictions and substance abuse prevention and treatment services.

The participant findings are followed by a selected literature review to add context to the participant discussion. The next section of this report examines challenges and gaps in services and elaborates upon many of the topics introduced here.

Participant Discussion

2.1.1 Current Addiction and Substance Abuse Issues

The combined study findings from all lines of enquiry confirm that alcohol is still the highest ranked substance abused in Ontario First Nations communities followed closely by cannabis (in the form of marijuana and hash), cocaine and oxycondone, (including Oxycontin and Percocet). However, the study findings firmly indicate that poly-substance abuse is rampant with Ontario First Nations people, such as alcohol and oxycondone.

Alcohol

Alcohol is the most prevalent addiction and abused substance in Ontario First Nations communities' according to all data collection streams conducted in this study. A number of respondents indicate alcohol as remaining the largest problem and top priority:

"Alcohol is still a big thing but because it's not the new buzz word, it's still the most abused substance and affects the most people in the most communities. It is still the number one substance of choice."

The extent of abuse is explained in part by the normalization of alcohol. Many respondents noted that while alcohol has remained the biggest addiction problem facing First Nations communities for years, it does not receive the same amount of attention in light of the newer substance abuse trends. A focus group participant captured this sentiment by stating:

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“We have become complacent, people have become complacent and it is normalized so when crystal meth and crack come in it becomes the big buzz – we have to solve a problem first before we start looking at moving on to fix another. We need to deal with alcohol – otherwise we are in panic mode rather than dealing with addictions. The more these things become “normal” the harder it is to deal with them.”

Alcohol and Poly-substance Abuse

An added complexity arises when alcohol abuse, the primary addiction, occurs in conjunction with other substances. Treatment centre staff members stated:

“Alcohol was the primary issue but now poly-substance abuse is a major concern.”

“We take people with all substance problems. We find out when they get here that they are abusing all substances, not just one.”

In First Nations communities, poly-substance abuse is regarded as a recent trend that has been steadily on the rise in the last five years. The main poly-substances being abused are alcohol, prescription drugs and cannabis in different combinations depending on region, age and substance abuse history. The shift from mono- to poly-substance abuse was expressed by a significant number of participants and was captured in the following statements from a key informant, followed by a treatment centre staff:

“Biggest change over the last 10 years especially the last five years is poly substance use – we do not see people using a single substance anymore – it’s so rare it’s not worth talking about.”

“You do not see any “True Drunks” anymore; those that only drink without [using] any other drugs. That is very different from a while ago. I think in the last five years it has been a lot more different drugs and not just alcohol abuse.”

One focus group participant offered comments regarding the importance of continuing to focus on alcohol abuse while acknowledging ongoing concurrent substance abuse:

“Fairly recently in the past few years there has been an increase in prescription drugs, though alcohol is still the number one favorite. Marijuana and alcohol are the stable addictions and the more exotic – crack and cocaine and opiate products (pain meds, patches, oxycodone) they are add-on. Nothing compares to the devastation that alcohol creates and has created on families. Alcohol continues to be the most prevalent drug within all communities.”

Prescription Drugs

There has been a substantial increase in the prevalence and abuse of prescription drugs, an emerging trend in the past five years. The data streams collected in

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this study indicate oxycodone, mostly Oxycontin and Percocet, are the prescription drugs most often abused in First Nations communities. However prescription drugs also extend to morphine, benzodiazepines and codeine (Tylenol 1-3). The following comments offer:

“The most pressing [need to address] is prescription drug abuse because it is relatively new and there are few things in place that can help fight it.”

“Prescription drug abuse is an emerging issue that we are dealing with, that is becoming more relevant and problematic.”

The proliferation of prescription drug abuse in First Nations communities is summarized in part by the following key informant observation:

“What we see more recently now is the increase of prescription drug abuse and it is fitting we are seeing that because a) it is not illegal and b) it is free (through Non-Insured Health Benefits (NIHB)). When a free drug is introduced to a community that is essentially impoverished, it has the propensity to make good people do bad things.”

The increase of prescription drugs may be attributed to availability, addictiveness and the ability to transport (especially to remote communities). To explain the shift from alcohol to increased prescription drug abuse, one focus group participant commented:

“We did a session with the clients yesterday who said prescription drug abuse is more prevalent than alcohol because it is easier to carry and smuggle in. The use of alcohol is quite visible. When you are transporting, it is pretty hard to hide. But prescription drugs can be brought in easily.”

Numerous participants commented on the economic opportunities associated with receiving prescription drugs. A youth focus group participant stated:

“Prescription drugs seem to be easy to get to, especially for First Nations people. People just make money off it; they pretend to be hurt and get money for [selling their prescription drugs].”

Senior citizens are a population that has been targeted as one avenue for accessing prescription drugs. Members of this age group often have a legitimate medical cause to be prescribed drugs; however, economic factors or “cabinet raid” theft was identified by participants as a source for abuse:

“We have the historical problem of doctors over-prescribing. We have the problems of Elders selling their own medication.”

“In the elder population, many are being taken advantage of by their family members by stealing their prescription medications to get high. An elderly family member does not want to pursue anything because that would get them in trouble

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with the law. The adult population has a huge increase in the number of robberies, smash-and-grabs; there have been four incidents this year.”

“A lot of the people are getting it from local, and sometimes from other places. They break into drug stores or people wait outside the pharmacy (which is a big issue here).”

Youth

Participants identified that addictions and substance abuse problems are starting at ages as young as nine among First Nations children. Participants note that substances abused by the youth include tobacco, alcohol, cannabis and prescription drugs.

“I think alcohol use is not as bad as prescription drug use. People are using prescriptions every day.”

“Young is about age 9 years starting with anything they can get their hands on, the harder the better.”

“Our community members are starting from ages of 8-11, they are into experimental stage of tobacco, drugs and alcohol. Young adults’ are asking elders if they have any pain pills they can take off their hands. We have problems of young people stealing from parents and elders their prescription drugs.”

“Alcohol and pot are primary starters for most people that come through here, they start drinking, and then pot and its late teens they start getting into other drugs. It is passed around if you do not know you can get high on percs then someone will tell you.”

“The youth are progressing right to the hard drugs immediately – it is nothing to see 15-16 year olds using Ecstasy, prescription drugs who did not use alcohol or cannabis first. They can get crack cheaper than alcohol.”

Fig. 1 illustrates the opinion of the NNADAP community workers and treatment centres workers as to the prevalence of various substances abused in their communities that supported the overall findings of this needs assessment.¹

¹ . (Note: NNADAP workers were asked on the survey and in the conference focus group to rank the substances 1-4 in priority and their responses are therefore weighted accordingly.)

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Figure 1: How prevalent is the abuse of the following substances in your community?

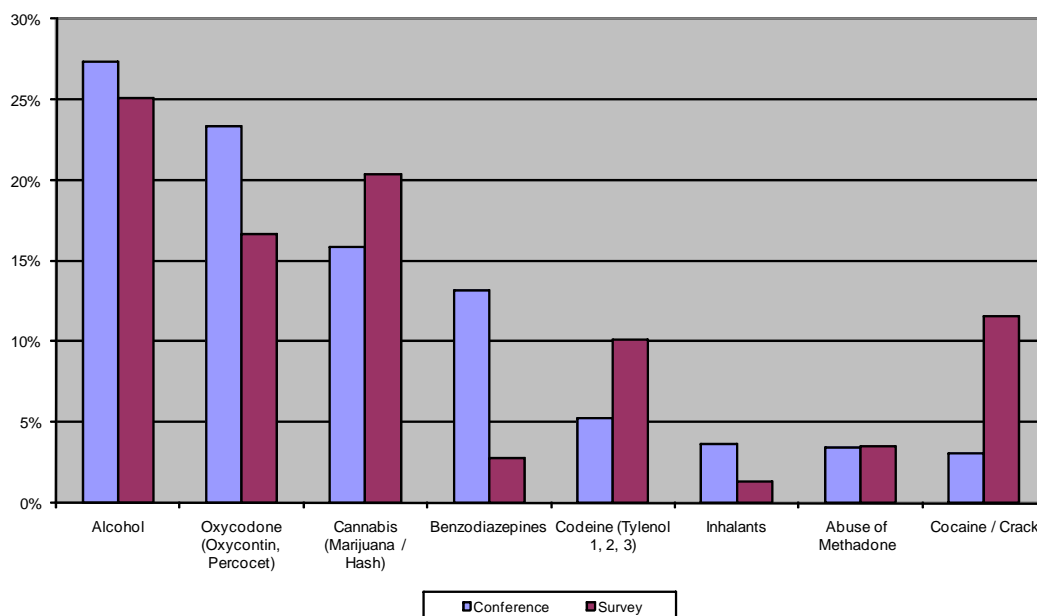


Figure 2: How prevalent is the abuse of the following substances in your community?
Conference Participants Priorities

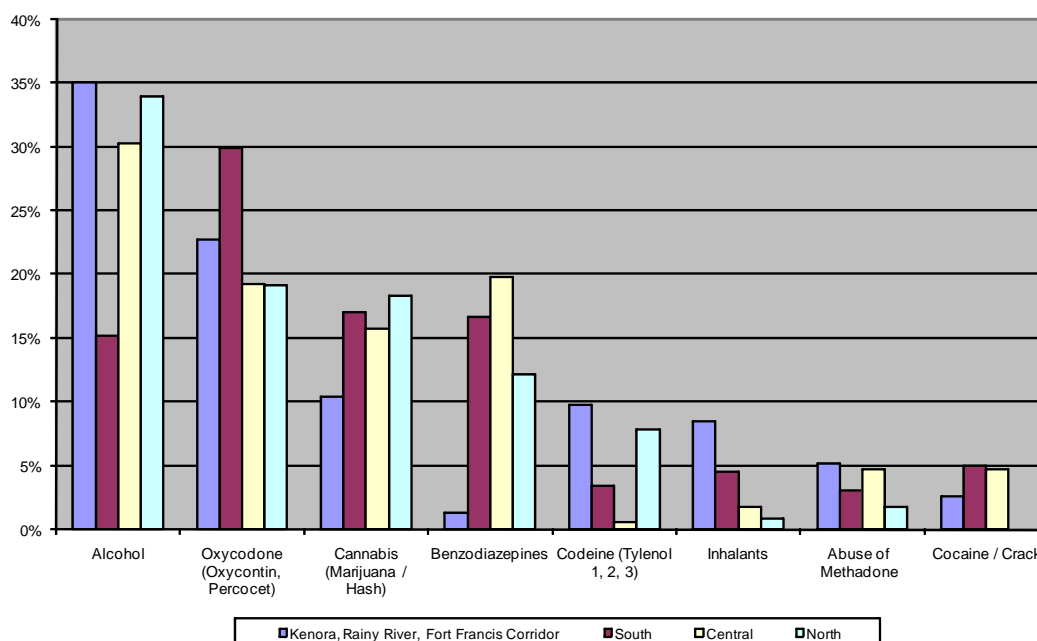


Fig. 2 suggests that there are some geographical variances in the leading five substances being abused by community members. For example, three regions identified alcohol as the top priority while oxycodone abuse was listed twice as high as alcohol abuse in the southern region.²

² The groupings for the conference focus groups were as follows: *Kenora/Rainy River/Fort Frances Corridor*: First Nations and organizations from the northwest Minnesota border area to Winnipeg border (along Lake

Concurrent Disorders

Study participants indicated that they believe 80% of their clients are seeing symptoms of possible mental health issues. The vast majority of survey respondents indicated that clients had difficulty accessing addiction services if they also have concurrent mental health issues. Half the respondents stated always or frequent difficulty (48%) and the occasional difficulty accessing services (42%) compared to those who never have difficulty accessing services (6%). The remainder did not respond or did not know. Treatment Centres and key informants confirm that addressing concurrent disorders is a significant concern. This will be discussed further in section 2.2.

2.1.2 Underlying Factors

The combined study findings confirm that many social and economic determinants of health, as well as the historical burden described earlier in this report influence, addictions and substance abuse in Ontario First Nations communities.

In this study, the following factors were identified as influencing addictions or substance abuse in Ontario First Nations communities:

- Childhood Abuse
- Criminal Activity
- Cultural Loss
- Domestic Violence
- Education level
- Employment level
- Gang-related activity
- Grief / Loss
- History of Violence/ Trauma
- Housing Issues
- Medical issues
- Mental Health Issues
- Peer Pressure
- Poverty
- Self-Esteem Issues
- Sexual Abuse

Superior) including two organizations from Thunder Bay. *South* participants included participants from east to west along Lake Ontario and Lake Erie and north to Parry Sound. *Central* region included participants from North Bay, Sudbury and Sault Ste Marie corridor. The *North* region participants included all participants north of Thunder Bay and Sault Ste Marie including the northwest and northeast communities.

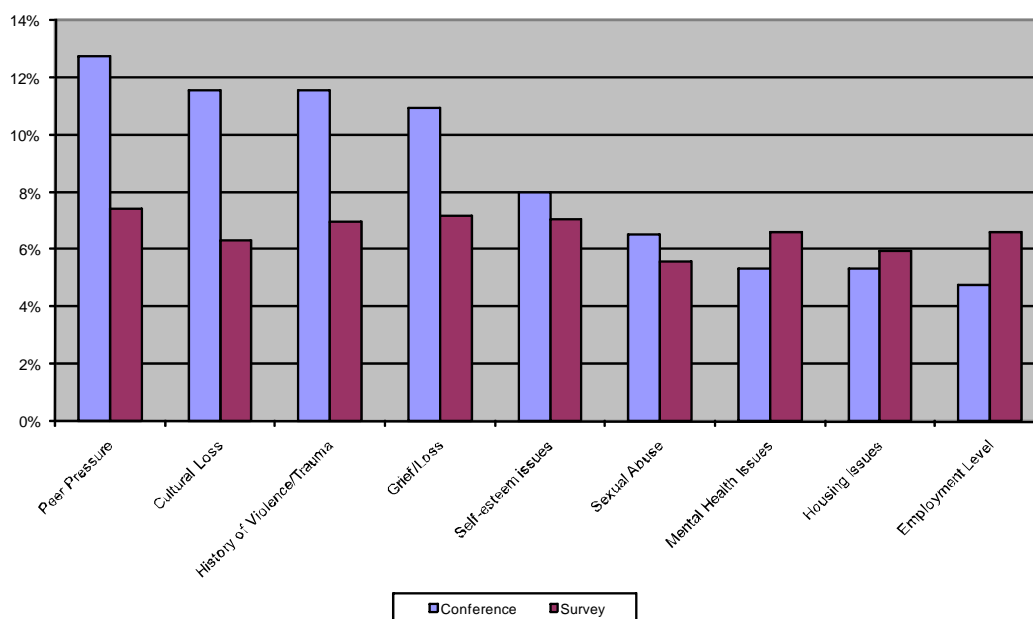
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Residential schools were not listed as a separate factor but could be considered to be overlapping many of the categories provided. Participants were provided an opportunity to list it under “other”.

Survey participants were offered an option to rank the factors as having little or no effect, or moderate to significant effect. The survey respondents tended to rank each of the seventeen categories as a strong factor influencing addiction or substance abuse.

NNADAP conference participants were asked to rank the top four factors that influence addiction or substance abuse in First Nations communities (Fig. 3). Participants expressed this exercise as challenging since they felt all have an impact. The ranking exercise by conference participants indicated peer pressure, cultural loss, history of violence/trauma and grief/loss, as some of the most significant forces.

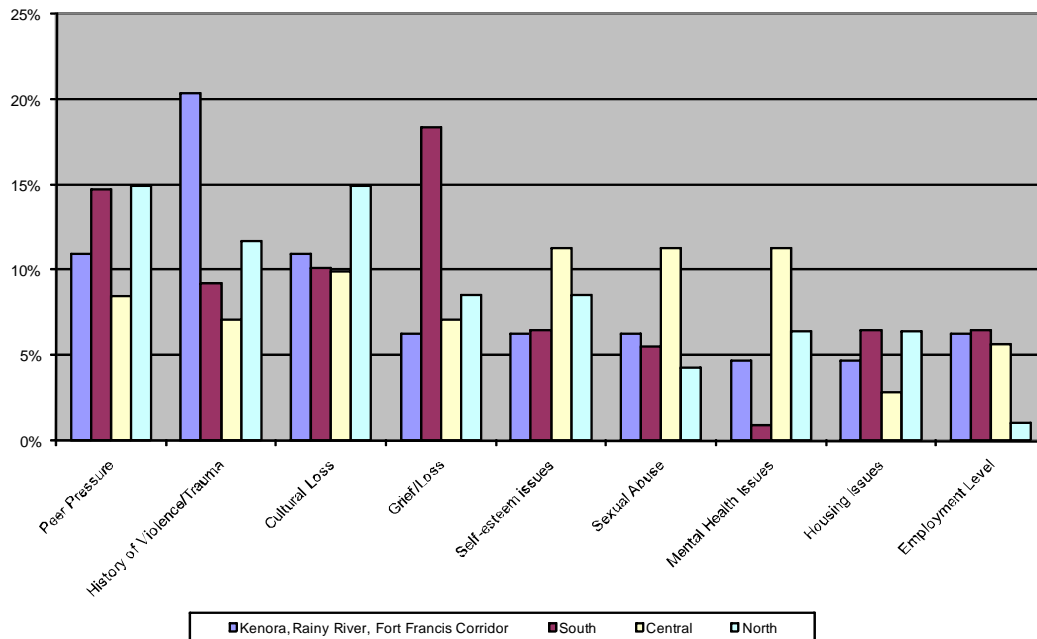
Figure 3: Factors Influencing addiction or substance abuse in your community?



There were regional differences in the top priority of underlying factors influencing addictions or substance abuse in communities (Fig. 4). Participants from the Kenora/Rainy River/Fort Frances Corridor identified history of violence/trauma as the foremost factor, compared to grief and loss in the south region. Two important factors in the north were identified as peer pressure and cultural loss by participants. The major factors in the central region were split between self-esteem issues, sexual abuse and mental health issues, while the south region ranked grief/loss and peer pressure as top factors.

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Figure 4: Factors influencing addiction or substance abuse in your community?
Conference Participants



Key informant interviews and focus group participants were asked, “What are the underlying factors that contribute to why people misuse drugs and alcohol?” and were able to discuss more factors than those listed above. Most notably, people interviewed discussed at large the impacts of residential schools and intergenerational trauma.

Residential Schools and Intergenerational Trauma

The impacts of residential schools was mentioned a great number of times by participants, both when discussing residential schools directly and when discussing other underlying factors listed below. Comments from participants regarding residential schools and their impact on addictions and substance abuse include:

“Residential school affects on addictions – the first six years of a child’s development is crucial and will carry them forward in their lives and when residential schools forced children to leave at six, the normal course of development did not happen and the children and parents were traumatized and their spirits were attacked; they experienced pain in their spirit and have chosen addictions to numb the pain.”

The issue of residential schools led participants to discussions of intergenerational trauma, such as:

“The grief the communities have suffered through various traumas including residential school abuse is carried on, it’s intergenerational, and there is anger and depression associated with the unresolved issues.”

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“Pain does not go away only because an apology was made. Pain filters down into the families and people do not know how to deal with that pain, so they turn to alcohol and drugs.”

“Residential school affects not only those who went but after generations – they missed out on parenting skills and parenting skills transferred.”

Cultural Loss

Many participants listed cultural loss as an underlying factor of addictions and substance abuse. The result of the cultural loss that participants see is that people are unable to know their roles in life and that they lose a sense of belonging and self esteem:

“Loss of traditions, it takes a community to raise a child and those teachings are lost. Before I went to residential school, talking with my grandparents and parents, I was taught my role daily that my life was a gift to my parents from the Creator and I wasn’t to do anything to damage that life – I was taught to honor my life.”

“My grandmother went to the residential school and sent her son without the culture. There are so many people who do not know who they are. If you do not know your stories, your songs, your language, how can you feel good about yourself? I think people have a hard time getting back to that. You should know it because that is who you are, but their self-esteem is so low. The people I have met in my life that have been able to experience that for the first time, their gratitude, sense of worth and sense of well-being is important. They will change their whole life around because they found a piece of themselves that was missing before. We say all the time that we need our language and culture, but we do not truly value it because if we did, we would have it.”

Abuse

Another issue that participants consider to be an underlying factor of addictions and substance abuse is physical, sexual and emotional abuse. Comments from interviewees include:

“Sexual abuse is really high in the community and a lot of people do not know how to deal with that. There is a lot of shame-based. Working with clients they talk about incest and it happens in the family, or even extended family.”

“I heard a lot of women who are suffering from sexual abuse, physical abuse. They use to cover those painful memories, to help numb them...”

Peer Pressure

Peer pressure was discussed as being an underlying factor in reference to youth. Comments included:

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“It comes down to personal choice and for our community it has become peer pressure amongst the youth.”

Also when discussing youth, participants mentioned that boredom amongst the youth was contributing to addictions and substance abuse:

“You see a lot of young people on the weekends walking the streets. We had a youth centre that was recently shut down, so that left a lot of young people with further boredom to contend with, especially on weekends.”

2.1.3 What Resources are Available to Address These Needs

Education, Promotion and Prevention Activities

Respondents indicated that there are many education, promotion, and prevention resources available within their communities. Activities include workshops, presentations, information sessions, lunch and learn programs, and radio shows that provide community members with information on addictions and substance abuse issues. These activities are facilitated in a number of different locations within the communities such as grade schools and secondary schools, community centres and in the homes through the use of radio shows. The target audiences for these activities include youth, adults, children, Elders, women, men, those with substance abuse problems, and their family members, with the majority of these activities are focused on the youth. Respondents also identified a number of topics for these activities that include, but are not limited to: drugs, alcohol, crystal meth, traditional healing, addictions, residential school impacts, gambling and mental health issues. Examples from participant include:

“The community has a “Mentorship” summer program for youth – high school student promoting culture.”

“Youth Action Alliance tobacco program – youth go into schools delivering presentations – it is a collaborative effort with M’Chigeeng First Nation funded through Sudbury District Health and Smoke Free Ontario.”

“Aboriginal Shield Program – youth centre staff and Rainbow lodge staff trained to deliver a drug awareness program to grades 7 and 8 – collaboratively.”

“Tribal police deliver drug awareness program called DARE to grades 5 and 6.”

Respondents also indicated that materials are published for the community, to increase awareness and to provide information that community members can refer to when at home.

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There were also participants that discussed the limited number of education and prevention activities in their communities. Comments included:

“We provide some prevention/promotion – all communities provide something but we don’t have a strategy for this based in our area – it’s something that we could look at that is more strategic.”

National Native Alcohol and Drug Abuse Prevention (NNADAP) Worker

The original intent of the National Native Alcohol and Drug Abuse Prevention (NNADAP) worker is to be responsible for planning, coordinating and delivering prevention and intervention programs to First Nation people with addiction and substance abuse problems. The main function of the NNADAP worker is to assist individuals and families in dealing with and reducing, alcohol and drug related problems. FNIH-OR Records show that there are 135 NNADAP workers in the Ontario region.

Participants discussed the NNADAP worker as a resource available to address the addiction and substance abuse needs in First Nation communities. While NNADAP workers were cited as a resource, respondents voiced concerns about the lack of consistent qualifications, roles and responsibilities for NNADAP workers throughout the province.

“Most communities have a NNADAP worker but it is our observation that the roles and responsibilities are not at all consistent across each First Nation.”

“Qualifications vary from nation to nation, their job description varies from nation to nation and our workers have to deal with it on a First Nation by First Nation basis.”

It was also noted that NNADAP workers are unaware of the flexibility of the program to adapt to the specific needs of their communities. Respondents noted that some NNADAP workers carry out one-to-one sessions, others carry out AA-style group meetings, while others still only offer referrals services to other agencies. FNIH-OR believes that most First Nations fund full-time equivalent positions and they may be given additional roles and responsibilities at the First Nation level. Study participants indicated that not all NNADAP workers are funded for a full-time position so they carry out other portfolios in addition to their addictions prevention work.

Direct Residential Treatment Services

Study participants named a number of treatment programs and centres across the province that provide services to First Nations youth and adults. They primarily referred to the First Nation specific programs, these programs are discussed below.

NNADAP Funded Treatment Centers

There are a total of ten NNADAP Treatment Centres across Ontario employing approximately 65 Treatment Centre counsellors. Each centre provides a baseline of treatment components which often includes, but is not limited to: assessment, alcohol and drug education, case management, client orientation, crisis intervention, professional consultation, cultural activities, individual and group counselling, individual and aftercare planning, life skills/personal development, individual treatment planning, referral and recreation therapy. Each centre is unique in programs offered, size of centre and special treatments and services available. A description of each of the treatment centres are offered below.

Anishnawbe Health

Anishnawbe Health is located in the heart of Toronto, ON. The centre has a total of 16 beds available for adults, youth and pregnant clients suffering from alcohol, narcotic, prescription and hallucinogen abuse. FNIH only funds the outpatient service of this program, which is a concurrent disorder program that offers day services.

Anishnawbe Naadmaagi Gamig Treatment Centre

The Anishnawbe Naadmaagi Gamig Treatment Centre is located in Blind River, ON. The 28-day residential treatment centre provides 16 beds to adult men and women who seek assistance in dealing with their addictions, particularly alcohol. The translation of the treatment centre name is “Our Helping House”, which is located on 30-acres of waterfront property on the North Channel of Lake Huron with walking trails and recreational areas. Part of the admission criteria is abstinence from alcohol or drug abuse for at least 72 hours. The treatment centre has a strong focus on cultural teachings and traditions, especially regarding the strengths of traditional values as a foundation to wellness. Components of the program include individual counselling to identify personal problems and set goals, group sessions, as well as lectures and discussion groups.

Dilico Anishinabek Family Care

The Dilico Anishinabek Family Care – Adult Residential Treatment Centre (ARTC) is located in Fort William, ON. There are a total of 20 beds available for adults (aged 18 and over) suffering from alcohol, narcotic, prescription, and hallucinogen abuse. Therapeutic community principles of peer support, cooperation, open communication and shared rehabilitative goals are taught. Correctional and pregnant clients are also able to enroll in the five-week treatment program, but intake priority is for First Nation’s clientele. On occasion, the centre will provide solvent abuse treatments. However, clients on methadone are not admitted as the centre “does not have the resources available” (Key Informant Interview). The centre can accommodate visual and physical impairments along with concurrent addictions. Follow-up and aftercare services are also offered by the centre.

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Ka Na Chi Hih Solvent Centre

The Ka Na Chi Hih Solvent Centre is located in Thunder Bay, ON. A total of 12 beds are provided to adult and youth males (target ages: 16-25) suffering from solvent abuse. A portion of services are offered for the entire family. The centre can accommodate visual and physical impairments along with dual addictions. Follow-up / aftercare services are also offered by the centre.

Migisi Alcohol and Drug Abuse Treatment Centre

Migisi Alcohol & Drug Treatment Centre is a 14 bed facility, located on the beautiful lake front of Matheson Bay, Wasuzhushk First Nation, near Kenora, ON. This residential treatment centre is available for alcohol and drug client referrals under a mandate from fifteen First Nation communities within Grand Council Treaty #3. Walk-in crisis, outpatient and follow-up / aftercare services are also provided. Concurrent disorders are accommodated during this four-week program at this treatment centre. Clients that are on prescription drugs are required to take medication in front of staff.

Native Horizons Treatment Centre

The Native Horizons Treatment Centre is located in Hagersville, ON. The centre provides 15 beds for adults and correctional clients suffering from alcohol, narcotic, prescription, and hallucinogen abuse. Physical disability, visual impairment, hearing impairment, and learning disabilities can be accommodated at this treatment centre. The centre also provides services for dual addiction and follow-up / after care.

Ngwaagan Gamig Recovery Centre Inc.

The Ngwaagan Gamig Recovery Centre is located in Wikwemikong, ON. The centre promotes healthy lifestyles, choices, traditional values as well as individual and family wellness. There are ten cycles of the four-week treatment program annually with a total of 8 beds that are available for adult clients with alcohol and prescription abuse. The treatment program involves intake, orientation, pre-treatment, goal setting, problem solving, identifying issues, decision-making, aftercare plans, as well as goals and objectives. Services provided can accommodate people with physical disabilities.

Nimkee NupiGawagan Healing Centre Inc.

The Nimkee NupiGawagan ("Thunderbirds Necklace") Healing Centre is located in Muncey, ON, with two main facilities (residential and operational) that include additional recreational space. A total of 9 beds are available for this four-month, gender based treatment program for First Nation youth (ages 12-17) and who are challenged with solvent addiction. The treatment centre will treat one gender exclusively for each four-month cycle. Services provided include dual addiction, follow-up/after care, out patient and day treatment services. NNHC maintains Accreditation by the Canadian Council for Health Services Accreditation.

Reverend Tommy Beardy Memorial and Wee Che He Wayo Gamik Family Treatment Centre

The Reverend Tommy Beardy Memorial and Wee Che He Wayo Gamik Family Treatment Centre is at a central location at the fly-in community of Muskrat Dam, ON. The facility involves a main building that houses operations and communal spaces for treatment, as well as individual cabins able to house individual families as they seek treatment. The unique family-residential treatment centre provides a total of 15 beds and services to adults and their immediate families that are suffering from alcohol, narcotic and prescription abuse. Services and treatment are also available for clients that are on methadone and also provide services for those with dual addictions.

Sagashtawao Healing Lodge

The Sagashtawao Healing Lodge is located in Moosonee, ON. The lodge provides a total of 12 beds for adults that are suffering from alcohol, narcotic and hallucinogen abuse. Services are available to those with dual addictions and physical disabilities.

Participants indicated that there are a number of mainstream treatment centres available, however most former clients that participated in this study stated they preferred to attend a First Nation treatment centre.

Withdrawal Management Services

Respondents indicated that while there are no services available on reserve, there is access outside of the community.

"I reiterated that we do not have a withdrawal management facility here. In the past I have had to do some home detoxification with families."

Study participants indicated that First Nations people in Ontario must access withdrawal management off reserve usually in a hospital setting.

Counselling

Respondents discussed counselling as a resource for addictions and substance abuse needs, but cautioned that there was limited availability. Some respondents indicated that counselling services were available within their communities, while others noted that services were available through other off-reserve agencies.

Alcoholics Anonymous

Alcoholics Anonymous (AA) is a program that is cited repeatedly as resource available to those suffering from alcohol abuse. While this program is frequently available in the communities a number of participants voiced need for variety as they question the effectiveness of the program:

"There are the traditional support groups and AA but there is a need for alternative programs."

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“AA is also available in most communities and here they, of course, only push abstinence. I mean their whole approach is completely based on total abstinence.”

Aftercare and Promotion of Stability

While the availability of aftercare following treatment and the promotion of stability differed across First Nations in Ontario, it is limited. One participant remarked,

“You can send people to treatment but there is no aftercare.”

Some NNADAP workers provide aftercare where possible, but many find that they are spread thin if the community expectation is that they are able to provide a continuum of care from promotion and prevention, to crisis intervention, case management and relapse prevention.

“We have aftercare sessions and counselors work with clients for aftercare. The aftercare plan connects them to outside resources – such as mental health – as there are a lot of concurrent disorders.”

Aftercare programs are often part of the services provided by treatment centres. Of the ten (10) NNADAP treatment centres nine (9) offer limited aftercare or follow-up services. Though it was mentioned that while these programs are available, they are not always mandatory and clients that need the help do not always take the initiative to get it. As one front-line worker stated:

“The door is open. I used to run aftercare programs and maybe there was one or two or three and it depleted; I started a new approach by keeping the door open and put out info if they are on probation to come in and sit down and talk for a while; checking in and checking out. I allow them that time to be comfortable instead of waiting for them – I make everything available, I am there.”

Participants discussed in detail the issue regarding the lack of aftercare programs. This will be elaborated upon in section 2.2.

Several front-line workers mentioned how they are in the process of, or wanting to develop more aftercare programs:

“Right now I am working on getting a relapse prevention program in the centre and doing after care.”

“I am trying to start a relapse prevention program to give them skills to deal with their situations.”

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Culture

Culture as a resource was identified by many of the respondents. Traditional ceremonies (such as Sweatlodges, medicine picking, traditional teachings, smudging, sharing and teaching circles, drumming, etc.) were all activities that respondents identified as resources in addressing addictions and substance abuse. As one participant commented:

“This program is culturally-oriented with the cultural approach. It is not visible in a sense, but if you look at the Native background, those people have a strong sense of traditional customs/livelihood/background. They have more strength (spiritually, mentally, and physically).”

Also, some respondents indicated that a Cultural Coordinator was present in the community, who was responsible for teaching community members about their culture, history, traditions and ceremonies, to restore pride and identity to the community. In addition, the Cultural Coordinator would bring Elders and other Traditional people into the community to share teachings and ceremonies.

Aboriginal culture as a treatment model is discussed in more detail in a later section of this chapter as well as in Chapter 3 of this report.

Training and Supportive Resource

Treatment Centres identified different training opportunities that they take advantage of, such as Motivational Therapy. Training differs across the province depending on the availability of training opportunities and the particular interest of a treatment centre. Most treatment centres are accredited or going through the process of accreditation which requires an ongoing staff training component.

NNADAP community workers are also undertaking training in their process of accreditation. Some of the certified training occurs at the annual NNADAP worker conference. All participants indicated a need for additional funded training to address changing needs and treatments used with clientele.

2.1.4 Treatment Modalities Currently Being Utilized

There are a multitude of modalities that have been employed for dealing with First Nations addictions. We must remember that the history of the deployment of such modalities is relatively short and the formalization and tracking of modality usage is relatively new, and not systematic. It should also be noted that the primary addiction, alcohol, has become concurrent with numerous other addictions that present many complex therapeutic challenges.

The “12 Step” Abstinence Program

First Nation communities historically have employed the “12 step” therapeutic abstinence intervention treatment modality for alcohol was most pervasive. The consultation component of this addiction service needs assessment and additional research shows that abstinence is still one of the most widely

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employed modality in First Nation communities. However not all treatment centres use all “12 steps” of the therapeutic abstinence model, rather focus on using only a number of the steps (e.g. steps 1-4) instead. One director spoke of respecting the needs of the community.

“In the minds of communities abstinence is where communities need to go because of the situation we are in.”

The proliferation of 12-step abstinence programs throughout Canada and other countries, most notably Alcoholics Anonymous (AA), shows evidence for its usefulness and application for prevention and abstinence from alcohol usage. This program sees addictions as a lifelong struggle and is premised on respect, mutual understanding and commitment to a structured support network (AA, 1972).

“Today First Nation communities have used the “12 step” program for many years and it has evolved to the point that many First Nation traditions and customs have been incorporated in the “12 step” process by First Nation service providers. This inclusion has been so pervasive that some people consider the “12 step” program to be a First Nation’s program.”

A Cultural Resurgence

With the resurgence of First Nation social and cultural activism in the 1970’s there also came recognition that First Nation communities must heal themselves from the ravages of addiction. Although it can be safely asserted that the western “12 step” Alcoholics Anonymous model was the first formalized treatment model employed, an important caveat was the inclusion of First Nation culture in such programming. Some communities see First Nation Nations’ culture as a healing model unto itself. A participant asserts how culture is being utilized.

“It is a spiritual program – both AA and culture are spiritual and we try to balance that.”

The Inclusion of Psychology

Over the last 30 years, there has also been a considerable amount of advancement in psychology, social work and psychiatry in western society. These disciplines employ various behavioral interventions that have implications for addictions which have been used in First Nation programs. It should also be noted that many of these therapeutic innovations have come in and out of “vogue” in the past 30 years which affect their usage in First Nation communities. Many First Nation staff are receiving such new training as detailed by the following comments from a Board of Directors President or Chair:

“We have done training with the staff with the mental health counselors in cognitive and behavioral therapies and we’re also exploring another therapeutic model.”

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It is also shown throughout the literature and in our consultations that the implementation treatment modalities occur at the discretion of personal initiatives at the community services level. This means that a particular person comes to the community with certain training and ideas about successful interventions, thereby new training or literature becomes available to professionals working the community. The following comment details how workers seek our information for their practice.

“We get this information based on what we have read, not really any formal training or manuals.”

In some instances, there has been reluctance to employ modalities other than the traditional “12 step” program. For instance, some First Nation programs are insistent that total abstinence must be included in programming and other modalities that do not include abstinence are not acceptable or effective.

Program Outcomes

Unlike earlier, more stringent treatment programs, newer approaches to addictions and drug misuse does not insist only on abstinence, but rather encourages any sign of reduced drug use. Some study participants recognize that while abstinence is the best goal for those who are severely dependent and/or addicted, they realize that this will take some time and that they may benefit from a variety of tools to move them towards this ultimate goal.

A participant states the realistic expectations they have by employing harm reduction.

“We use “harm reduction” treatment – meeting people where they are at.”

Other Modalities

As mentioned previously, increased use of psychology and the popularity of various types of therapeutic interventions spilled into First Nations communities. Some of them will be expounded upon in the following section. They include;

1. Cognitive behavioral therapy;
2. Social focus model;
3. Strength based model;
4. Problem solving focus;
5. Social focus models;
6. Reality theory;
7. Bio-social model; and
8. Emotional intelligence.

The remainder of this section looks at some of these other modalities and how they have been employed in First Nation communities.

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Motivational Enhancement Therapy (MET)

Motivational Enhancement Therapy (MET) therapeutic approach is based on motivational principals. It is premised on the fact that clients will be best able to achieve change when motivation comes from within themselves, rather than being imposed by the therapist. This is very much aligned to First Nations worldview and views of self-regulated behavior. The MET approach assists clients in moving through the stages toward action and maintenance. One participant asserted that by empowering the client, they can help themselves.

“It is important and by showing them how to be responsible for themselves, you will be able to change (their) own behavior.”

Drug problems are viewed as behaviours under at least partial voluntary control of the client, which are subject to normal principles of behaviour change. Drugs of abuse are assumed to offer inherent motivating properties to the drug abuser, which by definition have overridden competing motivations. The task in MET is to identify and strengthen competing motivations in order to reduce or prevent alcohol or drug use.

From these consultations, it appears that MET is available in all regions in some form or another. It is most prevalent in the central region and not as readily accessible in the northern region of the province.

Strength-based models

By far the most recognized and spoken of modality of intervention in the north of the province is the strength-based model. It is a systematic practice approach which emphasizes identifying, exploring, exploiting, and maximizing individual and system coping mechanisms, demonstrated successes, and natural and informal support systems to create and sustain quality social work practice. It is also similar to resiliency theory which also seeks to empower clients to concentrate on areas of their lives that are controllable. It is available in the other regions of the province but is not nearly spoken of as highly. One participant speaks of how they employ cost effective means to deliver such modalities.

“I know the staff will use a lot of visuals or alternative, for example, one staff member uses a lot of positive affirmation cards. The aim is to strengthen the positives and not the negatives.”

Cognitive Behavioral Therapy

Cognitive behavioral therapy was mentioned in the Kenora, Rainy River, Fort Francis Corridor and southern regions most often. It is available in the central region and in a limited amount in the north. It is a systematic psychotherapeutic approach that aims to influence problematic and dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure. It is dependent on highly trained individuals which may explain its absence in rural and outlying areas in the north.

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From the perspective of cognitive-behavior theory, alcohol and drug dependence are viewed as learned behaviors that are acquired through experience. If alcohol or a drug provides certain desired results (e.g., good feelings, reduced tension, etc.) on repeated occasions, it may become the preferred way of achieving those results, particularly in the absence of other ways of meeting those desired ends. From this perspective, the primary tasks of treatment are to (1) identify the specific needs that alcohol and drugs are being used to meet, and (2) develop skills that provide alternative ways of meeting those needs.

Reality Theory

A few of the respondents mentioned reality theory. It was mentioned primarily in the southern region and briefly in the central and north regions of the province. It was not mentioned in the Kenora, Rainy River, Fort Francis Corridor region. Reality theory encompasses a particular approach to psychotherapy and counseling. It is considered a cognitive behavioral approach to therapy since it focuses on helping the individual become aware of, and if necessary, change, his/her thoughts and actions. It is a form of cognitive restructuring.

Reality Therapy is a counseling method which focuses on the future. Its fundamental idea is that no matter what has happened in the past, our future is ours and success is based on the behaviors we choose. It does not try to explain away the past which is often a good method for First Nations people who have experienced past trauma. This participant sums up how they try to help the client move forward using this modality.

“Acknowledge, accept, non-judgmental, try to live in the moment. Some things are talking about re-victimization. You should re-affirm resiliency, to speak to your strengths.”

Emotional Intelligence

A few participants mentioned the utilization of programming that focuses on emotional intelligence. In fact, a participant details how emotional intelligence is used in conjunction with other modalities.

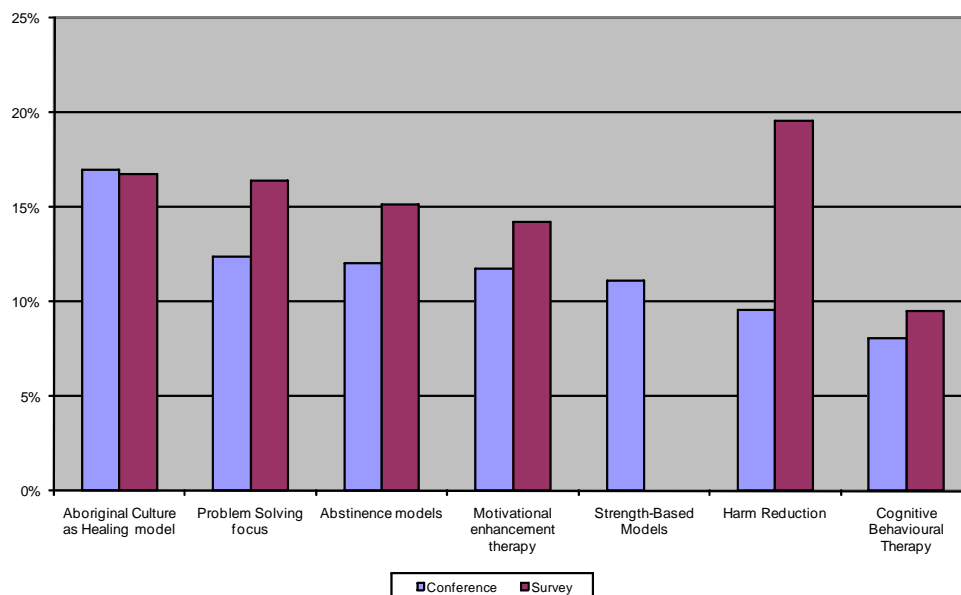
“I think where you have treatment centers with a combination of cultural teachings. From what I have seen, there is a specific one where emotional intelligence is being used.”

Emotional intelligence concerns the ability of a person to perceive, assimilate, understand, and manage their own emotions. The theory includes the awareness of and ability to manage one's emotions in a healthy and productive manner. It appears that such skills could have relevance in any modality chosen. However, this concept/construct was only mentioned by people in the south and the north regions of the province.

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Survey participants were asked to rank the effectiveness of the treatment modalities currently being used in programming and there top four responses were harm reduction, Aboriginal culture as healing model, problem solving focus and abstinence models (Fig. 5). Meanwhile, conference participants prioritized therapeutic approaches used with clients (from highest to lowest) in the same trend, although harm reduction was a lower priority.

Figure 5: Treatment modalities that are currently being used in programming

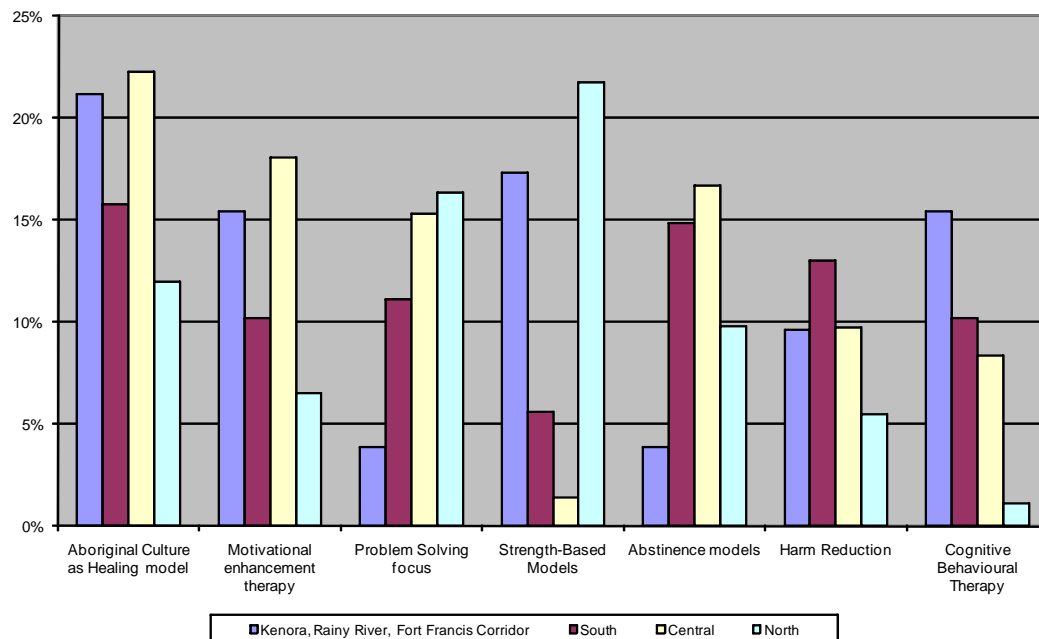


Conference participants from three regions prioritized Aboriginal culture as a healing model as the top therapeutic approaches used with clients and scored high for the fourth region. The top treatment modality used in programming in the north was strength-based models.

In Fig. 6 below, conference participants prioritized the top treatment modality as the use of harm reduction modalities in programming. They are employed mostly in southern First Nation populations in Ontario, according to conference participants. These results indicate they are not as widely used in the north, central or Kenora, Rainy River, Fort Francis Corridor regions.

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**Figure 6: Treatment modalities that are currently being used in programming
Conference Participants**



Integration of First Nation values, culture and language into Addictions Prevention and Treatment Services

The findings of this needs assessment indicate that Aboriginal values, culture and/or language are incorporated into community based substance abuse and addictions services using a variety of methodologies in a various combinations of approaches across the province of Ontario.

When asked if their addiction programs integrate any of the following First Nation cultural values and practices, survey respondents answered the following:

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	Yes	
Offer communal meals or feasts	33	91.7%
Restoring a sense of belonging through pride in identity, family, community and ancestry	32	91.4%
Restoring the wisdom of traditional teachings, practices and medicines that promote balanced health for the mind, body, heart and spirit.	31	86.1%
Providing opportunities to practice new ways of thinking, behaving and livings with others who are also committed to balanced health	31	91.2%
Offer/encourage smudging and/or sweatlodges	29	85.3%
Provide activities "on the land".	28	87.5%
Offer/encourage traditional medicines such as cedar, sage, tobacco and sweetgrass.	27	87.1%
Restoring the roles and responsibilities of men and women to resolve their own problems	27	81.8%
Restoring the roles of Elders to promote healthy living	27	81.8%
Provide "Circle" programs	25	80.6%
Speak in the First Nation language	23	74.2%

According to those that responded to this needs assessment several First Nations indicated that they utilized programming which included restoration and sense of belonging through pride in identity, family, community and ancestry as a methodology. Those that used this approach stated how healing is interconnected with the community and how the community comes together whenever a crisis emerges as stated here.

"Traditional healing means having a connection to the community."

"The entire community rallies around whatever needs to be done."

Several respondents also stated how that programming regarding self identity was incorporated because many Aboriginal people have lost their sense of Native identity. The following quotes from respondents point to this theme.

"I think a lot of them struggle with identity. They do not know anything about their culture and they are expected to know. If a teacher has a question about Aboriginal people, then they turn to the Aboriginal person. If they do not know of anything that makes them feel bad."

"Restoring pride and identity are keys to helping people combat addictions that is not necessarily based on ceremonies, rather teachings."

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The majority of participants in this needs assessment stated that they used the restoration of the wisdom of traditional teachings, practice and medicines that promote balanced health for the mind, body, heart and spirit as healing approaches to substance abuse and addictions services. Some of the statements made indicate that there is a higher success rate when Aboriginal culture and traditions are incorporated into the programming. Others indicate that even though they consider this approach successful, that Aboriginal culture and tradition as a modality is not valued and those offering these services are not paid adequately. The quotes regarding Aboriginal culture and tradition are noted here:

“I believe strongly there is an incorporation of Aboriginal values, language and culture, but I think that we are not valuing that enough, in terms of how we set up a funding approach.”

“I think that validating the place of culture and traditional approaches; paying for those services at par with mental health services.”

“Promote traditional cultural programs in the community- traditions life is alcohol and drug free to follow traditions/culture leadership needed and spiritual support person in regards to the cultural component in the program.”

Another approach that the respondents were asked about was whether they used the teaching about the roles and responsibilities of men and women in their programming. Some respondents stated how roles of men and women were fundamental for a community. Those that responded to this approach had the following comments to make:

“...the culture will ensure a sense of belonging and responsibilities to all community members’ roles of men and women.”

When asked whether their respective First Nation utilized the restoration of the role of Elders to promote healthy living many stated “yes”. Some stated they used Elders in everything they do and recognize the importance of Elders for cultural programming. Other respondents noted the shortage of Elders who know the teachings and can teach. Some of the comments made regarding the use of Elders in their programming are listed here:

“We have Elders as a part of most everything we do.”

“We need to recognize the substantial importance of traditional healers, people, Elders: the effect that they have.”

“I wanted to find out about my culture and I started talking to Elders and traditional people and got my identity and pride back which gave me the strength to keep away from alcohol.”

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Another approach that the respondents were asked about was: activities “on the land”. When asked whether the First Nation respondents utilized activities on the land as an approach to healing many stated that they did. It was found that the majority of programs that offer activities on the land were communities in Northern Ontario. Some of the quotes regarding this approach to healing were:

“What we are planning on doing is setting up a youth camp that will be very “basic” camp in the wilderness where young men and women can get away from the community to try to deal with the problem they have.”

“Land based programs are very much in demand but are not often availed of.”

“Whitefish Bay has a Life Skills program where they take youth into the bush to teach survival, learn from the land, etc. Youth love that.”

Another approach that the respondents were asked about was whether they offered/encouraged traditional medicines such as cedar, sage, tobacco and Sweetgrass. One respondent shared the impact that the teaching of tobacco had upon a client. The respondent’s comments are stated here:

“We have to make material recognizing that tobacco has a cultural component and our First Nations won’t be tobacco free – we may be tobacco wise.”

“For example, we had a youth woman returning to an isolated community where Christianity is very strong. She is constantly getting pressure from her brothers and friends to continue using. She said whenever she felt the pressure was too great and she found challenges in coping, she took her tobacco to the water. The strength was the power of prayer and we taught her the power of water as a woman. Over time, her mother recognized that she was doing something and asked about it. The mother and aunts then joined her. She was doing that on her own and then she had the support of the females in her community.”

“We go for nature walks – clean and free and enjoy the energy of life which is re-energizing life, we take them medicine picking, cedar picking, ask them to help build sweat lodge.”

When asked about the use of smudging and sweat lodges several communities stated that they utilized smudging and sweat lodges on a regular basis. Others commented on the impact that the sweat lodge has on the participants. The comments made regarding smudging and sweat lodges are listed here:

“Another thing she did in her community was that they decided it was time to have a sweat lodge. Somebody in that support group had land on an island, brought somebody from Thunder Bay to have a sweat lodge.”

“The youth at this program love going to sweats, are so proud of themselves. We get phone calls back saying, “I wish I tried harder, I miss going to the sweats.”

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When asked about using the language as an approach to healing many understood the importance of language. Others stated how the language has been lost and suggested the strength that comes with knowledge of Native language. The following statement about usage of language as an approach was made.

“Language is a big piece and to provide the therapy and support in the language and ¼ of our staff speak the language and these kids will be in an environment where speaking of the language is encouraged.”

Circle programming is also important for First Nation people. When asked whether the First Nations used circle programs within their respective community programming some stated that they used the medicine wheel teachings as tools. Others stated they used sharing or healing circles for their clients. Some of the comments made regarding use of circle programming are provided here:

“We use culture in the program: sweat lodges on Mondays, use medicine wheel, the spiritual room is available, and we smudge; teaching by doing with the cultural component – promoting and role modeling it.”

Other common themes that were noticed in this needs assessment were the use of Cultural staff as an approach to healing. In most instances staff was hired to undertake the planning organizing of cultural programming within the First Nations and/or organizations that they represented. Some of the comments made regarding the use of Cultural staff are stated here:

“We are fortunate to have a couple of staff members who lead a traditional lifestyle for many years and have a lot of knowledge in the area of different teachings.”

A few First Nations noted that they utilized a combination of Western and Aboriginal modalities within their community and/or organization. A comment that reflects this includes:

“This is part of our strategy planning that when possible there need to be integration between traditional and western practices and when working they tell clients they can be referred to traditional healer or be part of a traditional ceremony.”

Another common theme that emerged from the data was the usage of ceremonies as healing approaches. Comments regarding the use of ceremonies were:

“For example, youth coming out of fasting are so high on life. Their spirit is strong and nourished, they feel so good.”

“In utilizing Aboriginal culture values language we as Native understand there is no room for drugs and alcohol in our ceremonies and living with we learn about these ceremonies we are actually learning about ourselves.”

Literature Findings

This section look at the literature as it pertains to some of the areas of focus. It is not meant to be exhaustive but a means of highlighting what the literature indicates about the current situation regarding addictions in Ontario and other jurisdictions.

Demographics

Data from the 2006 Census reveals that the population of Aboriginal people in Canada has surpassed the one-million mark; 1,172,790 (3.8%) people identified themselves as either First Nations, Métis, or Inuit (Statistics Canada, 2008). Of this total approximately 256,000 Aboriginal people reside in the province of Ontario. 171,953 of the Aboriginal population are Registered First Nation members according to INAC in 2007. This represents approximately 22.1% of Canada's total Registered Aboriginal population (Ministry of Health and Long-Term Care, 2009).

In Ontario the First Nation population is young when compared to the rest of Canadian population. In 2007 36.1% of the registered First Nation people living on reserve were under the age 20. Correspondingly, only 6.8% of the registered First Nation people living on reserve where aged 65 or older (Ministry of Health and Long-Term Care, 2009).

In addition to the relative young Ontario First Nation population are correspondingly high fertility rates among First Nation women. Fertility rates for First Nation women in Ontario are significantly higher than for Canadian women. It was reported by INAC in 2000 that the total fertility rate (TFR) for registered First Nation women was 2.9 children. In that same year the TFR for Canadian women was 1.5 children, approximately half of that of First Nation Women in Ontario (Ministry of Health and Long-Term Care, 2009).

In 2006, 9.8% of Aboriginal identity respondents identified their mother tongue (the first language learned in childhood and still understood today) as being Aboriginal. A larger proportion (12%) identified themselves as having a working knowledge of an Aboriginal language. The most commonly identified languages were Algonquin, which includes Cree, Ojibway and Oji-Cree (Ministry of Health and Long-Term Care, 2009).

Alcohol, Drug and Solvent Use in Aboriginal Populations

The literature supports the participant's comments regarding alcohol as the most commonly abuse substance in First Nation communities. Dell & Lyons (2007) maintain that while the Aboriginal population has among the highest rates of alcohol abstinence in Canada, there are high rates of alcohol abuse; that is binge drinking and heavy use. This finding is confirmed in the 2002-03 First

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Nations Regional Health Survey report. The abuse of alcohol is the cause of many alcohol-related illnesses, injuries, and offences (Chansonneuve, 2007). However, Chansonneuve (2007) also notes that these instances are not necessarily related to alcoholism.

Alcoholism, a chronic and usually progressive condition, is the habitual and/or excessive use of alcohol (Chansonneuve, 2007). Alcoholism is now recognized by some as a disease, although it has been acknowledged that is a learned behaviour. According to a report from a 2003 Health Canada, alcohol (73%) was considered problems in First Nation communities.

The literature indicates that high rates of drug use also afflict the First Nation population. This supports the numerous comments provided by the participants of this study. According to a report from Health Canada (2003), drug abuse (59%) was considered problems in First Nation communities. Of concern is the emerging trend of 'crystal meth' in First Nations communities, and the connection between drug use and criminal activity such as gang involvement (Dell & Lyon, 2007). First Nation people suffer a morbidity rate from drug use almost three times higher than the non-Aboriginal population (Dell & Lyon, 2007).

There are high rates of solvent and inhalant use among Aboriginal youth. One in five Aboriginal youth reported having used solvents; and of these, one in three were under the age of 15 (Dell & Lyon, 2007). While solvent or inhalant use in First Nation communities has been identified as an alarming concern within both the Aboriginal and non-Aboriginal community, accurate and up to date information and data are not available on its prevalence.

Prescription Drug Abuse

A high priority mentioned by the participants in this study is prescription drug abuse. The Canadian Centre on Substance Abuse defines prescription drug abuse as, "any misuse or non-medical use of a controlled psychotropic pharmaceutical drug—that is, the use of a drug for something other than its intended medical or psychiatric purpose (for example, to get "high")" (CCSA). Prescription drug abuse is also the term commonly used to describe the excessive, chronic and harmful usage problems that some people experience with prescription medications. Individuals who take too much of these medications are said to be abusing medications. According to DSM-IV they can be classified under the diagnostic criteria given for substance abuse or substance dependence (addiction) patterns. The term "prescription drug abuse" is commonly used to refer to either or both groups and this often creates confusion (Floyd 2002). CCSA indicates that while most drugs can be used inappropriately, commonly abused medication include those that contain synthetic narcotics such as hydrocodone or oxycodone, e.g. Lortab and Lorcet, Percodan, Vicodin, Percocet, as well as Demerol, Dilaudid, codeine, methadone and Darvon-containing compounds. Morphine, while subject to the same potential for abuse as the others, is less commonly prescribed for routine outpatient use. Commonly abused tranquilizers are Valium, Xanax, Ativan, Tranxene and Klonopin.

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Sleeping pills (sedatives and hypnotics) that are sometimes abused include Dalmane, Restoril, and Halcion. Today older barbiturate sleeping pills such as Nembutal, Seconal, and Tuinal are seldom prescribed since they are extremely dangerous, causing possible overdose and being also highly prone to abuse (Floyd, 2002).

Chansonneuve (2007) notes the abuse of oxycondone as an emerging trend within Aboriginal communities. Intended to manage pain for terminal illness, it is increasingly being prescribed for non-terminal chronic pain. This prescription drug is highly addictive; tolerance develops quickly requiring higher doses, and within two weeks of regular use dependence can occur (Chansonneuve, 2007).

Prescription drug abuse is a relatively new issue with Aboriginal people and communities in Canada. A 2002 Calgary survey of a high-risk group of Aboriginal people entering addiction treatment found that 48% of respondents indicated that they used prescription drugs for reasons other than the drug's intended purpose. Dennis Wardman et. al. (2002) concluded that a high prevalence of inappropriate prescription medicine use existed amongst this population, and that the rate of inappropriate use was higher than in non-Aboriginal populations with addictions.

How addictive is it?

Opiate drugs are highly addictive and have the highest capture rates of any known drug. Some people can become totally addicted after just one use. Opiates cross the blood brain barrier and affect opiate receptors. When such receptors are stimulated, they produce analgesia and can also, when highly activated, produce euphoria. The theory is that the euphoria activates brain reward centers that make the brain say "I need some more of that". Further, it is purported that these pathways are also used to re-enforce normal behaviour such as eating, social interaction, exercise, and sex. However, opiates bypass normal regulation and can lead to problems. Eventually, the addicted individual can become a slave to the brain's desire for these drugs (Tessena 2008).

What is withdrawal like? What is the experience of withdrawal?

Each drug and each addicted person brings a different light to the experience of withdrawal. It follows that the nature and severity of withdrawal symptoms from drugs that cause physical dependence varies. In fact the experience of withdrawal varies according to the specific drug, the dose and duration of its usage, and the specific characteristics of the user (Floyd 2002). Withdrawal symptoms include restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps ("cold turkey"), and involuntary leg movement (NIDA, 2008).

Underlying factors

Participants were asked to identify underlying factors contributing to substance abuse. The overall health status of Aboriginal peoples is well below the national average (Dell & Lyons, 2007; Health Council of Canada, 2005; Mitchell & Maracle, 2005). The high prevalence of diabetes, circulatory diseases, and

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HIV/AIDS is well documented. Furthermore, there is a high rate of tuberculosis (TB) among First Nations and Inuit communities. The World Health Organization calls TB a “disease of poverty” (WHO 2008), and Health Canada links overcrowded housing with the spread of TB, stating; “First Nations communities with higher average housing densities have higher TB rates” (Health Canada 2008). The TB rate for First Nations people is eight to ten times higher than the general Canadian population (Health Canada 2008). A poor health status contributes to addictions.

Regarding provincially-specific general health surveys on First Nations populations, the most recent one for Ontario was conducted in 2001 (Statistics Canada 2006; MacMillan et al 2003). A startling statistic is that the majority of Aboriginal adults (57%) have been diagnosed with at least one long-term health condition. Hypertension (high blood pressure), arthritis and rheumatism were the most commonly reported chronic conditions, affecting over 25% of Aboriginals over the age of 15 while more than one in ten (11%) have been diagnosed with diabetes. This last figure is well above the diabetic rate for non-Aboriginals throughout Canada. Evidence suggests that rates of diabetes for First Nations are even higher on reserve (Statistics Canada 2006:41). Due to these health conditions, Ontario First Nations people rely on pharmacologies amongst other treatments to address their poor health.

Living conditions also play a role in maintaining a healthy life. Safe drinking water on reserve is a real challenge. The Ontario Ministry of Natural Resources released data from 2005 showing 37 of the 123 Ontario First Nations reserves (over 30%) have unsafe drinking water, some going back as far as 2002 (Assembly of First Nations 2007a:47). Air quality and overcrowding in the home are also major factors for Ontario First Nations homes as in the rest of First Nations in Canada (Assembly of First Nations 2007a:49; Statistics Canada n.d.).

Unfortunately challenges in health care and social problems lead to another serious issue for Ontario’s First Nations. A 2008 press release, by the Ontario New Democratic Party, quoted a report from the First Nations Chiefs of Ontario indicating First Nations youth in their province are committing suicide at up to 8 times the overall national rate (Ontario NDP 2008).

SUBSTANCE ABUSE TREATMENT THEORIES

Participants were asked to identify the treatment modalities used in their programs. Four common theories exist which attempt to explain the causes of addictions, and which most substance abuse treatment programs are based: the disease/medical theory, the social learning theory, the psychoanalytic model, and the family theory model.

Those who prescribe to the Disease/Medical theory view alcohol and drug addiction as a chronic, primary illness that has a 'no fault' element to it (Pearce and Holbrook, 2002). This theory contends that within certain individuals a physical or psychological condition prevents them from drinking or using drugs in moderation (Sunshine Coast Health Centre, 2008). Educating individuals and providing them with skills on how to live with this 'chronic condition' is a focus of the disease/medical treatment model, and patient abstinence from alcohol and drugs is encouraged.

In contrast, those who prescribe to the Social Learning theory view these addictions as learned behaviours, used as a means of coping with the stresses of life (Pearce and Holbrook, 2002). Modifying behaviour and improving coping and social skills is a critical element of this theory, with the goal of improving the individual's ability to function in a social environment through a pro-social behaviour model (Pearce and Holbrook, 2002). Unlike the disease/medical theory, abstinence is not the end goal. Instead, the social learning models utilize behavioural and cognitive modalities, such as restricted access, to reduce alcohol and substance abuse (Sunshine Coast Health Centre, 2008).

The Psychoanalytic theory maintains that, 'root causes' or deep issues are central to addictions (Sunshine Coast Health Centre, 2008). Based on psychoanalysis and used in a number of other disciplines, this theory is often criticized for its focus of addressing root causes and not on the 'imminent danger' posed by continued drug and alcohol abuse (Sunshine Coast Health Centre, 2008). However, a refining process of the theory has resulted in a number of modalities that are now making critical contributions to the treatment of addictions (Sunshine Coast Health Centre, 2008).

Finally, the Family Theory Model claims that the addictions of a specific individual cannot be addressed without first understanding the relationship with his or her family. Family Theory offers a wide variety of treatment methods, techniques, and interventions in which an individual's family members, partner, and friends are involved in the therapeutic process of treating an addiction or mental illness (Sunshine Coast Health Centre, 2008). Family Theory treatment modalities bring family members into the therapy process by providing support to them as well as the tools to support the individual in question.

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An emerging theory is the Biopsychosocial (BPS) Model that attempts to explain the “complex interaction between the biological, psychological, and social aspects of addiction” (Sunshine Coast Health Centre, 2008). The term is a combination of the individual factors that contribute to the model” biological, psychological, and social. A fourth factor, spirituality is also gaining ground, especially among clinicians and treatment providers, and in particular those in traditional addiction treatments (Sunshine Coast Health Centre, 2008).

Since its early incarnation, BPS has been expanded to reflect how factors such as genetic predisposition, learned behaviour, the need for self-medication, and family influences contribute to addictions (Sunshine Coast Health Centre, 2008). A weakness of the BPS model is its relative ‘youth’, and the model has yet to be integrated into a therapeutic model (Sunshine Coast Health Centre, 2008).

It has been shown that counseling services who offer a variety of treatment options have better success rates than those offering only abstinence-based programs (Korhonen 2004: 40). Harm reduction refers to any program, policy or intervention that has as its goal, the reducing or minimizing of adverse consequences of drug use. The key principles of harm reduction are: pragmatism, humane values, focuses on harms, balancing costs/benefits and the prioritization of immediate goals (CCSA 2008a).

It is asserted that the success indicators for abstinence programs are so strict that if a person begins usage again, even just one episode, the treatment is often deemed to have failed (Korhonen 2004: 27). Harm reduction programs are being seen as having a higher success rate as they reduce harms caused by substance dependencies. A number of NNADAP workers in particular indicated that they use principles of harm reduction in their programming.

2.2 Challenges and Gaps

Introduction

This section of the report will examine study findings particularly related to challenges and gaps regarding addiction prevention and treatment services for Ontario First Nations. The following themes will be discussed in this section of the findings: education and prevention; community and band council support; aftercare; community isolation; role models; continuum of care; pre-treatment; detoxification; rehabilitation; culture; flexibility of the system; changing face of addiction; prescription drug abuse; poly-substance abuse; mental health; training and staff pressures and lack of funding and communication. It will be followed by a synthesis of relevant literature on the topics presented herein.

Participant Discussion

As has been noted throughout this report, participants repeatedly emphasized that addictions intersects with social issues including sexual abuse, family violence and involvement with the justice system as well as mental health issues including anxiety, post traumatic stress and depression and economic determinants of health including poverty, poor housing, lack of education and employment opportunities.

Individuals

Many of the challenges highlighted by the participants can be organized within the four ages and stages of life. Participants acknowledged that the moment of addiction is not the only moment in an individual's life that needs to be examined. They stated that it was important to educate people before the thought of drug use occurs and to continue education people both through their lifespan and within a continuum of care model to reduce prevalence of relapse. Each age and stage of life carries with it particular challenges, roles and responsibilities that need to be considered when trying to understand the challenges and gaps something. One participant stated,

"[When] you look at the wheel...you start with the infant and it is the parents that have to be educated, they have to do all the work until they are grandparents; they need to recognize even as grandparents [they need to] help."

Infants/toddlers

Participants identified a gap in the long term research of the effects of drug addiction. Specifically, many people were concerned with the effect of prescription drug addiction on babies. One participant stated,

"We do not know the affects of opiates (oxy, percs and methadone) and drugs for our children – what will we be dealing with ten years from now."

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In considering the effect of these drugs on babies, many of the participants were looking ahead to the possible addiction and medical challenges of the future.

Another challenge identified by the participants concerning this first and highly vulnerable, stage of life is the lack of services for First Nations women who are pregnant and addicted to drugs. While programming is available to infants and toddlers through the Aboriginal Head Start on Reserve program, Brighter Futures and Aboriginal Healthy Babies Healthy Children, there is concern that First Nation pregnant women are less likely to access pre-natal and nutrition programming. There was further concern expressed that they might not disclose substance abuse. The overall concern expressed in this study is that there are simply not enough resources invested in the prevention aspect, which is a fundamentally important when addressing addictions in First Nations communities.

Children/Youth

Many of the respondents were quite focused on the youth and the lack of programming and services that exist in First Nations communities. This second stage of life is a time of experimentation in which many First Nations people first try drugs and/or alcohol. The participants spoke of many challenges relating to First Nations youth. These challenges concern the programming and education available to the youth before they contemplate drugs, when they are contemplating and experimenting with drugs, and when they have become addicted to drugs and/or alcohol.

The participants generally spoke of a lack of activities in First Nations communities that could occupy the energies of the youth. They feel that the lack of programming frequently leads to boredom. In addition, there is a great deal of peer pressure among youth to experiment with drugs. One participant stated,

“That is a huge gap in our community for ages 12-17; there is a real lack of services in the evening and the weekends.”

The programming that does occur is sporadic and infrequent. Due to funding, staffing and other issues, some programs will begin and then disappear within a year. A participant stated,

“[the] Gap is with the youth, many times I heard there is nothing for youth in communities, when programs do come along, it is good for a year but then people leave the job or they are less interested in their job and the program fades.”

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At the same time that communities identified lack of programming as a concern that might lead to increased substance abuse, young people indicated that even if programming was available they would not attend. This indicates the need for a real motivational hook to engage these otherwise apathetic teens. There was an emphasis placed by participants upon the positive effects of First Nations cultural programming. Many people stated that reconnecting the youth to their cultures and identities would keep them busy but also help them to understand who they are as people, which would encourage healthy behaviour.

Degrees of Use Substance use falls on a continuum based on frequency, intensity and degree of dependency:	
Experimental	Use is motivated by curiosity and limited to only a few exposures.
Social / Recreational	The person seeks out and uses a substance to enhance a social occasion. Use is irregular, infrequent and usually occurs with others.
Situational	There is a definite pattern of use and the person associates use with a particular situation. There is some loss of control, but the person is not yet experiencing negative consequences.
Intensive	Also called “bingeing”, the person uses a substance in an intense manner. They may consume a large amount over a short period of time, or engage in continuous use over a period of time.
Dependence	Can be physical, psychological or both. Physical dependence consists of tolerance (needing more of the substance for the same effect) or tissue dependence (cell tissue changes so the body needs the substance to stay in balance). Psychological dependence is when people feel they need to use the substance in particular situations or to function effectively. There are degrees of dependence from mild to compulsive, with the latter being characterized as addiction. Source: Kaiser Foundation

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Participants spoke of the need to educate the youth when they are pre-contemplative. According to many, this puts the age of exposure to the dangers of drugs and alcohol at about 8 years old. It is at this age where the youth should start to become aware of the impacts of using drugs and alcohol but also the long term medical effects of addiction.

Respondents identified a large gap in services available for youth who are in trouble and who are addicted to drugs and/or alcohol. One participant stated:

“There is no place for teenagers today that are in trouble and in need. This is a gap. I do not know where they can go.”

People mentioned the need to catch the youth, if possible, before addiction sets in. There is a gap in services surrounding counseling and programming when youth are facing tough circumstances. Frequently, the family situation for many youth may be toxic but there are few services that the youth can depend on to help them through these times.

The youth are also able to legitimately access prescription drugs. One participant stated,

“Most of clients we deal with there would be some who would have developed addiction through legitimate prescription but the majority are young people ages 8-12 who are starting out and are not responding to injuries. It links to issues around prescribing practices – NIHB and what they are allowed to cover and 8-12 year old kids having access as a result of prescriptions in the community.”

This can lead to problems of not only addiction, but these drugs put the youth at risk for being targeted for the prescription drugs.

Once the youth become addicted, there continues to be a lack of services and treatment centres available. Participants stated,

“There are lots of gaps in terms of youth services. There are youth solvent centres, but because there is such a shortage of youth treatment that is not solvent based, they also need to take youth struggling with other addictions.”

“There is the whole component for youth that is missing – it is limited where you can send youth for treatment – and yet we are supposed to deal with addictions – the continuum of care needs to be looked at and we need to fill in gaps – so there is enough space for everyone to go who needs to go.”

Many people spoke of the need to have youth treatment centres available but also the need to have these services be culturally appropriate. One participant stated,

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“We have no facilities for young women – I had to take a young girl to Barrie – we need a facility that will allow workers to wait with our people, facilities that are culturally appropriate – where we can sign songs, practice our culture.”

Another challenge identified by many participants in regards to youth is the intervention of the youth justice system. Many youth who begin to enter this system have an addiction to drugs and/or alcohol. However,

“The youth justice system does not recognize youth drug or alcohol addiction – an entire step is missing...there are resources out there but they are not geared toward native people – nothing appropriate for Native people and that can pose barriers”

Once in jail, participants stated it is much more likely that the youth become more addicted to drugs and become involved with gang activity. Upon their release, then, these youth can be heavily involved in many aspects of the drug trade in their communities.

Young Adults/ Parents

The third stage of life involves the youth growing up and taking on more responsibility. People begin to have children of their own, to look after themselves, and begin to be in charge of the community.

An overwhelming challenge mentioned by many participants is the lack of family treatment centres. The parents that are addicted to drugs and/or alcohol can feel torn between receiving the help they need and looking after their families. Parents are concerned with leaving their children with family members they may not trust or with losing their children to the child welfare system. These fears can prevent people from seeking treatment. Participants stated,

“These families are separated and these kids are cast into the child welfare system because we are unable to meet our fiduciary obligation to offer strong prevention and treatment services to families.”

“You have people like single parents with three kids that cannot go to treatment for six weeks. There are lots of single moms, so they end up losing their kids because they do not have appropriate treatment support.”

Solely focusing on the individual within treatment is inconsistent with First Nations family and community values. If the individual has an addiction then it is not only the individual that suffers but their family as well. If people choose to wait to get treatment, then the damage can be much more severe. In addition, the children are exposed to their parents' addiction for much longer. Participants stated,

“Family based treatment programs are missing – many mothers do not want to leave their children, put their children in care and it's the entire family that needs to heal.”

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“[There is a] significant gap around providing support for women with addictions and with young children because the system does not provide support around children care and they access treatment much later in their addiction after much more damage has been done. Often for women to access treatment, they do not have safe child care options within their own family situations.”

When people lose their children to child welfare due to addictions, this can be the impetus for entering into treatment. However, some participants mentioned that this move can be misleading. There is a difference in how you choose to come to treatment. One participant stated,

“People go to treatment for a variety of issues: some want a real life change, others are mandated, others may want to get kids back and their heart is not in the treatment programs so they relapse.”

Another challenge for people in this life stage is that when they consider going for treatment they fear they may lose their job. Due to the economic climate in First Nations communities, those people that have a job will consider treatment a liability. Though it may be better in the long run, treatment can last for two or more months and there is no guarantee their job will be waiting for them upon return. One participant stated,

“Also there are so few jobs whether their job will be there when they are back or who will look after their children and family while in treatment is a barrier.”

Participants also spoke of the need to make parents in the community more aware of the different treatment services that are available to them. It is important to let people know that they are not alone and that there are support networks available. One participant stated,

“We need to get out there in community and put the awareness out there in order for youth and adults to become involved – show them we are there for them to support them.”

Overall, participants spoke of a programming and education gap for people in this life stage as well. Parents who have substance abuse issues are difficult to reach. There are community information sessions and some workshops available but attendance is low. One participant stated,

“The ones who do not need it go to workshops to support the facilitator, but the ones who do need it do not go.”

Grandparents/Elders

In the last stage of life, Grandparents/Seniors/Elders face specific challenges in regards to substance abuse.

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Many participants stated that as older people, nearing the end of the physical journey, they are more prone to illness, accidents, and poorer health in general. As a result of the physical inevitability, many doctors prescribe a multitude of medication for older people. These prescriptions can include addictive medications such as oxycondone and other opiates. One participant stated,

“It is more common for the doctor to prescribe pills for older people.”

One of the main challenges identified by participants was that people in the fourth stage of life are at risk for being bullied by their children and grandchildren for their prescription medications. This is a very dangerous place for seniors and elders to be in.

“Some elderly people have their grandchildren blackmailing them into giving money or prescriptions – they will go without.”

“Participants mentioned that in some communities, there are youth waiting outside of pharmacies to steal or buy the drugs which the senior/elders have just picked up.”

In addition, some seniors/elders face challenging economic circumstances. Some participants mentioned that elders/seniors may be tempted into selling their medications to help them survive. One participant stated,

“There seems to be more pressure on elders to share or to give away their prescription and their old age pension money.”

Community

The community is the support network of individuals. In First Nations worldviews, the community is at the heart of the nation, supporting and nurturing the individuals. However, much of the treatment for addictions is very individually oriented. The individual usually must leave the community for treatment and then will return when they have completed the initial rehabilitation. Almost all participants spoke of the need to involve the communities in the continuum of care in order to sustain addictions-free living. Without the support of the First Nations communities, individuals will relapse. For participants, many felt as though their work in the treatment centres would be amplified if the communities recognized their necessary role in supporting individuals trying to heal.

Community support suggests a broad range of possible activities. Participants identified challenges within Band council support, role modeling, location and availability of services, and support for addictions-free living.

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Band Council Support

Participants spoke of the challenges of doing their work without the support of the band councils. Many participants wanted to see the councils acknowledging addictions as a priority in their communities. However, not everyone is ready to admit that addictions are rampant. One participant stated,

“I see a lot of the community members sticking their heads in the ground.”

Support from the band councils may take form of education, physical resources, and a commitment to change behaviour within communities. One participant stated,

“What I hear from community workers is that they do not have adequate support – from Chief in Council, community, etc. They might not necessarily have the support, backup or resources.”

In addition, participants identified the challenge of keeping drugs out of the communities. Many placed this squarely on the shoulders of the band council and local law enforcement. The participants stated that more needed to be done in this realm; they suggested band council resolutions and enforcement of by-laws around drugs and alcohol. Participants stated,

“If there is not someone willing to go to court to testify the legal system has nothing to go to court with – the community reality is there are lot of drug dealers who are family members, police and leadership are related and unique circumstances – perpetuates the sickness/cycle.”

“The police are unable to enforce everything, which is based on the laws. We can identify the drug dealers, but they need to be able to see this happen before they go in. Their hands are almost tied.”

Participants acknowledged that without the support of the band councils cracking down on drugs and alcohol, their work was simply a band-aid solution. They did acknowledge the inherent difficulty in creating and enforcing band council resolutions and trying to stop the drug trade and its associated crime. One participant asked,

“How do you expect to stop drugs coming into the community?”

Without the support of the Band councils, preventing drugs from entering a community is extremely difficult.

Support for Addictions-Free Living (Aftercare)

Participants maintained that in order to ensure success of individuals receiving care, the community needed to participate in the process. This means that upon returning to the community, the rehabilitated people should have a place where they can go to continue practicing the things that they have learned. Frequently, people that have been rehabilitated are sent back to their

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communities and are placed into the same environments that they left. This can serve to break down the lessons learned at treatment centres. The participants maintain there are high degrees of relapse in these cases. Participants stated:

“It is the environment around the youth that does not necessarily support their aspirations. If they go back to the environment, there is nothing to support that...Resiliency theory; there are no isolating factors in their environment to help maintain their resiliency”

“You are on such a high when you leave here thinking “Life is great” feeling empowered, but when you go home you realize you have changed but the community has not. As fast as it was there, it is gone”

Participants stated that a dedicated transition home in every community, a place of sobriety, would help immensely in these situations. In a transition home, there would be people of a similar mind, with similar struggles, who are dedicated to living the lessons learned in treatment. It also gives people a safe place to go and relieves some of the anxiety about returning to the community.

“lack of transition homes, they find they have potential in their lives and when they look at what is available to them in their community – they have fear about going back and lack of support from family and community when they go back... they don’t want to go back to their community so a transition home to help them continue is needed – it’s a big decision is you commit to a life of sobriety that you may also have to commit to leaving your community”

In addition, participants mentioned that families within the community need to be educated about what an individual has experienced within treatment and what kinds of supports they require upon return home. Participants discussed the importance of family support to the aftercare of an individual who has completed treatment. Participants stated,

“If you are in a program that takes 2 months, six weeks, how can they be put back into their community with the same peers, issues – the follow up isn’t there...it’s like icing on the cake to say we will help the person, but the family needs also has to be dealt with and their problems...it’s a community issue – if someone from the community has to be treated, there is a need for info sessions for community and family to educate them on how they can offer support”

“Our worldview and communities are about family and community; so why do we not have equal resources for family and community, using processes that make sense to them. It can blend appropriate Western therapies with cultural ones”

Participants discussed the need for informal networks and understanding within the community, but also the need for a more formal support system in place for people returning from rehabilitation. Participants spoke of a formal support system as part of the aftercare of individuals but also as part of the community. It would function to provide education and resources to all community members.

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Many people said that when an individual leaves a community for treatment, the family and community are impacted and these impacts need to be acknowledged and supported. Participants stated,

“Our communities still work in silos and do not do case management. We have to help communities to break down those silos; this is a part of after care. To be able to say “this is how we are impacting the family in these different regards” and how can we collaborate to better meet these needs”

“I think we need to look at funding a secondary support system, a network, in those specific areas that communities tap into. The community resources need to be focused the more positive prevention aspects; working on reconstructing the family, working with the young people, working on ensuring that communities have access to secondary support networks, ensuring that those professionals or secondary support networks have an understanding of the community and their unique challenges.”

One concern mentioned by the participants regarding care within the community was privacy. In small communities, secrets are difficult to keep. It is a challenge to persuade people to use the resources that do exist within some communities, as a lack of privacy is assumed.

“because of the size of communities and everyone knowing each other – they don’t often go for help because everyone knows what you are doing – if you ask for help – right away people know and you don’t want everyone knowing – they don’t want to be seen as weak by needing help.”

“I hear in my position that a lot of clients are apprehensive for going back to their communities because there isn’t anything for them and the fact they don’t trust some of the workers in their community because of confidentiality.”

Location

Another challenge mentioned by participants was the overall location of the community and what resources are available to it. Specifically this relates to resources available, transportation back and forth from treatment, and keeping people within the community.

In the north, it is more expensive to live and much harder to receive any services. Participants spoke of how much more difficult it was to create support networks of people within the communities of the north, when they are harder to access. In addition, individuals looking to find support networks outside of their community have to travel very far in order to receive treatment. One participant stated,

“if you are in Moose Factory island and have been through treatment, and looking for aftercare you have to take water taxi for aftercare – and cost is prohibitive and if on welfare can’t afford it – then in winter it freezes so that’s not available”

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Transportation, on a whole, was mentioned as a large challenge to overcome. Though geographically the north has accessibility issues, funding for transportation for clients coming home early from treatment is not easy to get. Frequently, individuals can get to treatment but their way home is not covered. Participants stated,

“We put them on buses, so if they fail they do not have transportation home. They have to find their own way and are not reimbursed.”

“Yesterday we did graduation for intake – and one man couldn’t get home – medical services wouldn’t pay for him to go home because he paid his own way to get here – he was so eager and willing to come for treatment, they wouldn’t pay his way home”

Participants stated that it was challenging for communities to continually send individuals away to treatment. Some people saw this as running counter to the creation of a cohesive, healthy community. Many community members identified the need to set up a treatment centre in their own community, which would solve the issues of sending community members far away and the cost of transportation. Participants stated,

“We need to put respect back in the community instead of taking away life”

The frustrating part in prescription drug abuse or solvent drug abuse is the lack of treatment options available. Right now, everybody seems to want to go off on their own. We have three communities that want to set up treatment centers for prescription drug use. From the government side, that is not feasible in the long run. The frustration has pushed the communities to the point where they want to do something on their own.

Role Modeling

Another challenge identified by the participants was the lack of role modeling within communities. Many participants shared stories of people in leadership roles within the communities, such as Chief or Council members, who have addiction issues. Participants saw this as countering their work at treatment centres, as the communities need to have people in visible roles that will set the standard. In addition, participants discussed isolated incidents whereby individuals in trust positions, for example counselors or NNADAP workers, may abuse substances and offered to buy drugs and/or alcohol for clients. Participants stated,

“The NNADAP program where I come from in 2004 all of the organization attempted to meet to deal with issues and I have been focusing on the administration component – I know for a fact there are three staff members using on the premises and they were not dealt with – many of my clients say they can get their drugs off the administration personnel who go on road trips – the partying that goes on with the Chief and Council system and our administration

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helps conduce this activity and these people continue to be employed in our environment”

“Many stories from Band members up to the Chief of the nation using – stories like my counselor ran out on me because he wanted to get drunk – where is leadership and role modeling”

Some communities have created policies which recognize that to be a leader within a community is to be a role model. Participants suggested that drug testing should be mandatory for all people in role modeling positions. This includes band council and counseling positions. Participants stated,

“One of the challenges at leadership level is to try and implement drug testing for all employees in the community (doesn’t matter if you work for Band, Rainbow Lodge, nursing home, etc.)”

“Some communities have ‘zero tolerance’ which means you can’t be in a position of authority/leadership and use at all – you can only be a leader if you are going to be a role model”

Continuum of Care

The continuum of care refers to the entire process of different levels of treatment that occurs once a person decides or is mandated to go to treatment for their addictions. Many of the participants felt that though they struggle to provide a holistic understanding of health, the delivery of different aspects of treatment is quite isolated from one another. On the whole, this is where many of the challenges lie. This is compounded by the fact that many treatment centres and workers, across the continuum, are constantly in crisis mode. Participants stated,

“I think the whole system of treatment centres and detoxification has to change. We are not the little machine where you push one button that addresses one piece of them.”

“We have been focused on crisis in NODIN – they are in a crisis mode so when a person shows up there isn’t a plan of care established – they see people two or three times and that’s it and you can’t help people – we are trying to turn NODIN around into a long term agency”

All participants agreed that Addiction prevention and treatment services must address a continuum of service which would include prevention (education and awareness), early intervention including a thorough assessment of client needs (complexity, stage of addiction, diagnosis of concurrent disorders) a full spectrum of treatment that includes /withdrawal management, pretreatment planning and support, individual, family and group counseling, residential treatment, transitional counseling, and aftercare. This continuum of care is currently not funded or available for Ontario First Nations.

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Pre-treatment and Detoxification

All of the participants expressed frustration at the current state of the pre-treatment process. Before a client enters a treatment centre, he or she may have had contact with different parts of pre-treatment. This includes assessment, referral, and/or withdrawal management.

Many participants felt that the assessments that are required of the clients are not culturally appropriate for First Nations people. They do not take into consideration the wide array of emotional issues that can feed into addiction. Participants stated,

“Assessments the government is putting out are not adequate for our people because they don’t include the feeling component: boredom, anxiety, loneliness that people with addictions feel”

“ADAT assessment – one of our long term plans is to talk to CAMH and determine whether it’s culturally relevant and it’s something Health Canada can do – an assessment that satisfies the provincial treatment centers as well as being culturally relevant”

There were many challenges within the referral process identified by the participants. Frequently, the workers who undertake the referral in the communities are not able to provide the treatment centres with all of the necessary information. This information can be crucial to things like detoxification in poly-substance abuse cases or concurrent disorders. One participant stated,

Training needs to be conducted in other communities for NNADAP workers that are doing referrals. When we take fly-in clients, we only have the history they provide. It is important for the referral agencies to be aware of the clients and the drugs they are using. We need a better referral process and information provided for intake; a better pre-treatment is needed.

Another challenge within the pre-treatment process is the detoxification program. Many participants identified large gaps in service available to clients. The process is integral to a successful treatment program and without a specific place to go for detoxification, the process will take place at the treatment centres. The treatment centres are not equipped for detoxification and in a four week program, half it may be spent getting the drugs out of one’s system before the actual rehabilitation begins.

Participants expressed frustration in the amount of time it takes to enter into a detoxification program. One person stated,

“They have to make an appointment to get into detoxification to start a tapering program which is about a month or two wait and that’s a gap”

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In addition, the detoxification process is not equipped to handle poly-substance abuse, concurrent disorders, or methadone treatment. The need for the presence of medical professionals in detoxification, who are familiar with drugs, addictions and mental health, was voiced by many participants. Many of the detoxification centres that do exist are not accessible by people in remote communities and they are equipped to handle detoxification for alcohol. All participants stated that the detoxification process needed to be longer, especially when dealing with drugs, poly-substance abuse and concurrent disorders. Participants stated,

“At the front end you have issues with detoxification, especially poly-substance abuse. They might need 6-weeks for medical and stabilization to get them ready for treatment. I have heard of clients shifting from one detoxification centre to another just to keep them dry. They lose people in the pre-treatment component.”

“Depending on where they come from, there may not be many resources, those in remote won’t have access with withdrawal management, they may have to do withdrawal management with a nurse practitioner and that may not always work...it’s hard for them to have a client fly to bigger city for withdrawal management because withdrawal management will only keep client for 3-5 days and if they need longer they have to be transferred to another facility”

“In general people are not encouraged to stay as long as they need to stay in detoxification – people are shuffled out quick and do not have treatment plan or assessment process in place. There is a high demand and not enough beds, space and they cycle people through and people come back reality is they are in detoxification for a few days and then have to wait minimum of four weeks in community without any support to get into treatment”

As well, participants highlighted the need for a pre-treatment plan. Success at treatment is enhanced by the client receiving knowledge about what will occur in treatment, what they can expect and what will be expected of them. These plans are not set up as often as they should be and, according to the participants, it can be detrimental to the treatment that follows. One participant stated,

“We need a very structured drug and alcohol treatment program, where clients know exactly what they are going to do each day sets them for success...Building a treatment program before entry is needed”

Rehabilitation

The challenges present in the rehabilitation stage of treatment revolve around availability of appropriate centres, clients coming from jail or court-ordered, and wait times.

One of the challenges identified by the participants is that there are not enough appropriate treatment centres available. Many people identified the lack of services available for youth or pregnant women. In some cases the youth oriented facilities that do exist are specifically solvent abuse based. These

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centres are able to take more clients, because they do not operate at capacity, but they are not mandated to take other addictions cases.

In addition, many people spoke of the challenge just to get into a First Nations rehabilitation program. The wait time between referral and entry into the program may be months, with no support in between. The treatment centres all have different requirements for how long a client must be substance-free and coupled with the long wait time to entry, clients may not be substance free upon entry. Participants stated,

“It is hard to get into rehab programs – there is no 1-800 # to get help and get into a First Nations facility”

“Pre-treatment continuum is lacking – referral may come in two months and during that two months there is no contact with client and when it comes time for treatment, the client gets on the bus and they may have used the night before”

The long wait times for rehabilitation programs are generally due to the overwhelming need for treatment. However, clients who are mandated to come to treatment by the courts can sometimes take the place of people who choose to come. In many of these cases, these clients come straight from the jail or hospital, without a full detoxification, and they cause a variety of problems. One participant stated,

“We could easily have a full intake without the court ordered clients – some of them are Treaty 3 and they take priority over other areas – they get priority over someone who wants to come or is more willing to come”

After Care

After care is an important part of the treatment process. It is a vulnerable time, after a client leaves the treatment centre and returns to their community. Frequently, they are returning to the same situation that they left. People in this situation are prone to relapse and the communities have little resources in place to support them.

NNADAP, as the workers within communities, are the ones who make many of the referrals to treatment centres. However, they are not funded for aftercare. The participants referred to their frustration, as they believed that NNADAP should be involved in the entire process but that they would be instrumental in helping a client to re-adjust to community living. Participants suggested that there needs to be formal support networks in the community to provide counseling, a recovery house, and other activities that supported sober living. Participants stated,

“For the after-treatment, I do not think we have good enough connection between treatment centres and people at the community level with post-treatment plans in place. There are different expectations of what the NNADAP worker should do at the community level, and vice versa”

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“Many people who have gone through treatment have left the community and there is no one in the community to support anyone – we as NNADAP workers do not know where they are or where they go. It is detrimental to NNADAP program or the other issue is they don’t even come through us because they get approval by Chief and Council and then they do not involve NNADAP in aftercare”

“We have no idea what resources are for after care –the clients tend to fade out once they complete we have no idea what relapse rates family needs to be more involved in aftercare – they go back to same environment and home (e.g., mom did treatment and dad is still using) aftercare should be part of case management and following along to work with them on that”

“If you have a problem and have already gone through the system and need to talk to someone there is a lack of “meeting the client where they are at”, continuing encouraging and supporting them and not judging when they make a mistake”

Culture

Participants discussed the necessity of including culture at every step in the treatment process. Many stated that including culture in a piecemeal way is a very surface approach and not indicative of holism. Culture needs to be included continually in order for it to have an impact on treatment. Participants stated,

“I come here and they are doing the “Feather and Buckskin” approaches to culture. I am trying to get through to my supervisors that you need the culture at the core and everything else will work. The medicines will work with the doctor.”

“Here they have a traditional approach to treatment (sweats) but they need to tie in cultural with aftercare programs and services – helping continuing with reclaiming who you are; find more traditional ways of offering promotion/services/healing and treatment”

Many participants discussed the positive effect that culture can have upon the treatment process but they also recognized that the revitalization of culture is quite important before people even get to treatment. Culture as part of prevention strategies was also highlighted as important. One participant stated,

“Work with people before crisis – cultural teachings – using sweatlodges and pipe and the connection to the land”

Frequently, the 12 step program is used. Participants spoke of the challenge of making the 12 step program culturally relevant to their clients. Some stated that they searched for a program that was cultural at its core, rather than augmenting the 12 step program to fit First Nations clients. Overall,

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participants spoke of the relative success of pairing the 12 step program with cultural elements. One participant stated,

“Integrating culture with the step 12 program – they work together if you work them together; if you just use 12 steps without culture, you will get lost”

There are inherent challenges in integrating culture into treatment programs. One of these challenges is the presence of Christianity. There are many First Nations people that are Christian and want to continue to practice that while in treatment. Due to different historical and current experiences with Christianity, not all First Nations people feel comfortable with Christianity. In addition, not all First Nations people feel comfortable with traditional spirituality. One participant stated,

“One individual who came here wanted to go to church and because of the state of the program, everyone had to go to church and that upset many of the other clients because they were forced to go to church and that person who wanted to go to church wouldn’t go into the healing lodge – mutual respect wasn’t there for that individual”

Another challenge for the integration of culture within the treatment process is the ability to represent the cultures of many nations. Treatment centres have intake from all over Ontario, which is traditional territory of the Haudenosaunee and the Anishnaabeg. The responsibility falls on the treatment centres to try and respect the nations from which their clients come and incorporate the culture of each as best they can. One participant stated,

“You have different people coming from different places; Cree, Ojibway, Mohawk, whatever. You have to collect all types of information for all types of nations”

Participants also noted that there is a need for additional recognition for traditionally trained and experienced workers. The lack of appropriate remuneration for their specialized skills makes it challenging for these people to support addictions programs on an ongoing basis as they are so highly in demand. Although federal spokespeople note they fund traditional healers, most programs and centres felt that not enough is done to fund a “traditional healing” approach.

Flexibility of the system

Another theme highlighted by the participants concerned the flexibility of the treatment system. Due to restrictions placed on centres by their funders, policies and self-imposed mandates, many individuals who need treatment can fall through the gaps. This can apply to treatment centres being flexible enough to incorporate new drug addictions as they arise. One participant stated,

“If you took all oxy off the street today, there will be something to replace it and while it has unique characteristics, having some type of plan to assist

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communities regardless of the drug is needed and helping communities understand that is needed; many communities just want a “fix to the problem”

The flexibility of the treatment system is challenging when a client relapses. The system is not able to take into account that an individual may have already completed the program and, due to a relapse, requires something different to help them. Relapses are a fact of addictions care and the only option for a relapsed individual may be to repeat the exact same program they completed before. Participants stated,

“We have seen people that have been to other treatment centers and need treatment again – so we try to tailor the program differently but people will work through the same steps”

“When we look at success rates, it’s difficult to determine success rates in addictions treatment because relapse rates are very high and you always have to provide an opportunity – if your service can sustain it – to allow clients to come back if that’s what they need...an abstinence based model can work – it sobers you up but it’s been my experience that it can only take a person to a point and then there is a need for something else

Changing face of addiction

Another prominent challenge mentioned by every participant was the changing face of addiction. In recent years, prescription drug abuse by First Nations people has been on the rise. Many of the existing treatment centres and the staff are set up for alcohol and standard drug addictions. Addictions to prescription drugs are different than alcohol and drugs, and the process of treatment may not always look the same. In addition to this challenge, many of the participants discussed the difficulty of poly-substance abuse and concurrent disorders.

Prescription drug abuse

Due to the recent rise of prescription drug abuse, there are gaps in the research and treatment literature. The participants, who are frequently front-line workers, are sometimes overwhelmed by what they encounter in their clients. Though the participants had received some, all at different levels, of training in regards to prescription medications, they all felt that it was not enough. What works for alcohol does not always work for oxycontin. Many participants spoke of the need for treatment centres that are focused solely on prescription drug abuse. Participants stated,

One of the barriers of prescription drug abuse is that it is something new. The answers really aren’t there. That is the biggest problem to me; people just don’t know what to do.

“I think a lot of our treatment centres are geographically focused. They were really put in place for alcohol. The staff has done some work around training and supporting them around emerging trends, we do not have any expertise for the things that they are seeing”

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The challenge of keeping up with the changes in drug abuse in communities extends to every part of the treatment process. Many participants pointed out that the time frame and medical needs of the detoxification process is much different when dealing with prescription drugs. The participants stated that the current detoxification centres, while doing what they could, were not set up to deal with prescription drugs either. This impacts the entire treatment process.

Poly-Substance Abuse

Another challenge mentioned by the participants was that individuals can develop addictions to prescription drugs, other drugs, and alcohol at the same time. Many of the treatment centres are not set up to deal with people coming off of poly substance abuse. Participants stated,

“There is nothing to address youth, multi-drug use – they progress to drug addiction within six months compared to a person who drank heavily for 10 years before becoming addicted – there is nothing to address is and lack of knowledge that this is happening”

“We have had some meetings with Health Canada and we are stressing the need for changes in our delivery system and they keep having us come back to the mandate of solely addressing alcohol and drugs but here at the Centre it goes beyond that, far beyond that”

Methadone clinics are another challenge that impacts poly-substance abuse. Participants were of two minds concerning methadone. Some felt that methadone clinics were necessary to help wean people off of heroin and opiates and that there was discrimination against people on methadone. Once again, these participants stated that detoxification centres and treatment centres were not set up to handle people on methadone. Other participants felt that methadone was being worked into the landscape of abuse, used along side of many other drugs and there was not enough counseling that occurred around it. One participant stated,

“When methadone started to become more available in First Nation communities and towns near First Nation communities – communities were desperate for a solution and saw methadone as a solution but a lot of people who started using methadone stopped using opiates but are now using crack cocaine”

“NIHB is paying for the drug and transportation for the methadone program. But if you look at the policy, it wasn’t strong enough on the provincial end. There should be some counseling support but it does not state a minimum time, so it is not happening. They are asked to fill out a piece of paper; a lot have not even spoken to the provider”

Another challenge mentioned by the participants is that the changes occurring with drug abuse are not simply with the drugs themselves but also the manner in which they are taken. People are finding new ways to take different drugs in

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order to maximize the high. This in itself can have a number of different effects on a person. For the participants, these trends are difficult but necessary to keep up with.

“The changing landscape of drugs use to opiates and crack has been very rapid – I cannot believe the explosion and methodology of use and risk taking within the drug culture (IV using pregnant women) and it’s now more common within the last 3-5 years”

Mental health

The presence of concurrent disorders was a prominent challenge discussed by the participants. Staff of treatment centres are trained to deal with alcohol and drug abuse. Their knowledge is limited concerning issues of mental health. Many participants stated that there is a need to know more about mental health, how to interact with them, and the drugs associated with particular illnesses. It was also mentioned that not enough research was being done into particular drug interactions in cases of addictions. This can become especially important during the detoxification phase. Participants stated,

“The issue that I see is that some people feel they have a lack of knowledge to accommodate someone with mental illness or diagnosis we aren’t fully aware of treatment”

“The abstinence model – the 12 step model- doesn’t work with some clients, especially those with concurrent disorders. “

“I see myself and my staff needing more training in mental health. We do not have the training and experience, we only see it. We want to know how to help teach them to cope”

Participants also mentioned that some centres will not take people who are on medication for mental health issues. Some participants spoke of this in terms of safety and general knowledge. Other spoke of it in terms of discrimination. While still others spoke of it in terms of the understanding of the clients and possible tensions that could arise. One participant stated,

“I think we need specialized service around mental health support...There are a number of people on medications for anxiety, bipolar, any mental health diagnosis programs but cannot get into treatment because the centres are not equipped. There are safety concerns”

Participants suggested that probably 80% to 100% of their clients actually have concurrent disorders. They argue that the fundamentals of mental wellness must be addressed before they can make in-roads to the addictions issues. They noted that while there are inadequate addictions services in First Nations communities there are also inadequate mental health supports in communities. Participants struggled with identifying effective solutions while addressing the concurrent disorders in isolation from one another. They recognized the need

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for more integrated service delivery but did not know if they have a mechanism, flexibility or resources to do so.

Training/staff pressures

As mentioned in other sections, one of the pressing challenges for the participants is the need for training in current realities concerning addictions. Participants spoke of a broad range of necessary training that needs to occur to ensure effectiveness of service and the safety of the workers in treatment centres. This training is needed at every level: to improve the referral process, to improve detoxification, to deal with concurrent disorders, to deal with poly-substance abuse, and to understand the overall changes in drugs. Without this consistent training the workers have to do the best they can with what they know and participants recognized this as a stressful work environment. Participants stated,

“Typically if the NNADAP worker is recently hired they have to learn a lot on the job.”

“Some of it relates to confidentiality, confidence in the workers that are in the community – some workers in the positions don’t have proper training or qualifications to do the job so the program and service is limited by what the worker is able to do and there is no overall supportive system for them”

“For our community we lack resources and training to understand what the drugs are impacting on individuals. There are different signs and symptoms on how they are using the drug; snorting, smoking, swallowing, etc. Our clients come in with withdrawals. As frontline and/or intervention workers, we need that training/understanding of the process and how to detoxify a client”

Participants stated that as front line workers, there are little resources available to them in order to help them function as healthy staff. The staff in treatment centres are prone to burn out because they are the only resource. In addition, many participants stated that their wages were not competitive. All of these stresses lead to staff recruitment and retention problems. Participants stated,

“We do lose people and have staff turnover because finance is a real concern. I see that as a real gap.”

“If you are looking for prevention, how are you going to talk to an addict about prevention when they are looking for a cure? The NNADAP worker is not meant for that.”

“Many NNADAP workers are really the one and only resource in their communities, dire need for training across board, for concurrent, poly substance use, mental health – their needs for training are extensive and isolation in communities is really difficult and leads to burn out as well as recruitment and retention issues”

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Lack of funding

Related to staff training issues is the overall lack of funding. Participants spoke of the funding challenge in two ways: as it related to programming and as it related to staffing.

The programming available at any treatment centre is directly determined by its funding. Participants spoke of the challenges in trying to create new programs to serve their clients, only to have them turned down by the funders. In addition, participants spoke of programs being subjected to cuts by the funders, which left the treatment centres scrambling to make more with less. One participant stated,

“A couple years ago we were looking at a web-based therapeutic program, for lack of a better word... The content was based on resiliency theory and emotional intelligence. This matches well with our program and culture. Based on an American program, the idea is that counsellors would provide internet based counselling for these kids as aftercare in their community. They would be able to access individual counselling, group life skills, but it was not funded... the barrier was that the government said “what if the youth are in their community, are getting counselling and that acts as the trigger to kill themselves”

In addition, participants were clear that the numbers of people needing service was on the rise. With high staff turnover and budget cuts, the amount of work expected by one person can be untenable. Many participants saw an increase in demand and a decrease in the kind of service they can provide. Some stages of the treatment process require more intensive, one-on-one work, which is less feasible with fewer staff and more clients. Participants stated,

“We are not sure who will be left to provide service, we will have high school drop outs with no skills and older people who will be too ill or retired to work... there will be a decline in who will provide service, huge increase on demand for services because NIHB reduced list of entitlements or limited access, our programs are being impacted because it costs us more to service community members – it just grows steady”

“I do a pre-treatment program of people coming from detoxification that involves spending a lot of time on a daily basis, but that involves really putting yourself out there. You understand the importance of healing and it becomes a family with the person you are working with, but I have a staff of one. They are unrealistic expectations. We need more staffing in our community, which leads to more money and all those things.”

In addition, wage parity was raised as an issue for workers and study participants noted that it contributes to staff turnover. According to participants, there are inconsistent requirements across the province for the level of education and professional certification that would be equivalent for services in a non-First Nation environment.

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Communication and Coordination

Another major challenge spoken about by participants was that of communication. Many treatment centres, detoxification centres and NNADAP workers operate in relative isolation from one another. Many of the challenges participants have spoken about previously, can be broadly related to this. Participants discussed communication challenges as they related to connections between treatment centres, funding, other provincial services and doctors.

For every level of care, many of the participants see benefits in communication between all centres and workers. To encourage such communication would allow for improved referrals, pre-treatment and after care. In addition, many participants spoke of the need to inform communities and community members about the addiction services that are available to First Nations people throughout Ontario. Participants stated,

“It is discouraging when you try and connect with the services in the south – you have to call one place, then call another, then call another; you do not get all the information that each service provides – I can spend an entire week just trying to get service for one client”

At the same time, another treatment centre felt frustrated because they do provide services to individuals with concurrent disorders and yet despite their best efforts, that information is not being communicated.

Another challenge related to communication concerned funding. The way treatment centres are funded promotes isolation, both across treatment centres and within them. Participants expressed a great deal of frustration related to ‘funding silos’, which prevents holistic healing as each step, and program, of the treatment process is funded separately. In addition, many participants maintained the need for more communication with non-First Nations agencies. Participants stated,

“The most major problem is the fact that coordinated efforts are lacking with respect to funding agencies. What we still see, and have seen historically, is the last minute dispersing of surplus funds at fiscal years end. We see the pressure to do a proposal. To get it in because someone says that funds are leftover and available. Of course these are “one-offs” and not sustained funding so the program or service never really has a chance to be successful. Those First Nations who don’t have a good proposal writer or who don’t have the organizational linkages often times lose out on such funding opportunities.”

“One of the things that is really important and it would be difficult but how do we integrate First Nations and non-First Nation services – there is a need a times for different planning services but when people come into our doors to mainstream agency I don’t know we do a good job of that and part of it is funding silos (e.g., youth suicide initiative – there is First Nation and non-First Nation planning table and these are kids that are dying period) we are at a point

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we can't be separate – as a community this is how we will address the needs of ALL of our community members”

“The biggest area of frustration is we talk about our own ways and how we always use healing holistically – we talk about that and yet all our funding comes down in silos and in ways that make it difficult to pursue healing in our communities the way we need to”

Many participants highlighted the need to work with other provincial agencies, such as jails. In the case of jails, some people come to treatment because they are court-ordered. When they come to treatment, sometimes straight from jail, they have not always had the necessary detoxification, assessment and the centre may not know what drugs they have been taking. Other people in jail with addiction problems can fall through the cracks and do not enter into treatment. One participant stated,

“There are no treatment programs in prison, no psychological assessment, many have FASD and do not get diagnosed and experience more abuse in jail system.”

Another communication challenge presented by the participants was the lack of connections with the doctors who are prescribing many drugs to First Nations people. Many participants identified some doctors as being prone to over-prescription and too easily manipulated by those who had problems. To compound matters, many of the most addictive prescription medications are covered by NIHB. Participants stated,

“For the prescription drug use, doctors might be prescribing too easily to make them readily available”

“If someone is sick or so, the first thing the doctors do is cover up the pain. They do not try to deal with the source of the pain. They do it to get off their back”

“One policy has to do with NIHB and fact that highly addictive time released opiates are covered by NIHB and those more expensive and not as addictive are NOT”

The participants believed that both education and collaboration were necessary to combat this issue. Few doctors are trained in addictions or concurrent disorders. Doctors should be trained in these realities so as not to work against the treatment centres. One participant stated,

“A collaborative approach between physicians/doctors and First Nation health centres is required to monitor the amount of drugs being prescribed within our communities to combat the issue on prescription drug abuse”

Literature Findings

This section look at the literature as it pertains to the gaps and challenges identified in this study. It is not meant to be exhaustive and much of the literature findings presented in section 2.1 also have relevance for the challenges and gaps noted in this section of the report. The literature findings provided here expand upon participant discussion regarding stages of Substance Abuse Treatment as well as discussion around impacts of prescription drug abuse, sources of prescription drugs, and treatment options including the debate regarding methadone treatment.

Substance Abuse Treatment Phases

The United Nations (UN) (2002) has identified two phases of the substance abuse treatment process; the stabilization phase (detoxification) and the rehabilitation-relapse prevention phase. Each phase has distinct goals, objectives and methods intended to address the symptoms and contributing factors of substance abuse, and/or to prevent relapse in patients.

The Stabilization Phase (Detoxification)

Throughout the course of this needs assessment participants expressed a need for detoxification services, especially with a First Nation focus. The UN (2002) report states that the stabilization phase is not a treatment modality, but is a necessary first step in the treatment process (Treatment Improvement Exchange, 2008). This phase is intended to address the withdrawal symptoms of those who, after prolonged use, are refraining from the use of drugs or alcohol (UN, 2002). It is during this stage that patients are provided medical care and pharmacotherapy to support patients in achieving abstinence. On its own, the stabilization phase is unlikely to effectively help patients achieve lasting recovery. As such, it should be seen as preparation for further abstinence and/or rehabilitation (UN, 2002). The literature indicates the requirement of detoxification for an individual to successfully recover from addictions. The study participants concur strongly with this finding.

The Rehabilitation-Relapse Prevention Phase

In much the same way that participants expressed a need for more detoxification services, the same needs was expressed for pre-treatment, treatment and aftercare services. The second necessary phase identified in the 2002 UN report is the Rehabilitation-relapse prevention phase. Three goals are set out for this phase: to prevent a return to active substance abuse, to assist the patient in developing control over urges to abuse drugs, and to assist the patient in regaining or attaining improved health and social functioning (UN, 2002). In order to improve the chances of success, this stage is intended for patients who are no longer suffering affects from withdrawal. Medication, counselling, education, group therapy session, peer support groups are all employed during this phase to prevent patient relapse. Study participants emphasized this need throughout all aspects of the data collection.

Prescription Drug Abuse

As identified by the participants of this study, the literature also identified prescription drugs as a concern in the addiction field. Generally prescription drugs are envisioned as the proper use of such drugs by doctors. Doctors prescribe various drugs for the ailments and maladies that their patients present them. Unfortunately, for a variety of reasons, the providing of prescriptions by physicians does not always achieve the intended results. Doctors have pressure on them to see large numbers of patients and they may provide prescriptions that are not warranted. Also they may be pressured to provide medication for ailments that are often feigned or exaggerated by patients.

Wardman et al. (2002) also offers the sources of prescription drugs. While some respondents of the 2002 study received drugs legitimately from physicians, others obtained drugs through inappropriate physician prescriptions. In addition, research respondents indicated that friends and/or strangers were also a source, and in many cases all of the above were used to obtain the prescription drugs.

In addition there are anecdotal reports of the elderly being exploited by younger people for their medication. There are even reports where elderly people are active agents in the selling of their own medication. There are no shortages of ways that people access prescription drugs.

Trauma, injury and pain medication

The treatment of pain and injury with prescription drugs can have an effect in addictions. Misuse of prescribed medications can lead to addiction and the over-prescription of medications can result in these drugs being sold illegally on First Nations reserves and urban centres.

An article by Dr. Lindsay Crowshoe, an Aboriginal physician practicing in Calgary Alberta, describes some types of drugs being over-prescribed to First Nations patients for post-injury and non-cancer pain. Dr. Crowshoe indicates codeine, containing analgesics and benzodiazepines account for the majority of medications prescribed to First Nations patients in Alberta for post-injury and non-cancer pain. In Calgary 48% of Aboriginal people with addictions are being treated for misuse of prescription medication, mainly sedatives/relaxants and opioids/analgesics (Crowshoe 2003).

Dr. Crowshoe also writes that Tylenol # 3 is readily available by prescription for treating pains related to injuries and chronic non-cancer pain. This mild narcotic is also commonly used recreationally and is frequently sold on the street. Benzodiazepine, a drug which causes depressive symptoms and dependency is also commonly misused. Both of these drugs are frequently used in combination with other drugs in suicide attempts (Crowshoe 2003).

Finally, Dr. Crowshoe provides anecdotal reports from nurses working on First Nations reserves in Alberta who report concerns of government-paid prescription medications being misused. One thing the nurses frequently see is

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numerous empty medication vials in patients' homes while doing their rounds. This leads nurses to question whether physicians are over prescribing pain medication (Crowshoe 2003).

This problem is not new as the federal auditor's office was aware of reports since 1997 of prescription drug misuse by some First Nations patients. The auditor general, in 2004 reported the number of First Nations clients obtaining more than 50 prescriptions over a three-month period had almost tripled, compared with what was observed in the 2000 audit. First Nations authorities are very concerned about the misuse of prescription drugs in their populations, especially as Health Canada funds prescription drugs for First Nations people through its Non-Insured Health Benefits program (Office of the Auditor General of Canada 2006).

Prescription drug misuse has also been viewed as a serious problem in Ontario First Nations and authorities there are taking steps to address these concerns. Recently the Ontario First Nations Chiefs took steps to address this growing problem. Resolution 68/08 to develop a "Prescription Drug Abuse Strategy" was passed at a special meeting of the chiefs in December 2008. It is expected this strategy will provide the mandate for the First Nations authorities to work with Health Canada to develop and implement the Prescription Drug Abuse Policy. Emphasis will be placed on the issues related to drug abuse awareness, addiction prevention and drug treatment options (Wawatay News Online 2008).

What are the impacts of prescription drug abuse on fetal development?

Study participants expressed concern regarding the impacts of prescription drug abuse on fetal development. A developing fetus is clearly harmed by opiates. Drug dependent pregnant women have a higher risk for spontaneous abortions, breech deliveries, premature births and stillbirths. Babies born to opiate-addicted mothers often have withdrawal symptoms similar to adults. These symptoms may last several weeks or months. Researchers have also found an increased risk of Sudden Infant Death Syndrome (SIDS) among babies born to heroin-addicted mothers (Narconon 2008).

It is clear that the full spectrum of physical damage that drug abuse can cause cannot be documented, one thing is certain: the effect of maternal drug use on fetal brain development is the most critical and most studied effect. The two broad classes of fetal brain damage are as follows: In the first 20 weeks of gestation, damage can occur during cytogenesis and cell migration.

In the second half of gestation, damage can occur during brain growth and differentiation. During the first half of gestation, especially during sustained abuse, it is likely to disrupt the complicated neural wiring and associative connections that allow the developing brain to learn and mature. Such abused drugs often freely cross the placental barrier; however, damage to the fetus also can occur via indirect methods. In particular, the vasoconstrictive properties of cocaine have been discussed as a potential cause for the delivery of growth-retarded infants (Wang 2008).

In utero opioid exposure has consistently shown a decrease in nucleic acid synthesis and protein production in the brain, suggesting that overall brain growth is compromised. Effects on neurotransmitter concentrations and production have not been confirmed. Behaviourally, prenatally exposed animals tend to show decreased exploration and increased response latency to noxious stimuli (Wang 2008).

What are the short-term and long-term physiological impacts on people?

Participants also raised questions regarding the impacts of prescription drug use on individuals. The literature suggests that the medication-dependent individual is frequently like the character in "Alice in Wonderland" who had to run as fast as he could just to stay in the same place. When addiction is firmly established the chief job of the person is to meet the requirements of the addiction for whatever substance is involved. Failure to meet these requirements is met with the severe punishment of mental and physical withdrawal. It is no longer so much a case of attaining positive results by taking medication as it has become one of avoiding negative results by making certain that the medication is always available. Particularly in the case of prescription drugs, to which easy access is restricted by the requirement for a physician's prescription, the addicted individual may have to spend an amazing amount of time and energy simply ensuring that he does not run out of medication. This often involves multiple doctor visits, visits to emergency rooms, and even phoning in illegal prescriptions or forging or altering prescriptions (Floyd 2002).

Medication-dependent persons invariably experience and almost always manifest impairments in their thinking, feeling and actions. Intermittent confusion, memory loss, impaired judgment, personality change, emotional disturbance (depression, mood instability, and irritability), social withdrawal and physical incoordination and sluggishness leading to falls, accidents and injuries are common. As time goes on, the person becomes less and less like their normal "pre-addiction" self and more and more like the stereotypical individual who is addicted to substances. Ethical deterioration in the form of dishonesty, secrecy, manipulation, lying and even stealing is a frequent accompaniment of many advanced addictions. These behaviours contradict the basic pre-addictive value structure of the individual and therefore cause great inner conflict, dissonance, shame and guilt - all of which serve to fuel the addictive process by increasing mental distress and the need for chemical relief of suffering. A vicious circle is established from which the individual with an addiction finds it exceedingly difficult, sometimes impossible, to break free without outside assistance (Floyd 2002).

While it was possible to obtain some information on this issues, the literature reviewed widely agreed that there is not enough reliable and valid data available on the prevalence and degree of prescription drug abuse in the Aboriginal population (Dell & Lyons, 2007; Health Canada, 2008; Chansonneuve 2007).

Drug Pushers and the Internet

Study participants spoke extensively about the source of prescription drugs in their communities. While recognizing that doctor prescription is one source the participants also recognized other sources. The literature confirms that the black market for prescription drugs is becoming more prevalent. Drug usage has become widespread and people who sell drugs now sell prescription drugs as well as the historical ones such as marijuana, hashish and cocaine. Specific data that looks at the rates of the selling of prescription drugs is hard to track but anecdotal information suggests that access is increasing as drug users seek prescription drugs such as ecstasy and other prescription drugs with regularity.

In addition it appears that the internet is now another avenue where people can access prescription drugs. Data is limited, yet anecdotally most people receive offers for drug sales in their email "inbox" on a weekly basis. This may be an emerging concern and little information on its rates of access is actually available.

Some individuals choose stimulants such as Ritalin and Dexedrine which can also lead to abuse. It should be noted that antidepressant drugs (Prozac, Paxil, Zoloft and many others) are not liable to abuse. They do not provide abnormal "highs" or euphoric experiences, despite their capacity to lift certain types of depression (Floyd 2002).

First Nations Gangs and Organized Crime

First Nation street gangs began forming in Winnipeg during the late 1980s (Public Safety Canada n.d.). Today they have spread to other places in Canada, particularly the three Prairie Provinces, British Columbia, Ontario and Quebec. There are structural and composition regional differences in Aboriginal-based organized crime's (ABOC). Street gangs are found primarily in Alberta, Saskatchewan and Manitoba. In Ontario and Quebec, Aboriginal-based groups are located near or along the Canada/U.S. border and are involved in criminal activities that facilitate cross-border smuggling and the inter- and intra-provincial distribution of contraband (CISC 2009).

Red Alert, Indian Posse and Alberta Warriors are the principal street gangs in the Prairie Provinces. These prairie gangs are found in the urban centers while a number of smaller, less influential street gangs are located in the smaller communities and reserves throughout the provinces (CISC 2009). According to the RCMP these gangs are not as well organized as other organized crime groups such as the motorcycle gangs (RCMP 2009).

Recruitment from Aboriginal populations occurs all over; in large and small communities, correctional institutions and on reserves. The main targets for recruitment are vulnerable Aboriginal youth. It is projected that the result of such recruitment will be the expansion through the Aboriginal communities as younger gang members graduate into more formalized organized crime groups as they get older. According to the RCMP Aboriginal gangs act as a training ground for the more serious crime gangs (RCMP 2009). There are reports that

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Aboriginal gangs are well established in the Canadian prison system. Many gang members report that the prison experience facilitates the development of Aboriginal gangs (Public Safety Canada n.d.).

It is commonly known that traditional Aboriginal culture has strong familial and cultural group allegiance. Communal bonding and the concept of belonging to a large group are important aspects of Aboriginal spirituality. According to research on Aboriginal street gangs in Edmonton poverty stricken youth from dysfunctional broken families are vulnerable targets for recruitment. Intergenerational trauma faced by Aboriginal populations has resulted in a significant degree of cultural and personal dislocation. The residential school experience, substance abuse, loss of cultural identity and general marginalization has contributed to the breakdown of the traditional family unit. According to reports the combination of these factors makes joining a gang an attractive alternate for some Aboriginal youth and even adults (Public Safety Canada n.d.).

Further the literature asserts that Aboriginal gangs are an anomaly when compared to other gangs in Canada. Aboriginal gangs have different causes and characteristics than other gangs and compared to other mainstream gangs their recruitment processes are considerably more violent. It is asserted that because of the use of tattoos, hand symbols, and strict chains of command Aboriginal gangs have more in common with the mainstream American gang membership and function (Public Safety Canada n.d.).

A major issue is rivalry between Aboriginal gangs which has resulted in violence as gangs attempt to establish greater market share within the illicit drug trade. Unfortunately the main consumers of these drugs are Aboriginal people in cities and on reserve. Research shows that gang structures and alliances are fairly fluid, as smaller gangs grow and shrink over time (CISC n.d.).

The distribution route for drugs is that the well-established organized crime groups such as the Hells Angels and Asian-based gangs provide drugs for the Aboriginal gangs who distribute the drugs to other Aboriginal people in cities and on reserve. The larger organizations also rely on Aboriginal gangs along the Canada/US border for supplies of stolen cars, illegal gaming, the illicit diversion of tobacco and currency and even human trafficking. The special taxation status on First Nations reserves also provides opportunities for organized crime groups to partake in tax fraud schemes (CISC n.d.).

It is reported that Aboriginal-based street gangs are involved in sporadic and disorganized street-level criminal activities, primarily low-level trafficking of marihuana, cocaine and crack cocaine and in small amount, methamphetamine. The gangs often employ violence as a means to collect debt for illicit drugs. Although the Aboriginal gangs' capability to plan and commit sophisticated or large-scale criminal activities is low, their propensity for violence is high, posing a threat to public safety (CISC n.d.).

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Study participants repeatedly identified the role that gangs play in pushing drugs in their communities. Two trends were identified by participants in this study: gang activity pushing drugs from Winnipeg into the Kenora/Rainy River/Fort Frances corridor, as well as a push from established networks in the south to the central corridor.

Methadone and other Treatment Options for Opiate Abuse

Study participants describe an ongoing tension in communities surrounding methadone as a treatment option. The literature discusses a number of treatments available for individuals who abuse or are addicted to prescription medications. From the onset, they may need to undergo medical supervision to help reduce withdrawal symptoms. This is just the first step. It should be noted that the research on treating heroin addiction has provided much of the information for effectively treating addiction to prescription opioids. Behavioural treatments combined with medications have proven effective (NIDA, 2008).

Methadone, a synthetic opioid that reduces withdrawal symptoms and relieves craving, has been used for more than 30 years to successfully treat people addicted to heroin. Buprenorphine, another synthetic opioid, is a more recently approved medication for treating addiction to heroin and other opiates. Buprenorphine can be prescribed in a doctor's office and has a better safety profile than methadone. Another drug, Naltrexone, is a long-acting opioid receptor blocker which can be used to help prevent relapse (NIDA, 2008).

The drug Naltrexone is not widely used, however, because of poor compliance, except in highly motivated individuals (e.g., physicians at risk of losing their medical license). It should be noted that this medication can only be used for someone who has already been detoxified, since it can produce severe withdrawal symptoms in a person continuing to abuse opioids. Naloxone is a short-acting opioid receptor blocker that counteracts the effects of opioids and can be used to treat overdoses (NIDA, 2008).

What are the advantages/disadvantages of methadone usage?

Advantages: Methadone has been used for 30 years and is dispensed legally from regulated clinics. It is a well-known and regulated treatment. At the correct dosage, methadone relieves cravings for heroin. You only need to take one dose a day. As long as you're receiving the correct dosage and do not continue to use other drugs, you won't get high. Methadone is sometimes covered by insurance. As a result, many users no longer have to take drastic measures to pay for their treatment.

If you do relapse and take heroin while on methadone, the heroin won't have much, if any, effect. This will reduce the temptation to relapse again. Methadone treatment can be flexible. Some patients stay on a maintenance dose of methadone for several years, while others may be able to taper off after 4-12 months. Methadone treatment can be a successful route to becoming drug-free, and dramatically improves a user's quality of life fairly quickly (Haiken 2008).

Disadvantages: At high doses Methadone is deadly. According to the National Center for Health Statistics, 3,700 Americans died of unintentional methadone poisoning in 2005. The total number of fatal methadone overdoses --including suicides and accidental overdoses -- jumped 66 percent between 1999 and 2005. (The government's report did not distinguish between people using methadone as treatment for heroin addiction and those who were using the drug for pain control or as an illicit drug) (NIDA, 2008).

Methadone has side effects. Among the most common are sweating, constipation, loss of sex drive, skin rash, and water retention. Less common side effects include vomiting and mood problems. Although methadone generally does not interfere with the ability to drive, it does make some people feel sleepy. Being on methadone is restrictive. Because you must obtain your daily dose from a licensed dispensing facility, you are effectively 'chained' to your clinic. It can be difficult to travel, and often you must obtain permission to be away, even for just a day or two. Clients in rural areas may have to drive a long distance to a methadone clinic, which can interfere with work and other activities. However, after a few months of daily supervised treatments, some providers may allow patients to take home methadone doses (Haiken 2008). Methadone is not effective if patients continue to abuse other drugs while on the program.

What are other treatment options besides methadone?

In 2002, the FDA approved buprenorphine (brand name Subutex), a drug for treating opioid addiction. Buprenorphine can be prescribed in a doctor's office, eliminating the need to be registered at a methadone clinic. At low doses, the drug helps individuals with addictions to stop using opioids without experiencing withdrawal symptoms. Because it has the potential for abuse, it's usually used in combination with naloxone, a drug that causes a systemic reaction to opioids. Suboxone is the brand name of the drug that combines buprenorphine with naloxone. Subutex is given during the first few days of treatment, while Suboxone is used during the maintenance phase of treatment (Haiken 2008).

Some reports claim that Suboxone works as well or even better than methadone but this is hotly debated. Patients with shorter histories of addiction seem to benefit the most from the buprenorphine/naloxone combination. Many methadone patients, according to the National Alliance of Methadone Advocates (NAMA), have attempted to switch to Suboxone from methadone because they want to leave the clinic system. Some patients often find that it doesn't work for them. NAMA recommends that if you start therapy with buprenorphine/naloxone and continue to experience drug cravings, then you are probably a candidate for methadone treatment instead (Haiken 2008).

Patients who would like to try the 'cold turkey' approach can look into a residential or outpatient program although most heroin treatment programs involve the use of medications, which reduces the severity of withdrawal symptoms while patients adjust to being drug-free. This isn't a stand-alone

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treatment for heroin addiction but can a helpful first step that can lead to a longer-term, drug-free residential or outpatient program, or a program that uses medications as part of the treatment. The best documented drug-free treatments, according to the National Institute on Drug Abuse for heroin, are therapeutic residential programs that last three to six months (Haiken 2008).

Concurrent Disorders

Another major gap indicated by the participants was the lack of services and resources for concurrent disorders. The literature shares this same concern. The recent Health Canada document, *Best Practices: Concurrent Mental Health and Substance Use Disorders*, defines concurrent disorders as any combination of mental health and substance use disorders that might affect an individual at the same time. The report emphasizes that many people experience overlapping mental health and substance use problems that require interventions that address both disorders concurrently. A concurrent disorders strategy should therefore include screening, assessment, treatment and aftercare interventions that target both types of disorders with equal emphasis and importance.

One particularly important section in the *Best Practices* document includes a description of the historical separation of three distinct populations: mental health clients, people suffering from alcoholism, and people suffering from drug addiction. In the past, mental health clients were treated within a system of mental health clinics or institutions. Those suffering from alcoholism received assistance from informal support groups or, in some instances, specialized residential treatment facilities. Drug addiction tended to be managed from within a criminal justice context.

Over time, and for a variety of reasons, both public and professional perception of persons with mental health and substance use disorders has shifted from viewing affected individuals as belonging to separate and distinct populations to being part of a larger group with overlapping mental health and substance use problems.

2.3 Approaches and Promising Practices for Addressing Substance Abuse

Introduction

The following section will highlight study participant discussion promising practices, relationships and policies in the field of addiction and substance abuse in Ontario First Nations. Sub-sections have been organized under the following categories:

1. Promising practices
2. Cultural practices
3. Treatment centre practices
4. Use of technology
5. Case management
6. Pre-treatment
7. Prevention, Promotion and Education
8. Community practices
9. Networking
10. Staff and Management practices
11. Relationships
12. Policies
13. Cluster funding
14. Policies in development

The participant findings are followed by any additional selected literature review that is not covered in the earlier sections to add context to this discussion.

2.3.1 Promising Practices

There have been many innovative approaches, structures and promising practices that been developed at the community, tribal, and regional levels to address First Nation addictions prevention and treatment needs. Respondents identified a large number of promising practices related to treatment modalities, program practices, program management and staff, leadership, community planning, tradition and culture and more. There is the general perception that the momentum achieved has to be enhanced and capitalized upon.

Cultural Practices

A primary approach that has been mentioned is that First Nations traditions and cultural values have been integrated in addictions practice. Respondents discussed the positive impacts of integrating cultural practices, such as sweatlodge ceremonies, drumming circles, sharing circles, feasts, singing, cultural walks, traditional teachings and language into programming.

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Participants gave examples of the cultural practices that they have seen in addiction and substance abuse services:

“We have a cultural unit who are responsible for traditional teachings and facilitation of the cultural teachings and sweat lodges, etc. – we have 4 staff on cultural team – the requests for these type of services is starting to increase and they are very busy.”

It is strongly believed that the integration of First Nation content in programming and services increases success and sobriety rates as this participant asserts.

“Integrating Aboriginal content more effectively meets needs of clients – most clients prefer it.”

“The return to cultural teachings and practices have made positive impacts.”

“I see success rate and sobriety rate as higher when they use culturally based programming.”

Cultural teachings and practices have abstinence requirements for participation which might contribute to perceptions of increased success. A part of this resurgence is the increased usage and demand for land based programs. These initiatives usually include all family members and are holistic in Nature. Participants identified a need for additional culturally relevant resource materials. Participants further indicate that success may increase due to the element of community based leadership and planning for these initiatives.

“A hugely successful program was the land based program that was used to support addicts and their families. We had some that focused on youth as well.”

While cultural practices were consistently identified as a best practice, respondents also consistently pointed out that funding for this best practice was insufficient;

“We find the cultural component is the key to helping someone with their sobriety and leading a good life. We need more resources for this.”

Promising Practices at Treatment Centres

Treatment centres have employed various practices to better meet the needs of their clients. Below are two examples of treatment centres that have developed innovative approaches with success and admiration from those in the field of addiction and substance abuse.

The Muskrat Dam treatment centre has developed a program where the entire family is provided with the services to help them deal directly with addiction and substance abuse problems or with the indirect effects of addiction and abuse problems. The main benefit of this program is that the whole family is kept

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together living under the same roof while they work through the treatment program. Families live in cabins together and prepare their own meals, which more closely mirrors healthy lifestyles when they return home. The treatment program includes individual counseling, couple counseling, group work and family work.

“If we had more centers like the Muskrat Dam treatment centre, potentially those families could be referred before the children are caught in the child welfare system. If they go into a family treatment facility that is a NNADAP facility or federally funded facility, then a determination can be made after a period of time through a case management approach whether the child needs to be brought into the child welfare system post-treatment, because the parents are not compliant or there are other abuse issues there.”

The Nimkee NupiGawagan Healing Centre recently partnered with the Canadian Centre on Substance Abuse (CCSA) and Carleton University, examining indicators of client treatment and length of stay. From this research, a four-month gender based treatment program for First Nation youth ages 12-17 and who are challenged with solvent addiction was developed to maximize treatment gains. It was noted that the four-month model has become the strength of the program. This has also led to a questioning of the length of programs with the belief that a long treatment model should be employed to maximize treatment plans.

“I think a strength of the program is the length of the program; that is four-months. None of the NNADAP programs are that long. There is no research, but what is the appropriate length of stay to match positive post-treatment outcomes? From this information we proposed the four-month model to maximize treatment gains. Here at Nimkee it was a financial matter as well. We could downsize our staff, provide treatment to more people for less money.”

Use of Technology

Program delivery methods were discussed as well. The use of technology was highlighted for its ability to connect those in northern and remote communities with critical mental health and addictions services. Telehealth, OTN and K-NET were most notably mentioned. It was noted that for Northern communities there were:

“Greater rates of psychiatric care with Telehealth technology than when they had to fly in; client were able to keep their appointments and received support as a result.”

Participants also pointed out the training possibilities of this technology:

“Many communities are on Ontario Telehealth Network or K-NET so we can post training so people don’t have to travel and go through expense and difficulty in to travel especially during winter months.”

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One final remark by a respondent is a reminder that:

“This is not just about using this technology for specialized regional services – it’s about regional providers learning about challenges in communities that clients live in to gain a better understanding to help people build resiliency and use resources – without living [in those communities] we don’t understand challenges people have about going home.”

Case Management

Case management was also discussed by respondents as a promising practice. Participants see multi-disciplinary case management approaches as an important caveat, in particular in its approach to mental health and addictions. The complexities of each case demand a case management approach be used. Participant stated:

“It seems that the case management approach is very much in vogue. This approach is multi-disciplinary in its approach to mental health and addictions. This is the way to go it seems.”

“Four of five years ago I was involved in a program that had a very intensive case managers’ approach. This was highly successful. It proved to be very effective in dealing with many of the issues such clients present especially as it relates to supports for addicts.”

The key piece is case management where there is a conversation between the addictions and mental health people.

“Different maladies present different approaches, post-traumatic stress disorder, addictions, depression. All have different aspects that are not necessarily the same as someone with a congenital disorder.”

Pre-Treatment

The use of pre-treatment preparation was discussed as an important factor for success. Pre-treatment was generally discussed as supporting the individual’s sobriety for admission to residential treatment programs through daily contact and counseling, moving them from the detox centre to supportive housing, as well as readiness counseling for program expectations. It has been identified as a huge gap currently, but where it is offered, participants noted improvements in readiness when working with clients. One respondent indicated that:

“We found in some of the communities [that] they did a lot of pre-treatment before clients went to adult treatment centre and we discovered clients were far more successful.”

More documentation on pre-treatment promising practices is underway according to some participants in the hopes that it will be more widely practiced.

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Prevention, Promotion and Education

Best and promising practices for prevention, promotion, and education activities were also identified, such as the use of guest speakers, educational workshops, and radio shows. Respondents discussed initiatives undertaken by a number of communities that promote healthy lifestyles instead of the use of drugs, alcohol, or other negative behaviours, and bring together the whole community. One respondent describes the following activity:

“Try Hugs Not Drugs - a day where we have over 1,000 people attend. Everything is free, all the booths do something interactive to promote services available that are healthy activities. Everyone participates in it.”

Other events include Sobriety Walks, and “Racing Against Drugs” which is held in cooperation with the police and RCMP once a year.

Community Planning and Input from the Community

A number of respondents identified best or promising practices that were related to community planning and community input. In one community, a client survey was undertaken to find out what was working and not working in the community. This offered community members a means to provide feedback on addictions and mental health programs, and also to identify what their needs were, and what gaps they felt existed. This also helped program workers and leadership identify what drugs were present in the community. Another effective method identified was monthly meetings with community members. Respondents also talked of the ability to listen to clients and respond to their needs when issues arise.

Respondents also discussed the importance of community planning. One respondent described the development of the Anisnawbe Health Plan which involved:

“Community people, Health Directors, other health care providers including nurses, doctors and leadership and it outlines a system they would like to see in their community as well as outside of their community and to have access to all kinds of services.”

As a result of this planning, it was decided that prescription drug abuse would be the focus of the plan and strategies.

Another respondent discussed the Kenora Chiefs Advisory Public Health Pilot project. This project is looking at community planning around the seven communities that are participating in the initiative with the Urban Aboriginal Access Centre in Kenora. One respondent commented that “this is an excellent pilot that has quite a bit of mental health capacity”.

Respondents discussed how the support of the leadership is critical to the success of the programs.

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“We have had amazing progress in our community - the Chief and Council supports the Drug Task Force and sits at the table. We have had drug busts in our community and people are taking note that people are serious about taking on the issues.”

Networking/Partnering with other Agencies

Respondents consistently identified networking and partnerships as a best practice. Participants describe how critical partnerships are to their program:

“These agencies come willingly and free of charge to work with us in delivering programs. They are a big help; without these outside agencies I would not have had the support and help that's needed to do my job. They are my life savers and I appreciate their help.”

“We have a strong relationship in the high school on reserve and with mental health addiction clinicians. This has resulted in a large number of referrals; we can offer prevention programs at school so it is more accessible to students.”

It was also noted that networking within the community was important. Sharing information with other community workers such as the youth worker, health babies program, and the healing and wellness worker was beneficial:

Participants noted that it is very helpful that the treatment centre directors get together twice a year. These meetings provide an opportunity for networking, sharing information, and collectively identifying trends.

Staffing/Management

Respondents had comments about best practices related to staffing and management. It was noted that a significant promising practice is to gather “dedicated, educated, committed workers”. Participants emphasized the importance of having workers who are positive role models for client success and this places an added responsibility on employees.

Capacity building and professional growth opportunities were highlighted in this needs assessment by the participants as a promising practice.

“I try hard to keep them up-to-date in their training; I feel that is one of my responsibilities to keep my staff prepared.”

“Our staff has received training in different areas, it is important to bring that training to the communities, even with the front line workers who need that training.”

Ultimately, the identified promising practices are about providing choices that fit people so they can maximize their likelihood of success. The innovative approaches provide educational and awareness activities that offer participants an opportunity to participate in healthy lifestyle choices as alternatives to unhealthy ones.

2.3.2 Relationships

Integral to the success of all First Nation addictions programs and services are the relationships that help them exist, sustain themselves and flourish. The consultation process showed several areas where relationships were established, desirable and needed. These integral relationships include:

1. Ontario Regional Addictions Partnership Committee (ORAPC)
2. Treatment Centre Directors
3. Service Providers
4. Police Partnerships
5. Interagency Groups
6. Medical Professionals
7. Child/Family Services
8. First Nations
9. First Nation and Inuit Health Ontario Region

Although many of these above mentioned relationships are efficacious, they also present challenges. Participants suggested there is a need for a more formalized relationship between the local, regional, provincial and federal levels of government and agencies and provided some examples particularly in the Nishnawbe-Aski Nation. Many participants recognize positive relationships that exist and emphasize the need for a better system of integration.

“We need something like that to lessen the work of the NNADAP worker. A system that strengthens integration with community supports.”

Another participant detailed:

“I think we need to have more systemic discussions with the provincial side of the business; the LHIN’s environment.”

Some participants worry about the dissension from within the communities as this participant asserts;

“It is almost like there is a split in our community between the people adamantly against drugs and wants them out, and others who to be a part of the people with the drugs and go to their parties, etc.”

In particular, participants are worried about the rise of identified concurrent disorders and how there needs to be stronger partnerships between mental health and addictions. There is a need for more sustained and persistent funding arrangements that include funding envelopes to ensure that such relationships continue and are present. For example it was noted at the national level there are good relationships to tap into such as the FNIH Mental Health Advisory Committee and the Mental Health Commission Aboriginal Advisory Committee process. Currently, the Regional Director of FNIH Ontario Region is able to

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bring issues forward from Ontario First Nations due the key relationships that been developed.

Participants recognize the importance of relationship building and spend an inordinate amount of time doing so particularly with outside service providers. However, this does take time away from providing front line services and an overall lack of financial resources hinders relationship building.

2.3.3 Policies

Cluster Funding

The new cluster model available from the First Nations and Inuit Health Branch and regions links programs that are similar, allowing those programs to share their funding. This model breaks down the “silos” that often isolated programs leading to the promotion of a holistic and integrated health plan. As one participant discussed:

“Now we would be looking at the clustered funding agreement model that we introduced this year, the expectation that we are laying on the communities is that you have flexibility to move money between these programs.”

Policies in Development

A number of policies are currently being developed at the National level.

First Nation and Inuit Mental Wellness Strategic Action Plan

Health Canada established a Mental Wellness Advisory Committee (MWAC) in collaboration with the representative bodies of Canada's First Nations and Inuit - the Assembly of First Nations (AFN) and Inuit Tapiriit Kanatami (ITK) - to develop a strategic action plan to improve mental wellness outcomes of First Nations and Inuit. The mandate of the MWAC is to develop a Strategic Action Plan to improve the mental wellness outcome for First Nation and Inuit and guide mental wellness policy and program development over the next 3 – 5 years.

“There has been the First Nations and Inuit Mental Wellness Strategic Action plan, but that is the beginning of the policy development.”

At the regional First Nations level, a major resolution has been developed to better address First Nations addictions prevention and treatment needs was passed recently. In December 2008, the Ontario Regional Chiefs passed Resolution 68/08, a “Prescription Drug Abuse Strategy” to provide the mandate for the First Nations authorities to work with Health Canada to develop and implement the Prescription Drug Abuse Policy. This strategy will emphasize drug abuse awareness, addiction prevention and drug treatment options

Resolution 68/08 provides the mandate for the Ontario Regional Chief and the Ontario Chiefs Committee on Health to work with Ontario First Nations plus

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Health Canada to develop and implement the Prescription Drug Abuse Policy. The Chiefs of Ontario Health Coordination Unit are also directed to coordinate the development of an Ontario First Nations strategy to address the prescription drug abuse epidemic

In addition, efforts have been made to improve the health of Ontario's First Nations populations. In January, 2008 the federal government announced a partnership with the Province of Ontario and the Chiefs of Ontario to invest \$3.7 million in the Ontario First Nations Public Health Initiative. This three-year initiative hopes to improve public health services to First Nations communities across Ontario (Health Canada 2008).

At the provincial/territorial level, the Union of Ontario Indians (UOI) recently introduced the War on Drugs Strategy. Partners of this strategy include the Government of Canada, Government of Ontario, Ontario Provincial Police (OPP), Anishinabek Police Service and community and tribal police services. The strategy is aimed at eliminating illicit drug abuse, trafficking and associated organized crime in Anishinabek Nations across Ontario. The War on Drugs is encompassed by four pillars: prevention, treatment, ogitchidaawin (protecting our own) and enforcement. A conference was held in late February 2009 on this Strategy and a report and next steps are expected shortly.

In February 2009, the Sioux Lookout First Nation Health Authority hosted a Chiefs Forum on Social Issues: Answering the call for Help Reducing Prescription Drug Abuse in our Communities. Chiefs, Health directors and frontline workers from all across Ontario attended this three day meeting to develop resolutions, strategies, and consensus on matters containing to prescription drugs abuse. Participants in all groups promoted raising education awareness levels, working together as a community and taking responsibility at the community level to combat prescription drug abuse problems. Participants also noted that solutions to prescription drug abuse must be a collective effort of community members, leaders, and professionals, and must be supported by the government. The conference resulted in a declaration entitled: "Mamow Na-Ta-Wii-He-Tih-Sowin: Healing Together" included in Appendix E.

At the NNADAP treatment centre and First Nation community level there are a number of policies that participants discussed currently being developed.

Drug and Alcohol Policies in Communities

A number of other respondents indicated that their communities were working on policies to address alcohol and smoking use within the community. In addition, one respondent commented on the policy development work currently being undertaken at the Tribal Council level. Policies around prescription drugs are also being developed, "We are seeing more tribal policy geared toward to prescriptions drugs. This is very exciting to see. We are seeing advocacy on behalf of these people".

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One respondent indicated that the NNADAP worker in her community was currently doing research into addictions, prevention and treatment policies, while another commented that her First Nation was developing a policy or *Declaration* to target addictions. Another respondent mentioned the “Taking Back the Community” committee which had initiated discussions on prevention and addictions policies for the community. This committee was composed by a representative from the Aboriginal Police Services, the Mental Health and Addictions worker, a council member, and any interested community members.

Residency Bylaw

A number of respondents discussed the residency policies in place or in development in their communities to prevent residents involved with the drug trade from remaining in the community. Some communities have relied on the Indian Act and Band Council Resolution (BCR) to support residency policies, while other communities are working to create bylaws to further support the principles of the Band Council Resolutions.

“Right now we are working on the Residency Bylaw. We do not know how that will help us, but that is one of the avenues that I think we need to take. If we develop a Residency Bylaw, it will give us more jurisdiction on who lives here, who we are allowed to deal with, gives the BCR more support. It establishes a process we have to go through to deal with these issues.”

Leadership and Staff Drug and Alcohol Policies

A number of respondents discussed policies related to staff and leadership. Some communities have a ‘zero tolerance’ policy, whereby individuals in a position of authority/leadership are not permitted to consume alcohol or drugs at all”. In some dry communities, band employees face losing their jobs if they are caught bringing alcohol into the community. Other communities are examining drug testing for band employees, such as band office employees, program staff, and police. As one participant remarked

“It is not accusing our staff of doing drugs, but its ensuring accountability that we do not have drug dealers running the community.”

Treatment Centres

It was noted that treatment centres have consistently revised their policies to adjust to changing needs and trends over the past ten years. It was noted that a number of treatment centres are currently going through the accreditation process, and this is fostering policy development, including “environmental safety, staffing, and self-care of workers”.

“There have been major influences on policies at the treatment centre level that are a direct result of accreditation.”

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One respondent who had very positive things to say about the accreditation process, added caution stating:

“There are many policies to implement due to accreditation. We were doing those things anyway, however because there are so many expectations (and it has been very good for our organization in terms of how we do things; everyone is engaged and participating), but we are expecting more. However we do not receive additional funding to do as good a job at policy development as we would like.”

Literature Findings:

This section look at the literature as it pertains to a few of the areas of focus. It is not meant to be exhaustive but a means of highlighting some of the positive actions that are occurring in addictions in Ontario and other jurisdictions.

Culture as Healing

Study participants extensively discussed the role of culture in addiction prevention and treatments services. The Aboriginal Healing Foundation (2007) maintains that culture is the critical element to substance abuse treatment programs for Aboriginal people, which confirms many of promising practices undertaken particularly by Treatment Centres. A “culture as healing” approach uses traditional methods to promote health and well-being in a deeper, significant way for both patients and service providers (Chansonneuve, 2007). A number of promising cultural practices have been identified by the AHF as a result of the intense and in-depth work in understanding and addressing issues related to the residential school system. This was widely corroborated throughout the literature reviewed.

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1. An Aboriginal approach identifies and addresses the underlying causes of addictive behaviours unique to the historical experiences of Aboriginal people in Canada.
2. The wisdom of Aboriginal cultures and spirituality is at the very heart of healing and recovery.
3. The relationship among suffering, resilience, experiential knowledge, and spiritual growth is acknowledged and honoured.
4. The interconnectedness among individuals, families, and communities is strengthened.
5. The differing pace at which individuals, families, and communities move through the stages of healing is understood and respected.
6. Healing encompasses a range of traditional and contemporary activities with an equally valued role for everyone in the circle of care.
7. Community health and community development are inseparable.
8. Culture is healing.
9. Legacy education is healing.
10. Healing is a lifelong journey of growth and change

- Aboriginal Healing Foundation 2007

Additional cultural practices have been identified as promising. Providing opportunities and environments for the positive interaction between children, youth, adults, and Elders is critical to successful Aboriginal programming. Providing urban Aboriginal people the opportunity to engage in traditional activities, such as hunting and being on the land, regalia-making, and drumming have also proven effective (Chansonneuve, 2007).

A number of treatment modalities have been identified as best practices within substance abuse treatment processes some of which are being explored by Ontario First Nation Treatment Centres.

Participants spoke of the increased need for integration with community programs. The literature suggests that community reinforcement and contingency contracting is a multi-component behavioural treatment integrating contingency-managed counselling, community-based incentives and family therapy comparable to the community reinforcement (UN, 2002A). Studies reviewing the effectiveness of this type of approach conclude that this treatment “retained more patients, produced more abstinent patients and longer periods of abstinence and produced greater improvements in personal function than the standard counselling approach” (UN 2002A, pg. 12).

The literature suggests that for some Aboriginal substance abusers, community-based outpatient programs work best with flexible services that include both harm reduction and abstinence strategies and provide a wide range of individually-targeted assistance (for issues, employment, etc.) Residential

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treatment is generally used only for severely dependent clients. Thus, they serve only a small percentage of those who have alcohol problems. What is most important is to recognize the success of treatment centre programs depends on strong aftercare service in the home community (Korhonen 2004: 37).

As noted by the participants, relationships have been developed to more effectively meet current Ontario First Nations addictions prevention and treatment needs. The Centre for Addictions and Mental Health offers an Aboriginal-specific program in partnership with Aboriginal Service providers in Ontario (CAMH 2009). Since 2000, the National Native Addictions Partnership Foundation has encouraged Aboriginal groups to work together to overcome addictions through the coordination of culturally relevant addictions services (NNAPF 2008).

2.4 Priorities

Introduction

This section highlights priorities for enhanced addiction prevention and service needs. Since the priorities emerge from previous discussions regarding the current situation, challenges and gaps, as well as innovative approaches or best practices, this section will briefly synthesis participant reflections on priorities for next steps. This priorities feed into the draft strategic plan outlined in Chapter four.

Participant Discussion

Participants in these consultations are the real addictions experts in their communities. They work on the ground and see what occurs in the field of addictions on a day-in-day-out basis. What follows are some of the priorities presented by participants during our extensive consultation and survey processes.

The priorities identified in our consultations are;

1. Education and Prevention
2. Treatment Options and Access
3. Training
4. Inclusion of First Nation Tradition/Customs
5. Communication / Policy
6. Funding
7. Prescription Drugs

Education and Prevention

Most participants asserted that education and prevention is a priority as a means to reduce the levels of addictions. Education and prevention should target all ages and stages of life, according to the participants. As one moves through the cycle of life, levels of understanding and life experiences change. It is important that education and preventative measures match the experience and understanding levels of all sections of a community. Education and prevention initiatives should be well targeted and sustained over long periods of time to maximize their impact. They should also build upon Traditional Knowledge as well as First Nation cultural values and practices.

Infants and Toddlers

Infants and toddlers are too young to understand much of the prevention programming that targets youth and adults. However, many of the participants spoke about the need to make youth, adults and seniors aware of the impact of addictions upon this vulnerable section of the community. In addition, toddlers

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could be targeted to be educated in how to live a healthy, addictions free life particularly by engaging parents in joint activities. One participant stated,

“Addictions are very serious and more awareness needed – it is increasing, more children are in care because of it.”

Youth

Almost all of the participants believed that this age and stage of life was one of experimentation. It was recognized that this stage is when youth become experimental and begin smoking tobacco and then try drugs or alcohol. It was felt that much of the education and prevention work needed to be targeted at this section of the community. One participant spoke of the need to catch youth quite early,

“Can not teach prevention in high school but if 95% of them are using by then, even in public school they are using. By the time they get to high school and multi-drugs and when they started, things have changed and we have nothing.”

“We need more specific education programming for young people so they can stop the cycle of addiction.”

According to participants, much of the education and prevention tactics should be geared toward engaging the youth in fun and drug-free activities. Many participants felt that though school is a necessary site of education and prevention, it should not be the only place. Not all pre-contemplative or early using youth attend school. The youth need to be reached outside of school as well. Participants stated,

“Focus on promotion, prevention, pre-contemplative stage, work with youth to give them ability to make good choices, decisions...provide a building with spas, swimming pools, couches to provide six month treatment program and then as well focus on young people – “feed them well/nourish the individual.”

“When we are looking at the young people in our community, probably from the age of 13 on, you become more adolescent than First Nation. Your culture and identity is being a youth...There is a whole piece of emerging that we hope we have given them roots by them and their wings are emerging.”

“I find that some of the students who are more academically inclined are the ones not reaching towards the drugs. The other students are the ones who choose to do the drugs and not come to school.”

In addition, many participants mentioned that education and prevention should focus on a positive way to live one's life, rather than simply communicating an anti-addictions message. Participants maintained that building the self-esteem, and the skills of the youth, in addition to providing them good role models, was part of a successful strategy. One participant stated,

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“Program dollars for youth to build leadership and positive role modeling, at that time when they are at the contemplative stage.”

Young Adults/Parents

At this age and stage of life, young adults and parents begin to shoulder more tasks in the community. This is the stage at which people can become parents. With a lack of role models within the community, and the intergenerational affects of colonization, grief and addictions, it might be difficult to develop positive parenting skills. Participants stated that developing a supportive network for parents could help with fighting addictions within communities. With that support, people become aware of what a positive role model looks like and begin to take these steps in their own lives. One participant stated,

“Parent education and even parent support are needed. Maybe parents have seen it happening for all their lives and do not realize it is wrong. What if they are buying it for their kids and sharing?”

In addition, parents that are fighting addictions may not be aware of all of the treatment options available to them. Participants stated that parents are frightened of entering treatment and losing their children. Education needs to occur around the networks of support available.

Elders/Grandparents

Many participants maintained that in this age and stage of life, seniors are vulnerable and sometimes out of touch with the addictions that may be affecting their children and grandchildren. The kind of drugs and the methods in which they are ingested have changed drastically in recent years. With the rise of prescription drugs and the fact that this segment of the population is prescribed drugs more often, seniors and elders are at risk of being targeted for their medication. They may be bullied or even attacked for their medication. Seniors and Elders need to be educated in the signs of prescription drug abuse. Participants stated that seniors and elders needed to be educated in the use of prescription drugs as well. One participant stated,

“We have elders on prescription and sleeping/pain drugs and it is never addressed and they don’t come and say they need treatment. No family member comes to say I think my family member, elder is taking too many prescription pills because it is never talked about.”

Some believed that educating everyone is the key to success. One participant stated,

“We need more resources for training (professional, medical, clinical). Educating care givers, parents and grandparents. When you educate them they will be able to understand and know their youth. They will recognize the users and what to do about it.”

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Some participants suggested that by educating and involving the entire community in addictions healing and prevention, the community would benefit greatly. One participant stated,

“We need to reawaken the natural volunteers and helpers in the community and that is a key piece toward empowering people and community wellness/healing through unselfish acts of one person to another the relationships between people change forever and it changes in a positive way. The idea of mobilizing the caring power of communities was traditionally there.”

In addition, participants stated that the usual method of conveying prevention and educational materials was not working. The people that came to workshops were usually people that did not have addiction problems. The question remains how to reach those members of the community that do not come to workshops or are not in school. The participants maintained that education and prevention needed to be more creative, to engage people at all stages of life and keep their interest. Participants stated,

“The information needs to be conveyed to community members on a consistent basis in a medium that gets to them through radio, calendar of events posted at band office and be consistent. If you are consistent then the next week you have more people, if you are consistent and continue the process, people will come to see the validity of it.”

“Preventative information getting to people in communities in a different way because paper does not do it, it is not effective (e.g. posters don’t work). Maybe it is home visiting, people love humor – put on a play/skit something that will stick in their mind and catch them.”

Treatment

In regards to treatment, the participants identified a number of different priorities. Though the participants expressed concern with many aspects of treatment, their priorities were: access to treatment, treatment for concurrent disorders, treatment for poly substance abuse, pre-treatment, aftercare, and wholism.

There was concern that not all treatment options are equally accessible. Rural and remote communities have the most difficulty in accessing programs and services as detailed by these participants

“I do know that rural and remote communities are extremely under resourced for services and supports for individuals struggling with substance abuse.”

“Treatment facilities that are up to 3 hours away. There are long wait times. We need more treatment and detoxification facilities.”

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“We are isolated, have no road and have been isolated all our lives, lack of access to services available in the south. There is a lack of finances to be able to afford the services available in the south to travel to get them.”

There is also difficulty with concurrent disorders and the lack of resources and training for such challenges. Many treatment centres have restrictions concerning people with concurrent disorders. In some cases, participants shared that clients with concurrent disorders were advised by people to be deceptive about their situation so that they could get into some kind of treatment. This is a problem for treatment centres when these clients have issues that the staff is not trained to deal with. Participants stated,

“We are only dealing with addictions, we get referrals for concurrent disorders but we refer them elsewhere because we cannot meet their needs. We are not really certain if they are getting their needs met at those other centres, we do not have that communication with the other treatment centres.”

“Centres that can deal with concurrent disorders, such as addictions and mental health issues. You cannot take them into treatment because there are few facilities to take them.”

In addition, poly substance abuse was of great concern to the participants. Not only has there not been enough research surrounding addictions to multiple drugs, but knowledge about the appropriate treatment (including detoxification) is lacking. Participants maintained that treatment centres must be flexible enough to include addictions to more than one substance and the staff must be trained appropriately to handle it.

“There are not enough specialized treatment centres to address the addictions to pills. Treatment centres still have four week programs which may not be long enough to address the addictions.”

“In our region the absolute priority is access to detoxification because we are dealing with poly-substance there is limited access and it’s difficult.”

Improvement with every aspect of pre-treatment care was identified as a priority among the participants. There were many issues expressed with the quality and availability of appropriate detoxification facilities. Overall, the participants felt as though the pre-treatment stage, which is quite crucial, should involve a more dependable referral process, a development of a treatment care plan, improved wait times and better access to transportation.

“We do not have enough detoxification/withdrawal management services; they are also generally set up to deal with alcohol only and we are dealing with people on crack, crystal meth, oxycontin, percocet and we need longer detoxification/withdrawal management.”

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“When you go to the action quadrant (referencing handout), to meet the gaps required to address addictions – whether it’s alcohol or cocaine it is important to have all the tools in our catchment area for all 12,000 people in our area; it is fragmented when you have to send people down to Bellwood or Beaver Lake Camp; there are waiting lists of three years and that does not provide the best of services. We need detoxification, treatment and aftercare in all our communities.”

Participants also identified the need for more youth centres and family residential centres as important. There are not enough youth treatment centres, though some individuals maintained that it might be more advantageous to put more money into education and prevention that targets youth. Regardless, the participants stated that drug addictions among youth were climbing and they need to have a facility that isn’t too far away. It was maintained that it is not only the individual that needs to heal, but the entire family. Having family residential centres and involving the family would alleviate many of the concerns that possible clients have. Although participants often mentioned the need for more family based treatment centres, some specifically mentioned the need for treatment programs specifically for women that enabled them to bring their children to avoid the child welfare system.

“Fear of failure takes away from confidence level, self-worth and we want to support but our hands are tied (e.g., 16–17 year old kids). Where do they fit in for age for services, if they can not get child into care because of age and mother would not go to treatment?”

“The treatment component is huge but if you give people a place safe to live for addictions, go through a treatment program and come back, that is very good. But the problem that is not being addressed is family. There is more work that needs to be done in our family unit for that.”

After care is an important part of the healing process, in which a client leaves treatment, re-integrates themselves back into a community and tries to live addictions free. In many communities there are no resources available to help clients after they have successfully completed a treatment program. Participants felt that this was a contributing factor to relapses. Many clients return to the same situation they left and with no support network in place, they have a difficult time. Participants suggested a dedicated sober living house, to help with this transition. In addition, the participants were firm in suggesting that the communities needed to play a supportive role in the after care of all clients. This would help to create drug free activities, awareness, role models and a more supportive environment for those people returning from treatment.

“There are few aftercare programs in the communities after treatment. We need more community based aftercare for people who want to change.”

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“Relapse prevention services are minimal at best in the community. There is a lack of qualified councilors in communities, mental health workers and nurse may not have ability to assist a person.”

Participants also identified the introduction of wholism at every stage of the treatment process as a priority. This refers not only to the use of First Nations culture but also to the healing of all parts of an individual: mental, emotional, physical and spiritual. Participants also stated that wholism would ensure that it is not just the individual who is treated but the family as well. This could involve making the family aware of what the individual needs to maintain sobriety and their role in helping with care.

“I would like to see more wholistic treatment because the clients are on methadone when they go in the clinic but the family needs treatment because the entire family is suffering.”

When mainstream services look at providing services to their clients, it is a very individualistic framework; the needs of that one client. We are more of a collective people. We are not individualistic, Aboriginal people are collective. When the service providers are not present, you fall back onto the family.

“The contributing factors to addictions: poverty, lack of self-esteem, hopelessness, unemployment, apathy, boredom, prejudice.”

Training

In order to meet the challenges presented by addictions treatment, the staff must be properly trained. It was mentioned by the participants that the current training is not keeping pace with the variety of addictions and situations that the staff faced daily. The participants highlighted four priorities in training: Concurrent disorders, poly substance abuse, doctors and the community.

Concurrent disorders were of great concern among most of the participants. They felt that the workers at treatment centres, at detoxification centres, and at the community level were not familiar enough with concurrent disorders. It was stated that many times clients with concurrent disorders get turned away from treatment, because the facility cannot accommodate them. As well, there is not enough knowledge about how to work with concurrent disorders. The participants maintain that many people with concurrent disorders are falling through the gaps. Participants stated,

“Mental health and addictions go hand in hand but many treatment centres only will deal with addictions.”

“Presently, depending on the medication of the clients, through the screening process the less medicated the struggle for clients and the perception of other clients sitting in the group has been a bit of a negative but not necessarily impacted but if you had someone who needed a fair amount of medicine or they needed a fair amount of medication, what would you do – it comes up.”

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“How much of the addictions that we see are a result of the trauma that people have been through and not knowing how to get through it. They may not be schizophrenic or bipolar, but they need to be in a safe place to deal with those feelings.”

The participants felt that handling poly substance abuse was also a priority. Many youth and young adults are suffering from more than one addiction at once, which can affect their body in many different ways. As stated earlier, there is not enough research done on these drug interactions. Many centres are still set up to handle alcohol addictions and these workers do not have enough training on multiple drug addictions and how best to handle them. Participants stated,

“Our clients come in with withdrawals. As frontline and/or intervention workers, we need that training/understanding of the process and how to detoxify a client. If we do not have any training, how can we assist the client to help themselves? What are the risks of having them here without understanding the drugs they are taking and withdrawal effects– could it be fatal?”

“I thought I understood the face of addiction, I do not and I do not think we can help our kids until we open our eyes to the fact that thirty days detoxification is not enough. Three months straight and clean is not enough time. We need to be honest and real about the face of addiction the treatment is very different and will take a lot longer.”

It is often thought that training deficits are only at the entry level positions but there also exists a training shortage at the upper levels, even with medical professionals. Doctors can work against the treatment centres by overmedicating their clients. It was maintained by many participants that doctors do not know enough about addictions and need to be trained. Participants stated,

“Need more doctors who are trained in addictions and concurrent disorders. Doctors need to be more accountable for the prescriptions they are filling.”

“Physicians need to take some responsibility in prescribing medicine. An education component and collaborative approach between physician and First Nation health centre.”

Finally, community training was identified as a priority among the participants. Many community members who have loved ones who enter treatment, do not understand what these individuals require upon returning to the community. In addition, the community addictions workers need up to date training and a support network they can reach out to for help. The workers in the community are the front line for addictions and need to be trained in how to best prepare individuals who seek treatment. These workers also need to be clean and working on being role models to the community. Participants stated,

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“We need to provide the training at the community level.”

“We need workers in communities to be educated, clean and sober and not “bootlegging” we need them to be responsible, accountable and firm that they will work.”

Inclusion of First Nations’ Traditions

Many participants see the need for more sustained inclusion of First Nations traditions and customs. As stated earlier in this report, many AA programs include many First Nations customs and traditions. This participant detailed how they include First Nation traditions and customs.

“A big portion of our program is based on traditional teachings, we have Elders working with us. We have sweat lodge weekly. A good portion is based on Traditional teachings.”

Further some participants see a role for educating clients about their First Nation history and lineage. Participants stated,

“Inclusion of legacy issues – a lot of people don’t know about their history or what has happened to us and we are looking at incorporating this by continuing consulting with Elders and having cultural programming.”

“We want to give them the understanding of where they came from, the history of their communities, clan systems, life before contact – pre-1670; give the kids a strong sense of connection and identity of who they are.”

There is a challenge however in having traditional work related expenses covered and deemed to be acceptable or equivalent to mainstream work. Traditional medicines and healers are not always recognized by the funding agency as being a viable and safe way to treat clients. Some participants maintained that due to funding and policy restrictions the way in which First Nations cultures could be integrated into a program was limited. A participant stated,

“There is also not recognition of a need for traditional trained and experienced workers. Even if those workers exist, there’s little or no remuneration for them, so there is no incentive for people to offer that approach.”

In addition, First Nations cultures should be integrated into programming across the board, according to participants. This would increase the activities available to youth, adults and seniors, while at the same time approaching healthy living in a creative and holistic manner. One participant stated,

“We need to be creative from everything from community kitchens to craft corners have to be examined. Something as inspiring as building a couple of canoes. We

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need to have our Aboriginal focus on all aspects of treatment. A focus on land-based treatment looks after a lot of these things.”

Another participant makes a summation statement with respect to the construction of all First Nations addiction programming and services.

“People need to go back to the seven grandfather teachings – you have to work toward having a good life, its not given to you, it’s a journey and you need direction and seek direction – the Creator gave life and you are responsible – the children are sacred gifts.”

Communication / Policy

Communication and policy were identified by the participants as necessary priorities. It has been stated that the funding and operations of the majority of treatment centres and workers operate in silos. There are very few communications networks that are set up with funding agencies, with doctors, with the band council and police, or with other treatment centres.

There are policy issues that are often confounded by a lack of communication and direction. Often times what is articulated at the upper management level does not translate to the grassroots. For instance problems seem to arise in connecting healing to addictions as detailed by this participant.

“There is no direct link facilitated by funding agencies between healing.”

One of the things that is really important and it would be difficult but how do we integrate First Nations and non-First Nation services – there is a need a times for different planning services but when people come into our doors to mainstream agency I don’t know we do a good job of that and part of it is funding silos (e.g., youth suicide initiative – there is a First Nation and non-First Nation planning table and these are kids that are dying period) we are at a point we can’t be separate – as a community this is how we will address the needs of ALL of our community members

The participants outlined the need for a communication network to be created with doctors in the province. Not only, as mentioned previously, do doctors need to be trained in addictions but they should work closely with the treatment centres. In some communities there are informal relationships that have been created with the local doctors but participants maintain these relationships are necessary all over the province.

“A whole lot of people come into play to deal with prescription drugs; the Professional medical people – you have to change their way of thinking they can not just push pills.”

“Develop a way to work with the hospital to have protocols set up working with Registered Nurse and doctor and having meds monitored, having it set up for

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the work and then with mental health in the community, having an appointment once a week – all working together for that one individual.”

Participants maintained that the band council and the police need to work more supportively with the treatment centres. Many participants discussed the need for the band councils to take addictions in their communities more seriously and to make it a priority. This could include dedicating money for infrastructure, funding educational initiatives, passing/enforcing anti-drug band council resolutions, and acting as role models for the community.

“Chiefs need to follow policies but they do not do that. If there is a policy in place they should follow it because it is hard to apply something that they do not enforce.”

“Addictions should be number one on the list of priorities, however, it is not. They are more afraid of addictions and new drugs than diabetes at this point.”

“We feel like an outsider when we come into the school. I wrote a letter to the school staff and people who are leaders in our community. I see our people and community breaking apart and they are not working together; people used to help one another and no one was better than anyone else.”

Particularly when attempting to deal with concurrent disorders or poly substance abuse, the participants stated that the lack of communication between treatment care centres, at any level, could have a negative impact on the client. The people who make the referrals should be in contact with the treatment centres and know the kind of information they need. It should be easier to find places for First Nations people in treatment centres and valuable time is wasted calling all over trying to find placement.

“Lack of coordination of service need an Aboriginal wide organization a Critical system. To have a 1-800 number central body that will find us a bed wherever we need it in Ontario, a counselor on the other end can tell them where a detoxification centre is and that detoxification centre in turn will connect immediately with a healing centre to avoid people falling through the cracks. Pool funding to use it effectively.”

“Networking within tribal areas is important. We need more communication with our areas to give information for what is working or not working in First Nation communities in regards to addictions – we can learn from our neighbours.”

At a broader level, the participants spoke about the need for improvement in provincial and federal policies concerning addictions and addictions care. If there is no understanding at the governmental level, it can restrict activities at the grass roots level. Another participant details the need for policy change,

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“I do not think you will get major changes until you change policies. If you make it harder for people to get, that changes. But at the community level we cannot change Federal policies.”

“We have all these social problems, we are forgetting that we are subject to government funding, regulations and policy but I said to government people at our Directors meeting was that we need the government to develop a national mental health policy which allows communities to access federal funding to address mental health issues.”

Funding

A perpetual problem with respect to addictions is funding. The funding that exists is not always a dependable, renewable source. Many participants stated that people that work in the field of addictions need to be focused on the present challenges but must always cast their eyes towards future generations. Participants stated,

“The major issue is that there is no consistent stream of funding.”

“Where are you, why are you not providing for the future? What resources are you setting aside financially, why aren’t your present employees supported for training locally? Why aren’t you promoting family and family events/education/training?”

Another participant details the dire need for funding to deal with the mushrooming nature of addictions and the complexities it brings with it. The changing face of addictions brings with it the need for money, space and flexibility to incorporate all of the new challenges. Participants stated,

“We do not physically have the space to deal with what we need to deal with – we need capital and infrastructure dollars.”

“We are funded provincially and federally and we cannot accept anyone who is on legal prescriptions. We need an addiction doctor on site and then we can take the clients with co-occurring disorders.”

Participants also mentioned that funding was a priority for training. There are many stresses placed on the staff of treatment centres and, because they are front line workers, they may not always be able to leave for training. The participants mentioned many incidents of burnout, lack of wage parity, and staffing concerns. Overall, the participants felt that training dollars were needed to help the staff in their daily interactions with clients. Participants felt that the staff needed to be armed with better knowledge of how to deal with the changing landscape of drug abuse. Participants stated,

“We have professional development training but it’s difficult to provide all staff training because we run 365 days a year and part of enhancement is to look at dealing with new trends, needs, mental health, etc.”

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“More funding for training dollars so that we can keep up with changing landscape of drug and substance abuse and be prepared to pro-actively deal with it – a proactive training strategy.”

Due to the difficulty in accessing many of the treatment and pre-treatment facilities, some participants stated that there was a need for community control of addictions treatment. There were some participants that mentioned they would like to see treatment facilities in or near their own communities. Other participants stated that this may be difficult because of the lack of confidentiality. Most participants agreed that some kind of funding for community based programs to combat addictions was necessary. One participant stated,

“Would like money to go directly to communities for own local community-based solutions.”

Prescription Drugs

Issues surrounding prescription drugs were identified as a priority by the participants. Every stage of the prescription drug abuse process needs to be improved upon. This includes the prescription of the drugs, the awareness of the problem and the treatment for prescription drug addictions.

As stated by the participants, the lack of communication with and lack of education in addictions with the medical profession leads to a host of problems for the treatment centres. Many participants believe that the doctors are overprescribing these medications, particularly to youth and seniors who tend to be hurt or need medication more often. These segments of the population are vulnerable for addiction to prescription drugs and vulnerable to attacks for their prescription drugs. They may also choose to sell them to supplement their income. One participant stated,

“Oxycotin and percocet – people have to realize are they using for their health or creating problems for other people. There is a vicious circle and it is profit and business for doctors which becomes profit for individual and addictions for others.”

In addition, the participants maintained that there was a lack of understanding within the community that prescription drug abuse was a problem. According to the participants, more awareness needs to be created in the community regarding what prescription drug abuse looks like and its long term affects. The participants stated that this was another area in which band councils and police needed to be more stringent. One participant stated,

“The Chiefs and Councils are not doing anything about the new drugs coming into the community to deal with the oxys and percs. But other groups are starting to deal with it.”

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Participants stated that prescription drug abuse has been on the rise recently. The rise in use and addiction has been difficult for treatment centres to keep pace with. Many treatment centres are oriented around alcohol and some have expanded to include other drugs such as crack and heroin. However, prescription drugs such as oxycontin require different training and it must be remembered that these drugs may be used in conjunction with other hard drugs and/or alcohol. Participants stated,

“Real abuse and misuse of prescription drugs has exploded in the last 4 years. Before it was mainly alcohol and marijuana.”

“Our treatment centre has a waiting list for oxy for six months but we need to be sure the clients are stabilized. Way back we were set up for drug / alcohol and were not set up for change in trends.”

“All of us are coming here with alcohol, but we do not have the personal experience with oxys or percs. It is hard for me to understand where they are coming from, or where they are at. We need more information on how to help them. We need an information toolkit to describe the symptoms, what to look for, what is involved, what kind of approaches are helpful, etc.”

This final section of the findings chapter is important as it provides an opportunity for front line workers, community members, policy makers and leadership to identify their priorities for enhancing and renewing the addictions prevention and treatment services. These priorities will feed into the strategic plan presented in Chapter 4.

Chapter 3: Discussion and Summary Analysis

This needs assessment drew upon extensive evidence from more than 350 people with expertise in the field of Ontario First Nations Addictions prevention and treatment services. The needs assessment also examined relevant and current literature in this field to provide both a contextual analysis and trends for future strategies to better meet the increasingly complex needs faced by Ontario First Nations and individuals struggling with addiction. This section of the report will interpret the combined findings with a view to developing a strategic plan for enhancing and renewing the addictions prevention and treatment services.

An overall conclusion from the Ontario Region First Nations Addictions Service Needs Assessment is the need for the establishment of a collaborative and integrated continuum of care for addictions prevention and treatment services. Furthermore, to maximize positive health outcomes in the area of addictions, it is important that this continuum of care include health, mental health and social services sectors as well as the community. It might further be argued that the justice sector should be included in the continuum of care.

In Skinner's work (2007) on *Rethinking the Continuum of Care*, he discusses the concept of "treatment doorways" clustering into a number of relatively distinct but broadly defined sectors. In Ontario First Nations, there are numerous points of entry to seeking support, but the infrastructure or broad collaboration currently is not formalized enough to really provide the assistance required. For example, the points of entry for Ontario First Nations include the addiction treatment sector, (NNADAP workers, addiction workers, etc.), the mental health sector (mental health workers, community or regional mental health programs, social workers, nurses, etc.), the medical health care sector (physicians, nurses, nurse practitioners) and the community and social services sector (child and family services, police; community wellness workers, etc.). Each sector has an understanding of their core roles and responsibilities, but a formal model has not been established to ensure that a continuum of care is provided by the combined efforts of these different service providers. There is an absence of case management because there is not a formal protocol or model for an inter-jurisdictional or multidisciplinary approach. While there is a potential for duplication in services in the absence of such a structure, the more obvious finding of this needs assessment is that there are gaps in services. This leads to individuals and families often not receiving the support they require in a timely manner.

Due to the geographical size and diversity of Ontario, as well as jurisdictional issues it would be challenging to propose one collaborative model for all Ontario First Nations. However, there is an opportunity to cluster services more effectively within regions to better meet those specialized needs. There are examples in Ontario whereby the province, the federal government and the

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Local Health Integrated Network have begun to examine this type of collaboration.

Health Canada's work in the field of addiction has determined that people with untreated concurrent disorders or multiple diagnoses are more likely to continue using substances and to experience poorer outcomes from stand-alone addictions treatment services. They suggest that integrated approaches addressing substance use and mental disorders have proven to be more effective in helping people with concurrent disorders (Health Canada 2002).

In British Columbia, they have undertaken a number of Task Forces on mental wellness issues, homelessness and addictions. They found that the most unfortunate impact of the stand alone approach was experienced from the perspective of the consumer, whose concurrent mental health and addictions issues often went undiagnosed, and when recognized, represented two separate service systems for the individual and/or his or her caregivers to navigate. In British Columbia, this is starting to change. At the ministerial level, addictions and mental health have merged, and a consistent policy framework is being developed to guide service delivery throughout the province. At the regional level, health authorities are coordinating and integrating mental health and alcohol and drug services. At the service delivery level, mental health and addictions personnel are coming together to learn from each other and to develop collaborative approaches to dealing with people who struggle with both issues.

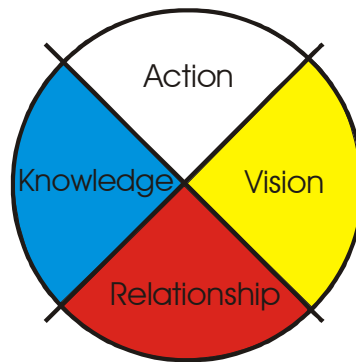
While Ontario First Nations may not be in a position or willing to integrate mental health and alcohol and drug services to the extent of the BC model, there is certainly support indicated in this needs assessment to increase coordination and collaboration. This is particularly considered worthwhile given the limited resources available. For example, there was a funding freeze in the mid 1990's of the Indian Health envelop which is core to the NNADAP programs. As a result, the NNADAP program has not received any significant funding enhancements beyond an annual 3% increase since that time.

However, there are additional funding sources available particularly through the Local Health Integrated Network and the Ministry of Health and Long-term Care, as well as potential (albeit limited) enhancements that may filter through the First Nations Addictions Advisory Panel (FNAAP) planned national program framework that might be more effectively leveraged through a regional collaborative effort. The regional clusters could more effectively ensure a continuum of care including education and prevention activities, withdrawal management, pre-treatment, treatment, aftercare and promotion of stability for Ontario First Nations. The regional clusters might also be able to respond more rapidly to the changing needs of community addictions. A number of participants in this needs assessment not only indicated a willingness to re-profile some of their services to better meet the needs of Ontario First Nations in their region but provided the research team with examples of funding proposals to enhance their service delivery model.

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Most would argue that the greatest challenge will be in bringing all the parties to the table in geographical regional clusters to work collaboratively together. Many parties have historically competed for scarce funding. This model would potentially bring former competitors together to share the funding resources with clear roles and responsibilities for providing services within the continuum of care. However, the greater challenge will be ensuring that the continuum of care is First Nation designed, delivered and managed with First Nation culture and values as a foundation to the services provided, *not* an add-on.

There are principles of collaboration that can guide this work found in First Nations cultural values.³



Vision

Within a First Nation cultural paradigm, vision is considered the most fundamental of principles. Visioning First Nations' well-being involves examining the complete picture of health including, physical, mental, emotional and spiritual health issues. A visionary process is one in which the stakeholders identify their vision for the health and wellness of their community. This is often referred to as intuitive knowledge.

³ This interpretation and language is the intellectual knowledge of Andrea J Williams under the direction of Shirley Williams. Please cite appropriately. The circle or medicine wheel is a central expression of culture, representing a unifying force in life. It is a representation of traditional theology, philosophy and psychology. There are different but related versions of the medicine wheel for different Aboriginal groups. One common aspect is that they are based on the four directions and four seasons. A circle is a symbol of completeness and perfection. Central to the teachings of the medicine wheel is the goal of Bimaadiziwin or "living a good way in life". This entails balancing oneself within all aspects of the four quadrants of the wheel. Today four-quadrant models or working wheels are used to organize work and situate activities within an Indigenous framework.

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In collaborative planning and program delivery with First Nations, it is important to:

1. Define a clear vision – this responsibility rests with the community
2. Enable a community engagement process, which will also include an education or awareness component, for all parties
3. Re-instill confidence in what community members know from life and work experience and the knowledge that has been handed down to them through generations.
4. Invest in the capacity building and education of First Nation communities, as they are the only ones who can make changes to address the identified problems.

Relationships

Refers to the experiences that one encounters as a result of relationships built over time and examines how we relate to people. It provides an opportunity to gain an understanding of the attitudes and awareness that exist at this particular point of time, regarding the individual, community and national wellness issues, including language and culture, residential school impacts, emotional, addictions and mental issues, as well as availability of community supports.

In First Nation teachings, it takes time to establish relationships, by learning from one another, by ensuring that all are kept informed of the issue, process and progress in achieving the vision.

This involves:

1. Developing workable, cross-cultural partnerships
2. Ensuring that community protocols are observed to enable all participants and stakeholders in the situation to share their knowledge, ideas and thoughts in a safe environment.
3. Fostering mutually reciprocal relationships
4. Engaging advocates, community groups and community members to support the vision.

It requires making the issues more human as it is sometimes too easy to consider people struggling with addictions or mental wellness as less worthy of support, particularly those that struggle with repeated relapses. Making the issues more human requires educating the media, policy makers, government, and the general Canadian public on the realities faced by First Nations people and convincing them that the situation is socially unacceptable. It might also require reminding First Nation community members of their responsibility to be non-judgmental.

Knowledge

Whereas vision is considered intuitive knowledge, the western quadrant is referred to as learned knowledge. It is the opportunity to confirm what was known intuitively, learn from other promising practices, develop policies and reflect on what will have the most impact in to achieve the vision. It is important to understand that the information shared is well-thought out,

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reflective of the situation and as such should be treated with the respect this wisdom and learned knowledge deserves.

Some ways to implement this teaching is:

1. By creating a new culture or way of doing business with other communities, funding agencies, and government
2. By utilizing an inclusive process that is more responsive, effective and accountable to the people they are meant to serve
3. By integrating cultural approaches to policy development based on First Nation perspectives and knowledge.

Action/Movement

This component is important in that it activates positive change to improve the program so that it better achieves the vision (expectations) of the First Nation community, resulting in the healthy development of their children, families and communities. While it is important to reflect upon what has been learned and take the time to thoughtfully articulate solutions in the development of a useful and effective program, strategy or policy, it is the action that will move First Nations closer to achieving the desired vision.

This teaching emphasizes that:

1. Programs must be designed, managed and delivered by the community groups
2. Capacity building must be integrated in all policy and programming, to provide for the development of new skills for First Nation people
3. There is a need for long-term sustainable funding to support success in moving towards the vision.

An underlying theme that intersected all the findings was the importance of identity and sense of belonging as a cornerstone to healing. The literature affirms that ultimately personal identity and self-esteem are closely bound up together, and emerge from a sense of personal value, of personal worth, of being needed, of being loved for what you are, not just for what you do. This is true health and wholeness and depends greatly upon experiences of parenting as children (Sawrikar, Hunt, Chansonneuve, and Tait). The literature in Section 2 of this report clearly demonstrates that assimilation policies have disrupted healthy family lifestyles in Ontario First Nations leading to prevailing addictions and mental wellness issues. This is why participants are embracing a resurgence in First Nation cultural knowledge in addictions prevention and treatment approaches.

Research indicates that abstinence programs generally have less success rates than other programs. This is thought to be because the success indicators for abstinence programs are so strict. If a person begins usage again, even just one episode, the treatment is often deemed to have failed (Korhonen 2004: 27). In Ontario First Nations, this perception of failure continues to perpetuate low self-esteem and poor sense of person worth. The most obvious policy example of reinforcing failure, is that Non-Insured Health Benefits (NIHB), considered a Treaty Right by First Nations and administered under Health Canada will not

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pay return transportation for a client who is unsuccessful in completing a treatment. The client is penalized and judged for perceived “failure” by the funding agency (not the treatment centre) and essentially discarded except for the extraordinary efforts of the treatment centre to find a way to get them home safely. Often an individual will isolate themselves even more from positive community practices and find a sense of belonging with unhealthy activities. Community members, front-line workers and leaders need to continue to be relentless in the provision of service. And policy gaps such as those identified above must be remedied immediately. It is imperative that the federal government and in particular the government of Ontario accept that programs will not succeed unless they are community driven.

Economies of scale dictate the level of resources available to address the myriad of complex social economic and health needs in Ontario First Nations. Even if there were unending amounts of financial aid available, it would take more than financial resource to facilitate change. The participants spoke firmly of the need of First Nations Leadership to drive the addictions and wellness agenda, and advocate for the social determinants of health. Ontario First Nations also require political will of leadership at the provincial and federal levels to facilitate change. However, the most compelling change agent is ownership from individual grass roots individuals and community engagement.

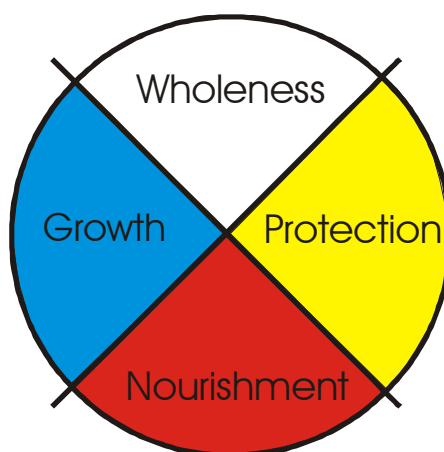
First Nation people must combine individual gifts to support the health of their communities. And as noted earlier, this often means boosting self-esteem and confidence in what First Nations people know, so that individuals realize they have a gift to share. First Nations have a strong collective upon which to build upon their caring and sharing nature. It happens informally throughout Ontario First Nations communities in spite of the overwhelming hurdles of grief, loss and social issues. The more that can be done to increase sense of belonging, the more success Ontario First are likely to have in combating addictions and building healthy communities. As communities gain confidence in what they know as solutions and begin to initiate other steps that are more culturally appropriate and effective with their community members.

Throughout this report, the participants and authors have identified First Nations cultures, values, identity and self esteem as the cornerstone to healing. Therefore, it was felt appropriate to share an example of how culture can be utilized as the foundation of programming within a continuum of care, as opposed to a component of programming. The following four quadrant model provides an example of how First Nation cultural values can be implemented as a tool to wellness. The model is not presented as a solution but as *one* illustration of how the richness of knowledge contained within Indigenous knowledge which can be adapted as programming to address addiction prevention and treatment needs. This model is an interpretation developed by Williams Consulting and relates to restoring respect and offering a sense of belonging for Ontario First Nation community members, particularly those struggling with addiction. Traditional Teacher Shirley Williams, from Wikwemikong shared a teaching which comes from lessons from her father,

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John Simon Neganiwane, Wikwemikong and teachings from Eddie Belrose, Alberta, as the Williams Consulting research team continues to articulate conceptual models based on holistic cultural approaches to addressing substance abuse and other issues faced by First Nations people.

The following description summarizes how First Nation cultural values could be applied in practical approaches to addressing addictions prevention and treatment services.⁴



Protection

In the eastern quadrant, in this model one finds the value regarding protection. This refers to those things that provide protection in our lives. For example, Elder Shirley Williams shared that if you have been taught not to like yourself, you tend to punish yourself by using drugs and alcohol to try to fill that void. In this model, this teaching suggests that First Nations have an obligation to protect their community members who are turning to drugs and alcohol. There are layers of protection such as:

1. To protect the individual who may not be ready to accept the damage they are doing to themselves or why.
2. To protect the children and family members, and
3. To protect the community from the damage inflicted by drug and alcohol abuse.
4. They need to go somewhere where they are safe, where they have access to trained counsellors, as well as support from people who have experienced similar challenges. They need safety and they need to know where they can go to be safe.

The implication of this teaching for addiction programs is that it is important to meet the client where they are at. This means support workers need to go to the community member experiencing difficulty and not necessarily wait for them to come to the worker once they admit they have a problem. Needless to say it is

⁴ This interpretation is the intellectual property of Andrea J. Williams under the direction of Shirley Williams and should be cited appropriately.

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extremely important to be non-judgmental while reaching out to protect individuals, and subsequently children, families and communities.

In Prochaska and DiClemente's Stages of Change Model, this would involve working with the pre-contemplative client who is not considering change. Techniques they identify as helpful during this phase include: validate lack of readiness and clarify that any decisions made is their own. Workers can encourage re-evaluation of current behavior, self-exploration with forcing action and explain and personalize the risk.

Nourishment

In the southern quadrant of this model one finds the value regarding nourishment. This refers to those aspects of life that nourish and sustain First Nations people.

1. This value often begins with physical nourishment of First Nation community members struggling with addiction. Food and feasting represent kindness; increases strength and feasts encourage a sense of belonging.
2. There are other activities that nourish individuals mentally, emotionally and spiritually. It can include using traditional medicines, going medicine picking, beading, singing groups, spiritual gatherings, speaking with Elders, as well as some ritual expressions of Aboriginal culture like smudging, fasting and sweatlodges. The important aspect of nourishment in this concept is that it encourages positive energy and building healthy relationships.

Prochaska and DiClemente's Stages of Change Model would suggest that in this quadrant, addiction workers would help patient identify social support, determine if the client has underlying skills for behavior change and encourage small initial steps towards addressing their abuse or addiction issues.

Growth

In the western quadrant of this model one finds the value regarding growth. This refers to the stage whereby individuals demonstrate more willingness to gain a better understanding of themselves and examine healthier life experiences.

1. Growth refers to the importance of pursuing positive life experience. Traditional teachings suggest that every time an individual learns something new they grow a deeper understanding in the meaning of that knowledge.
2. This stage is self reflective and one examines themselves more objectively including the underlying causes of any destructive behaviour.
3. In this quadrant, staff and community members need to help individuals find themselves and restore self respect. Elder Shirley Williams suggests that some First Nations people struggling with addiction are in such emotional pain they simply can not face the pain by themselves. She also suggests that it takes time, and that clients can only address these issues a bit at a time.

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4. It is in this quadrant that support staff work closely with clients on self-esteem esteem and identity issues. It is important that First Nations begin to believe that they are important and have self-worth.
5. With some renewed confidence in self and positive life experience, at this stage individuals can begin to safely reflect on past life experiences. Sometimes individual are unaware of the consequences of their actions and this is difficult to handle. Often First Nation people with addictions have not forgiven themselves for something they have done or experienced in the past. It is important for them to learn forgiveness and focus on positive life experiences.

For example, Prochaska and DiClemente would argue that in this stage of growth, the focus of work with the client would be on restructuring cues and social support and bolster self-efficacy for dealing with obstacles. Workers would help clients' combat feelings of loss and reiterate long-term benefits of the healing journey they are engage upon.

Wholeness

In the northern quadrant of this model one finds the value regarding wholeness. This refers to the stage whereby individuals begin to find more harmony and balance in their lives. When individuals focus more energy on one aspect of life to the exclusion of others, whether it is substance abuse, gambling, or working too much, they come to an understanding that something else suffers – often children and families in the First Nation community.

1. As one work towards wholeness, they begin to set goals for the future. While ideally many communities want people to move towards abstinence, that goal might take time. Individuals might need to move forward in stages until they have confidence that they can lead a balanced, harmonized life.
2. This quadrant reinforces principles that “everyone has a gift” and is valuable to our families and communities
3. This quadrant is empowering – re-instilling within the client respect for self, family community, and ultimately Canadian society

Prochaska and DiClemente would suggest that in this stage of change, workers and clients would not only plan for follow-up support, but would rreinforce internal rewards, discuss coping with relapse and as the client moves through the circle or four quadrants again they would gain deeper motivation, better understanding of triggers for relapse and continue to develop stronger coping strategies.

Overall, this model is based on motivational and encouragement values. Most importantly this model recognizes that it takes time to move towards living a healthy life when dealing with the social economic challenges faced by First Nation community members who are struggling with addiction. It reinforces what was confirmed in the literature and the findings from participants that improving confidence and understanding of identity and improving self-esteem will lead to improved health outcomes.

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The needs assessment findings indicate that different approaches are required depending on what stage an individual is at regarding addiction or substance abuse. For example, there is a strong need for prevention activities for young people or new users of substances. This can involve an education and counseling component. This is important due to reports from the young people that they are turning to opiate use, primarily prescription drugs. It is worrisome in that they not only inhale the substance but are beginning to inject the opiate. This could lead to an increase in transmitting communicable diseases.

The literature and study participants indicate that once individuals have passed the experimental or early use stage and become addicted to substances, then the focus needs to shift to early recognition and direct intervention.

There is a need to increase education and awareness with people who have a legitimate need for narcotics to address their related ailments. Care must be taken that their rights are not affected by anti-drug efforts. At the same time, they must be educated about how their prescriptions must be safe guarded so that they are not abused and used inappropriately by others. In particular, seniors in our First Nations communities need to be educated or provided support as they are often bullied by younger people who take their prescriptions from them. As a result of colonization, it is difficult for many First Nation people to say no to the young people for fear of losing them particularly through suicide, so it is a delicate balance.

It is important to remain non-judgmental and offer ongoing support. Many studies suggest that the earlier an individual becomes involved with an individual struggling with addiction, such as an elder community member or close friend, then the quicker the healing process will be expedited.

As mentioned earlier in this discussion, the cornerstone to addressing addiction and wellness issues is the provision of a continuum of care. It is possible to develop multi-disciplinary teams, not only in geographical clusters but also at the community level. Although resources may be limited, they are still present in First Nations communities. This shift requires a change management strategy. It also involves re-awakening the natural volunteers and helpers in the community to enhance sustainability of community programs. Numerous treatment centres are currently accredited and others are undergoing accreditation. Organizations achieve accreditation by undergoing an objective evaluation of the care and quality of services they provide to clients, and then comparing these findings against a set of national standards. Accreditation Canada's accreditation program includes standards on First Nations and Inuit Community Services and First Nations and Inuit Addiction Services. Accreditation is a process that benefits staff, facilitates team building, and provides an organization with access to valuable advice from other health care professionals. By participating in accreditation, organizations demonstrate to clients, communities, stakeholders, and partners, and their commitment to quality. There are Accreditation organizations that are sensitive to First

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Nations cultural significance and these boards apply wholistic frameworks to the accreditation standards and integrate cultural relevance into their assessments.

Accreditation can be an accountability and evidence of standards not only for individual programs but also for networks. A network might be the combination of service providers in a geographical cluster group that provides a continuum of care for addictions and concurrent disorders. Alternatively, a network might be a community based multi-disciplinary team such as Six Nations Health and Department who is accredited through the Canadian Council on Health Services Accreditation Program. Services accredited through this network in Six Nations Health include: Ambulance; Clinic Nurse Program ; Community Health Clerks; Community Health Representatives; Dental Services (Support Staff); Dog Control; Healthy Babies / Healthy Children; Health Promotion; Long Term Care / Home and Community Care; Maternal / Child Program; Medical Transportation (Support Staff); Mental Health; New Directions; School Nurse Program; Sexual Health Nurse Program; SHARE-AP Research Program and Social Development. (Retrieved March 17, 2009 from <http://www.snhs.ca/Welcome.htm>) A network does not have to be large to be accredited; it can be applied in smaller First Nations. A potential advantage of accreditation is that not only does it place an onus on the service provider or network to demonstrate their quality service, but it could also place an onus on funders to ensure that the continuum of care is appropriately resourced.

In conclusion, the literature and the study participants confirm that many First Nation individuals will require four or five tries at addiction treatment before they achieve success. As such, community members, front line workers, and leaders we need to be relentless in our provision of service. The door can never be shut to addressing addictions and mental health issues with First Nation members. First Nations have a responsibility to protect, nourish, and encourage growth and wholeness for each of their community members.

Marlene Brant Castellano states that:

“The knowledge that will support our survival in the future will not be an artifact from the past. It will be a living fire rekindled from surviving embers and fueled with materials of the 21st century.”

This reinforces the notion that First Nation cultures are not stagnant. First Nation cultures have not been lost. The core values, language and wisdom of those who came before is still there. When participants and the research team discuss First Nation cultures as a tool for healing, this is not a suggestion that First Nations must return to the past. Rather it is imperative that Indigenous Knowledge is the foundation of addiction prevention, education and awareness, treatment and aftercare program development. First Nations must continue to build upon their strength, resiliency, cultural values and distinct identity to engage the healing power of our communities and more effectively respond to addiction prevention and treatment service needs.

Chapter 4: Draft Strategic Action Plan

The primary objectives of the regional needs assessment is to provide a comprehensive examination of addiction treatment and prevention services within the FNIH (Ontario) Region; and, based upon these findings, to develop a comprehensive report that identifies strategic areas for action for optimizing services within the region. The aim of the regional needs assessment process is to ensure that the region's First Nations communities have access to an effective, sustainable, and culturally-appropriate continuum of addictions prevention and treatment services. This chapter will present four broad strategies designed to build commitment among key stakeholders to the identified priorities that are essential to its purpose and responsive to the findings. The advisory committee will review and elaborate upon these broad strategies.

Goal Statement

To strengthen a coordinated continuum of care of First Nations addiction prevention and treatment services within communities in Ontario to achieve a desired state of well-being. This health and wellness continuum of care will be culturally based, flexible and build upon successes and emerging First Nations needs and trends to support the promotion of an addiction free lifestyle and will be supported by a competent, skilled workforce comparable to provincial standards.

Vision

To promote and support the health and wellness of First Nations people and communities in Ontario to lead healthy lives.

Target Population

The target population for this strategic action plan includes First Nations individuals, families and community members in Ontario. First Nation people reside in 133 First Nations communities in this province, as well as off-reserve in urban and rural communities. The on-reserve population ranges from small communities of 150 members to some of the largest communities in Canada of 20,000 members for a total exceeding 175,000 First Nations people according to INAC in 2007. This represents approximately 22.1% of Canada's total Registered Aboriginal population (Ministry of Health and Long-Term Care, 2009).

In Ontario the First Nation population is young when compared to the rest of Canadian population. In 2007 36.1% of the registered First Nation people living on reserve were under the age 20. The findings of this report emphasize the need to focus strategies for addressing addictions and promoting healthy living on this young demographic including youth and young adults. In particular, the

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addiction patterns for the younger population indicate more use of opiates, cocaine and crack than the middle age population.

In addition to the relative young Ontario First Nation population are correspondingly high fertility rates among First Nation women. Fertility rates for First Nation women in Ontario are significantly higher than for Canadian women. It was reported by INAC in 2000 that the total fertility rate (TFR) for registered First Nation women was 2.9 children. In that same year the TFR for Canadian women was 1.5 children, approximately half of that of First Nation Women in Ontario (Ministry of Health and Long-Term Care, 2009). Concerns regarding impacts of substance abuse on fetal development were raised repeatedly in this study, therefore strategies are designed to address this pressing need. In addition, findings of this study indicate that young single parents (usually women) are losing their children to the child welfare system due to their struggles with substance abuse, again indicating a need to proactive address this situation.

Approximately 7% of the registered First Nation people living on reserve were aged 65 or older (Ministry of Health and Long-Term Care, 2009). Many concerns were raised by study participants that Seniors and Elders were being bullied or exploited for their necessary prescription drugs and/or lacked awareness about the appropriate use of their prescriptions.

In addition to targeting the First Nations populations, the strategies are also directed toward leadership at the First Nation, Federal and Provincial governments and other stakeholders including the Local Health Integration Networks.

Furthermore, the diversity in First Nations, tribal affiliation, and the vast geography of this province necessitate flexibility in approaches and actions identified in the strategic action plan. The strategies need to address prevention and treatment approaches for all ages and stages of life from pre-natal to Elderly people. Approaches must be directed to individuals, families and community supports with a focus on building healthy families and healthy communities. It is important to note that treatment services do not just rest with residential treatment facilities, but treatment is initiated from a request for help, referrals to intervention, aftercare, relapse prevention and promotion of healthy communities. Treatment is integrated in all aspects within the continuum of care.

4.1 Strategic Priorities

Strategic Planning is a systematic process through which an organization agrees on, and builds commitment among key stakeholders to, priorities that are essential to its purpose and responsive to the environment. Four *Strategies*, that is, a coordinated, broad approach or direction that informs organizational resource allocation have been identified in this study.

An *outcome* is a desired state of well-being – a set of conditions, experiences or behaviours – that is the goal for change or improvement. Outcomes have been identified for each Strategic Priority.

Program and management functions are the means an organization employs to implement strategies and accomplish the purpose. In this strategic action plan these functions are listed as *Actions*.

An *indicator* is a specific piece of information that measures all or part of the condition, experience or behaviour that is the desired state of well-being or outcome. Good indicators are:

1. Meaningful – they clearly relate to the outcome (sometimes having face validity)
2. Powerful – research indicates that a change in the indicator predicts a change in the condition of well-being that are trying to measure
3. Actionable – it is possible to change the indicator by an individual, group, organization or institutional action.

There are linkages in the strategic priorities which emerged from this study with those articulated by Ontario First Nations in their Strategic Health Plan approved by Chiefs in Assembly in November 2008. Ontario First Nations concur that strategic planning and implementation of the plan is vital to improving and transforming the health status of First Nations in a systematic way. Five strategic directions were identified in the plan which included:

1. Nation-building
2. Improving relationships between FN entities
3. Managing knowledge and information
4. Strengthening communities
5. Advocacy to improve quality of life

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The Strategic Health Plan identified seven core that can be implemented by most levels of the First Nation Health System in ways appropriate to their mandate and role. It was also identified that all levels of the First Nations Health System must work together to bring about the desired changes and results. The seven core strategies identified included:

1. Assert treaty rights for health
2. Advocate and support First Nations jurisdiction to govern their own health systems
3. Align Ontario First Nations health system levels to transform the status of First Nations health
4. Develop processes to support Ontario First Nations health system
5. Improve flow of communications within the Ontario First Nations health systems
6. Use technology to expand access to health information
7. Implement strategic management system for sustainable change and results

Strategic Priority #1: Training and Supportive Resources

Strategic Priority #1: To increase training opportunities and supportive resources	
Outcomes	
<ul style="list-style-type: none"> • An appropriately trained accredited workforce who are financially compensated in accordance with provincial equivalents. • Effective coordination and collaboration with other service providers. • Reduction in individual use and harms associated with drug and alcohol use • First Nation culturally based healing program is in place to support client recovery. 	
Actions	
1.1	To develop appropriate training materials and resources for employees to be better equipped to meet the changing substances being abused by First Nation people – trained workforce.
1.2	To financially support ongoing accreditation at the individual, service and network level.
1.3	To develop a change management strategy to support a multidisciplinary pre-treatment and aftercare model at the community level. (Notes: Leadership and employees have to be prepared on how to work within a different model).
1.4	To address factors contributing to addictions through First Nations and Regional Advocacy regarding the identified underlying factors and the social determinants of health.
1.5	To develop First Nation policies to address substance abuse.
1.6	To develop resource kits and a communication strategy to build upon First Nation capacity and historical responses to heal their communities (volunteerism).
1.7	To conduct appropriate evidence based research to demonstrate effectiveness of treatment modalities – particularly initiate research around First Nation culture as a treatment modality.
1.8	To improve physical infrastructure through enhanced capital funding.
1.9	To increase funding levels for program delivery, resources, training and wage parity.
Indicators of Change	

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- Stable and adequate funding for service enhancement, training and infrastructure
- 20% increased in accredited programs and workers
- 20% increase in consistent use of effective resource materials
- 20% increase in client satisfaction as a result of appropriate programming

Strategic Priority #2: Education and Prevention

Strategic Priority #2: To enhance education and prevention knowledge, skills, tools and approaches for addressing drug and alcohol abuse and the underlying factors contributing to addiction	
Outcomes	
<ul style="list-style-type: none"> • Reduction in the prevalence of fetal effects of drug and alcohol use. • Reduction in the prevalence of prescription drug abuse. • Reduction in the prevalence of youth drug and alcohol abuse. • Traditional First Nation healing approaches in place to support client recovery. • Reduction in individual use and harms associated with drug and alcohol abuse. • More prevention services and supports in place for First Nation people. 	
Key Activities	
2.1	To provide education and prevention activities for targeted age groups including fetal development, pre-contemplative, new users (youth) and established addicts.
2.2	To develop toolkits that contain appropriate approaches to more effectively reach the population (i.e. less focus on community workshops and increased focus on contained audiences i.e. schools, staff meetings, AHSOR, church services, interagency wellness fairs, etc.
2.3	To integrate land based activities and First Nations culture as vehicles for communication and education around substance abuse.
Indicators of Change	
<ul style="list-style-type: none"> • 10% increase of young people participating in education and prevention programming. • 20% increase in program participation due to improved toolkits and approaches to reaching community members in need. 	

Strategic Priority #3: Continuum of Care

Strategic Priority #3: To improved availability of crisis intervention and direct treatment services for First Nations people who are abusing drugs and alcohol	
Outcomes	
<ul style="list-style-type: none"> Enhanced development of a coordinated continuum of addiction prevention and treatment services for and by First Nations that includes traditional, cultural and mainstream approaches. Reduction in individual use and harms associated with drug and alcohol use. First Nation communities are recognized and supported as important resources by developing capacity to address alcohol and drug abuse. First Nation promising practices and community based research is supported. 	
Key Activities	
3.1	To provide targeted crisis intervention and direct treatment service strategy towards youth. (Notes: They are increasing using substances other than alcohol, they are highly at risk for developing addictions and they represent the fastest growing population. In the current model, the onus of responsibility is being placed on those with complex issues and who lack the maturity to deal with it).
3.2	To provide targeted withdrawal services appropriate for the type of addiction and within a First Nations-based or culturally safe model.
3.3	To provide targeted intervention and direct treatment services for alcoholics (alcohol is primary substance they are addicted to).
3.4	To develop and provide targeted direct treatment services for poly-substance abusers.
3.5	To develop and provide targeted direct treatment services to address concurrent disorders – substance abuse and DSM4 mental health disorders, as well as anxiety, depression and PTSD.
<p>Notes: A priority will be to re-profile some of the existing NNADAP treatment centres to deal with changing substance abuse needs – for example:</p> <ul style="list-style-type: none"> family-centred treatment centre youth treatment centre – but for poly substances not just inhalants alcohol treatment centre (for 45+) continuum of care treatment centre (i.e. Thunder Bay for withdrawal management, pre-treatment, treatment, aftercare and transition) <p>It is assumed that all new programs will have a strong foundation on First Nations cultural values.</p>	
3.6	To research and develop toolkits offering more consistent treatment modalities which are proven effective to respond to multiple substance abuses. (Emphasis on “First Nation Culture as Healing” as a treatment modality; at least in one example. Move away from exclusively abstinence based treatment options).
<p>Notes: The pressing issue of today is prescription drug abuse, but treatment strategies have to be flexible enough to respond to the issues of tomorrow</p>	

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Indicators of Change
<ul style="list-style-type: none">• Community based research initiatives are funded.• Promising practices are documented and disseminated at the community level.

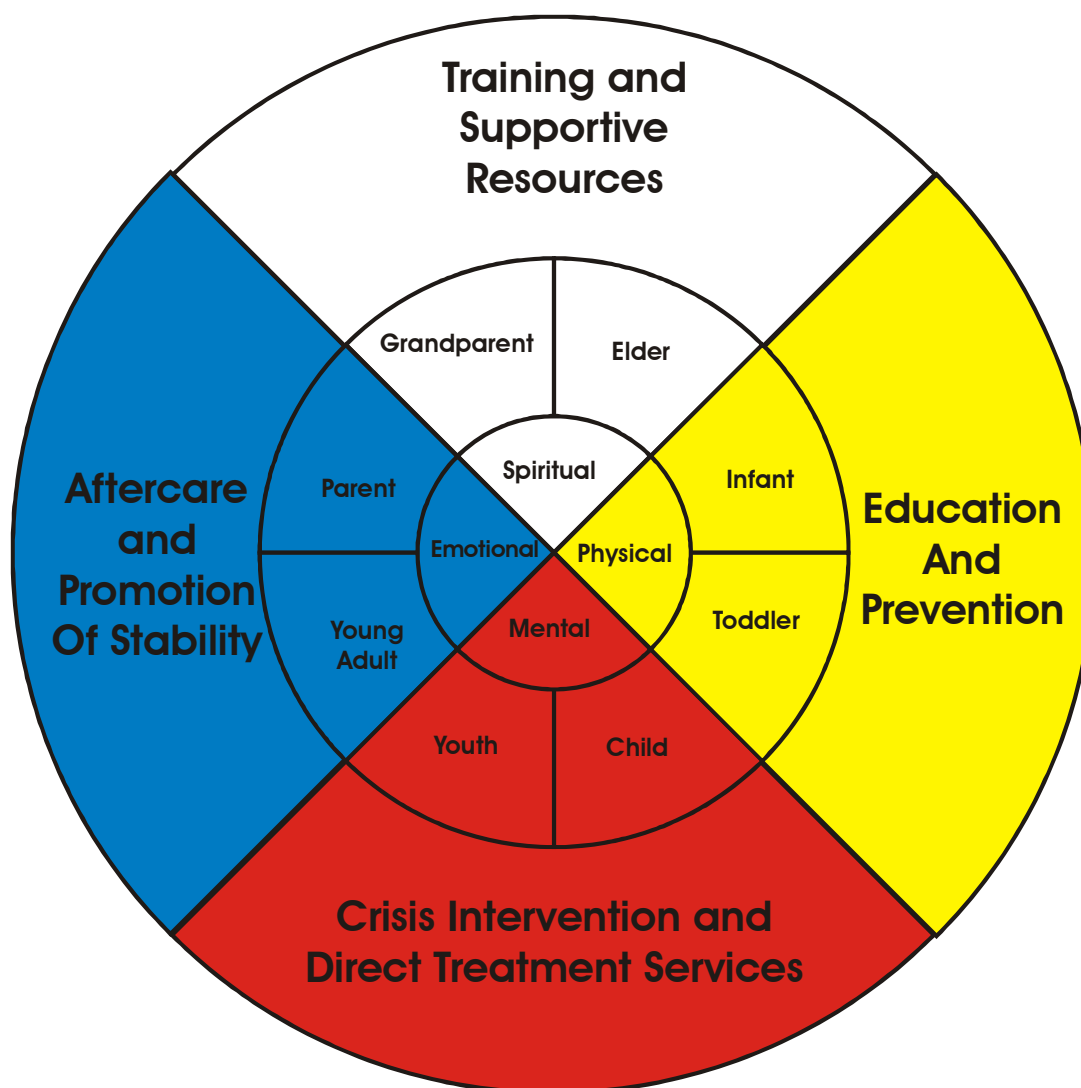
Strategic Priority #4: Promotion of Stability

Strategic Priority #4: To enhance the promotion of stability and promote health lifestyles for First Nation communities, families and individuals	
Outcomes	
<ul style="list-style-type: none"> • Clarified and strengthened roles and responsibilities between addictions, mental health, and related human and health services among federal, provincial, and First Nation delivered programs and services. • A culturally safe and effective multidisciplinary and comprehensive continuum of addiction prevention and treatment services for Ontario First Nations people. • Culturally appropriate services and strategies are First Nation developed, implemented and evaluated in collaboration with local and regional service providers. 	
Actions	
4.1	To develop an coordinated continuum of care model which includes a formal aftercare component to support individuals in their relapse prevention
4.2	To develop an aftercare program with increased onus on community supports and responsibility and less emphasis on vulnerable clients to have sole responsibility to implement their aftercare program.
4.3	To increase multidisciplinary support at the community level through existing health and wellness staff members, mirrored on the ACT teams
4.4	To offer transition housing in the First Nation communities
4.5	To develop a community based toolkit to support aftercare and relapse prevention (such as a Welcoming feast for individuals completing treatment; to offer employment in the First Nation communities for individuals who have successfully completed a treatment program etc)
Indicators of Change	
<ul style="list-style-type: none"> • 25% increase of First Nation leadership and communities have developed community wellness action plans. • 20% of First Nations have addiction prevention and treatment in their health services strategic plans. • 20% increase in community participation for aftercare and relapse prevention. • 10% increase in F/P/, First Nation, LHIN and service providers working collaboratively to provide continuum of care. • 10% decrease in relapse. • An agreement between First Nations, federal and provincial governance regarding roles and responsibilities related to funding and delivery of addiction and mental wellness programs and services. 	

Appendix A: Detailed Methodology

In this section, we will be discussing findings from focus groups and key informant interviews during the twelve site visits, key informant interviews as well as survey findings from 38 First Nation communities and eighty nine participants at the NNADAP conference on November 28, 2008. This section of the report provides quantitative and qualitative information from the participants. Each discussion of participant findings is followed by a summary of what the relevant literature has to add to the findings.

In addition to the questions asked of the participants through the different lines of inquiry, Williams Consulting provided a four quadrant model to help focus discussion within a continuum of care and throughout all ages and stages of life.



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The following twelve site visits were completed a total of 198 focus group participants and 29 key informant interviews :

- October 27-28, 2008 at Ngwaagan Gaming Recovery Centre (Rainbow Lodge), Wikwemikong. Four focus groups were held with 22 participants in total and three key informant interviews. Types of stakeholders included: NNADAP workers, staff, Board of Directors, Community Specialist, Chief and Councillors, Mental Health workers and Child Welfare.
- October 28-29, 2008 at Anishnabie Naadmaagi Gamig Treatment Centre, Blind River. Four focus groups were held with 21 participants in total and one key informant interview. Types of stakeholders included: NNADAP workers, staff, Board of Directors and referral programs.
- October 30-31, 2008 at Sagashtawao Healing Lodge, Moosonee. Four focus groups were held with 22 participants in total and one key informant interview. Types of stakeholders included: NNADAP workers, clients, staff, Board of Directors, doctors and service providers.
- November 3-4, 2008 at Dilico Anishinabek Family Care, Thunder Bay. Four focus groups were held with 39 participants in total and eight key informant interviews. Types of stakeholders included: staff, community service providers and clients.
- November 5-6, 2008 in Sioux Lookout. Six key informant interviews were held. Types of stakeholders included: Sioux Lookout First Nation District Health Authority and community service providers.
- November 6, 2008 at Eagle Lake Health Centre, Eagle Lake. One focus group was held with 16 participants. Types of stakeholders included: staff, councillors and clients.
- November 7, 2008 at Migisi Alcohol and Drug Treatment Centre, Kenora. One focus group was held with 17 participants. Types of stakeholders included: staff and Board of Directors.
- November 10, 2008 at Native Horizons Treatment Centre, Hagersville. Two focus groups were held with seven participants in total and two key informant interviews. Types of stakeholders included: NNADAP workers, staff and Board of Directors.
- November 11-12, 2008 at Nimkee Niepigaioagan Healing Centre, Muncey. Three focus groups were held with 16 participants in total and two key informant interviews. Types of stakeholders included: clients, staff and Board of Directors.
- November 13, 2008 at New Directions, Six Nations of the Grand Territory. Three focus groups were held with 18 participants in total and two key informant interviews. Types of stakeholders included: clients, staff and community partners.
- November 18, 2008 at Reverend Tommy Beardy Memorial Family Treatment Centre, Muskrat Dam. Two focus groups were held with 15 participants in total. Types of stakeholders included: clients and staff.
- November 20-21, 2008 at Curve Lake First Nation. One focus group was held with 5 participants in total and 8 key informant interviews. Types of stakeholders included: staff, Chief, Anishnawbek Police and youth.

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Key Informants were held with forty individuals including:

- Completed eight interviews with First Nations and Inuit Health Ontario Region
- Completed four interviews with Provincial Territorial Organizations (PTO's)
- Completed ten interviews with Ontario Regional Addictions Partnership Committee (ORAPC)
- Completed nine interviews with Treatment Centre Directors
- Completed one interview with Chiefs on matrix, but others participated in site visits
- Completed five interviews with First Nations representatives.

The charts depicted in this section illustrate quantitative findings from surveyed communities:

Aamjiwnaang First Nation	Dokis First Nation	Ojibway of the Pic River First Nation
Alderville First Nations	Fort Severn	Oneida Nation of the Thames
Algonquin of Golden Lake	Garden River First Nation	Onigaming First Nation
Anishinaabeg of Naongashiing	Ginoogaming First Nation	Sandy Lake First Nation
Aroland First Nation	Hiawatha First Nations	Sheguiandah First Nation
Bingwi Neyaashi Anishinaabek	Longlake #58 First Nation	Six Nations of the Grand River
Cat Lake First Nation	Mohawks of Akwesasne	Slate Falls First Nation
Chippewa's of Georgina Island	Naotkamaygwenning	Thessalon First Nations
Chippewa's of Saugeen	Nibinamik First Nation	Wahta Mohawks
Constance Lake First Nation	Nipissing First Nation	Walpole Island First Nation
Curve Lake First Nation	North Caribou Caico F.N	Webequie First Nation
Delaware Nation	North Spirit Lake	Whitefish River First Nation
		Winnamin Lake First Nation

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As well as NNADAP workers from the following areas:

Alderville First Nation	Hiawatha First Nation	Ojibways of Onigaming
Anishinaabeg of Naongashiing	Iskatewizaagegan #39	Oneida of the Thames
Aroland First Nation	Keewaywin First Nation	Rama First Nation
Attawapiskat First Nation	Kenora	Sandy Lake First Nation
Batchewana First Nation	Kingfisher Lake First Nation	Shawanaga First Nation
Cape Croker	Longlake #58 First Nation	Sheguiandah First Nation
Cat Lake	M'Chigeeng First Nation	Six Nations of the Grand River
Chippewa of the Thames	Matawa First Nation	Thunder Bay
Chippewas of Georgina Island	Mississauga First Nation	Tyendinaga First Nation
Chippewas of Saugeen	Mohawk Council of Akwesasne	Wabaseemoong Band
Christian Island, Beausoleil First Nation	Moose Deer Point	Wahta Mohawks
Curve Lake First Nation	Moose Factory	Walpole Island
Dokis First Nation	Moosonee	Walpole Island First Nation
Eabametoong First Nation	Muskrat Dam First Nation	Wannamin Lake
Eagle Lake	Nippising First Nation	Webaganie First Nation
Garden River First Nation	North Constance Lake First Nation	Whangosig First Nation
Ginoogaming First Nation	North Spirit Lake	Whitefish River First Nation
Gold Lake First Nation	Northwest Angle 37 First Nation	Wikwemikong First Nation
Henry Inlet First Nation	Ochiicha Gw'e Babigo'ining	

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Appendix C: Document Review

AA Meetings.

This single page document lists the days and times in which numerous centres/groups will be having there AA meetings.

Aiken, Mike (2008). Youth lead traffic stops at Wabaseemoong. Daily Miner and News, Tues, September 30, 2008

This newspaper article discusses the recent action taken by youth council members to help change the drug abuse problems in there community. The youth were stopping cars at the entrance of the community searching cars for intoxicants. The youth sick of what is happening in there community wanted change. Treaty 3 police joined the youth and eventually took over the searches.

Amazon.com (2008) Book listing for: Focused Genograms: Intergenerational Assessment of Individuals, Couples and Families.

This one page document is a listing for a book from amazon.com

Anishnabie Naadmaagi Gamig Substance Abuse Treatment centre (2008). Pamphlet.

A pamphlet describing the program of the treatment centre.

Anishnabie Naadmaagi Gamig Substance Abuse Treatment Centre (2008). Welcome to Our Centre.

This 41 page bound document contains all information regarding the centre. It includes services offered, description of facilities, centre mandate, the referral process of patients, program description/schedule, and organization of the centre.

Assembly of First Nations (2009) Canadian Human Rights Complaint: Information Sheet (Letter to Chiefs, PTOs and Tribal Councils)

This one paged information sheet discusses the updates on Human Rights Complaint regarding Child Welfare.

Bergman, Stanley (2008) Email communication to Janice Thibodeau re: CBT Certificate Program – Training Program.

This email was sent to the executive director of Anishnabid Naadmaagi Gamig Substance Abuse Treatment Centre to discuss the Cognitive Behavioural Therapy Certificate Program training for those working at the centre. Program Testimonials and a Proposal where attached in the email.

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Bressette, Nora (2007/2008) Nimkee NupiGawagan Health Centre Inc. Annual Report 2007/2007.

This 41 paged report provides background on the centre including vision statement, mission statement, goals, program descriptions, and governance and management. The report goes on to present and discuss statistics of 2007/2008 including client profile, chemical use, and education level among others

Campbell, Ida (2008). Letter to Chief Isadora Bebamash of M'Chigeeng First Nation re: Non-insured Health Benefits Program.

This document from Health Canada provides the Drug Utilization Reports from 2004-2008 for the community of M'Chigeeng First Nation. Annex A of the report contains numerous charts and tables which provides additional information of the drug utilization trends in the community.

Canadian Centre on Substance Abuse (2008). Prescription Drug Abuse: FAQs.

This 20 paged document provides the reader with frequently asked questions and there answers. All questions and answers were prepared by medical doctors.

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

This 51 paged document discusses the situation in Canada regarding youth substance abuse. Topics covered in the report include: substance abuse and harm to youth; what substance are being use by the youth; the governments response to youth substance abuse; a neuroscience perspectives; gaps in approaches to youth substance abuse and a call to action.

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

This 47 paged document discusses the current situation in Canada regarding substance abuse. Topics covered include: new directions in alcohol policy; harm reduction; drugs and driving; availability and use of evidenced-based treatment; abuse of prescription drugs and alternative sanctions for cannabis use and possession.

Centre for Addiction and Mental Health (2008) Methadone Saves Lives.

This pamphlet provides information regarding Methadone Maintenance treatment (MMT)

Centre for Addiction and Mental Health (2008) Opioid Dependence Treatment Certificate Program

This one paged document provides information on the opioid certificate program. Laying out the courses and workshops that are required.

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Centre for Addiction and Mental Health (2005). Beyond the Label: An educational kit to promote awareness and understanding of the impact of stigma on people living with concurrent mental health and substance abuse problems.

This 119 paged report discusses stigma busting activities that can be held in a group setting held by a facilitator.

Chansonneuve, Deborah (2007). Addictive Behaviours among Aboriginal People in Canada. The Aboriginal Healing Foundation Research Series. Prepared for: the Aboriginal Healing Foundation

This 125 paged document discusses: addictive behaviour and residential school abuse; using the wisdom of culture to promote healing and promising practices.

Chief Arthur Moore (2009) Prescription Drug Abuse (Speaking notes for presentation given in Feb 10, 2009 in Thunder Bay, ON at the Chiefs Forum on Social Issues)

Concurrent Disorders Policy Network (2006). Concurrent Disorders Policy Framework

This 39 paged document discusses: a provincial context of concurrent disorder policy; prevalence and impact of concurrent disorders; a vision for Ontario; goal statement; framework objectives and guiding principles.

Copping, Valerie (unknown). Intergenerational Trauma Treatment Model.

This booklet discusses the Intergenerational Trauma Treatment Model (ITTM) program that is offered by the author.

Crosbie, Lorena and Amber McCart. (unknown) Intergenerational Trauma Treatment Model – Implementation considerations. PowerPoint Presentation.

This 8 page document is a print out of the slides of a PowerPoint presentation discussing the ITTM program developed by Valerie Copping.

Dell, Colleen Anne (2008). Informing Next Steps: A Review of Health Promotion and Intervention Strategies Addressing Prescription Drug Abuse among First Nations in Canada

This 90 paged document discusses: the extent of prescription drug abuse; responses to prescription drug abuse; health promotion; cultural relevance and health promotion; education and awareness; harm reduction and treatments.

Dell, Colleen Anne and Tara Lyona (2007). Harm reduction policies and programs for persons of Aboriginal decent In: Harm Reduction for Special Populations in Canada. Canadian Centre on Substance Abuse.

This 20 paged article discusses the implementation and policies and programs of harm reduction and Aboriginal Communities.

Dilico Anishinabek Family Care (2008). Youth Outreach (YOW) Services pamphlet.

This pamphlet describes the YOW programs and the services that they provide.

Dilico Anishinabek Family Care (2008). District Mental Health and Addiction Services: A Holistic Approach to Recovery, pamphlet.

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This pamphlet describes the different services available and provides a map of the locations of the programs along with the head and district offices.

Dilico Anishinabek Family Care (2008). Day Treatment School-Based Services, pamphlet.

This pamphlet describes the program for youth that have social, emotional and behavioural concerns.

Dilico Anishinabek Family Care (2008). Infant /Child Development Services, pamphlet.

This pamphlet describes the program for children 6 and under. The programs aim is the help parents develop healthy mental, physical, emotional and spiritual development.

Dilico Anishinabek Family Care (2008). Family Preservation Services, pamphlet.

This pamphlet describes the program for families and the services that are provided. Services include effective parenting, behaviour management, anger management, problem solving, and communication.

Dilico Anishinabek Family Care (2008). Mental Health and Addictions Services, booklet.

This 11 paged booklet provides an overview of the services provided for those with mental health and addiction problems. Services are provided to children, families and adults.

Dilico Anishinabek Family Care (2008). Well-being and Balance for Anishinabek Children, Families and Communities, booklet.

This booklet contains the health and welfare services provided by the centre for children, families and the whole community.

FCC Niagara (2008) Intergenerational Trauma Treatment Model.

This one page document is a print out from the FCC Niagara website (www.fccniagara.on.ca). It discusses the ITTM program for those that have experience trauma.

First Nations and Inuit Health – Ontario Region (2009) Trends in Opiate and Benzodiazepine

Prescription Use in Sioux Lookout Zone. For the Chiefs Forum on Social Issues. Thunder Bay, ON, February 10, 2009

This 8 paged handout provides the reader with an overview of the trend in opiates and benzodiazepines drug use in the Sioux Lookout area.

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Grand Chief Stan Beardy (2009) Speaking notes for the Chiefs Forum on Social Issues. Thunder

Bay, ON. February 10, 2009

Health Canada (2006). Best Practices: Early Intervention, Outreach and Community Linkages for Women with Substance Abuse Problems. Canada's Drug Strategy.

In this 120 paged report topics discussed include: gender difference, barriers to accessing intervention services for problems substance use; specific client-related considerations and needs; early intervention, outreach; community linkages and key informant and focus group interviews.

Health Canada (2001). Preventing Substance Use Problems Among Young People: A Compendium of Best Practices.

This 294 report looks at the substance abuse problems among the young in Canada and the best practices that are use to treat the addictions. Topics discussed include: substance use patterns of Canadian youth; principles of youth substance use problems prevention; exemplary programs from the scientific literature and exemplary Canadian programs.

Health Canada (2000). Straight Facts about Drugs and Drugs Abuse

This 64 paged document discusses topics including: the harmful consequences of drugs; Canada's drug strategy; Canada's drug laws and the types of drugs that are prevalent in Canada.

Health Canada (1999). Best Practices: Substance Abuse Treatment and Rehabilitation.

This 97 paged report discusses the best practices that are seen in treatment and rehabilitation for substance abuse problems. Topics discussed include: the effectiveness of specific treatment approaches; matching clients with treatments and therapists; the influence of other factors on treatment effectiveness; social populations; services delivery systems; economic benefits of substance abuse treatments and issues and limitations concerning research.

Herie, Marilyn et. al. (2007) Addiction: An information guide. Centre for Addiction and Mental Health.

This 30 paged report discusses: what addictions are; what causes addictions; FAQs about addictions; help for people with addictions; change, recovery and relapse prevention; help for partners and families and explaining addiction to children

Johnson, Autumn (2008). Addiction Counsellors Training Survey: Ontario Regional Addictions Partnership Committee. Final Report.

The report summarized the results of the Addiction Counsellor Training Survey. The survey was administered by ORAPC at the NNADAP conference in November 2007. The report provides demographics, level of training, certification maintenance, type of NNADAP program, and recent training among others

Johnson, Jan (2007) Shared Places: An Introduction to Tribal Histories and Cultures. Part 2: Indigenous Aesthetics / Expressive Culture: Historical Trauma.

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This two page document is a printout of class notes from the University of Idaho. It discusses the historical trauma that Native Americans have faced, the six phases of unresolved grief and coping strategies among others

Keewaytinook Okimakanak Research Institute (KORI) (2006). Impacts of Prescription Narcotic Use, Misuse and Abuse in the Robinson Superior Treaty Area. Report to the Dilico Ojibway Child and Family Services Strategy Committee.

This documents primary focus is regarding prescription narcotics especially oxycotin in Northwestern communities. The report includes an environmental scan, literature review, and surveys completed by community members.

Maxwell, Jane Carlisle (2006). Trends in the Abuse of Prescription Drugs. The Gulf Coast Addiction Technology Transfer Centre (GCATTC)

This 14 paged document discusses drug abuse problems throughout different cities in the United States of America, and the National trends for the years 2002-2005

Migisi Alcohol and Drug Treatment Centre (2008).

This four page document gives the four week schedule of a patient in the treatment center.

Migisi Alcohol and Drug Treatment Centre (2006). Mobile Community-Base Aftercare Treatment Support Program.

This document is a pilot project for a proposed regional aftercare services infrastructure. The proposal includes the statement of need, goals, program description, work plan and budget among others.

Mitchell, Terry L. and Dawn T. Maracle (2005) Healing the Generations Post-Traumatic Stress and the Health Status of Aboriginal Populations in Canada. Journal of Aboriginal Health. March 2005. pg 14-24

The authors of this publication discuss the inequalities between Aboriginal and non-Aboriginal people in Canada and it's relation to and importance of post-traumatic stress disorder/response. They also note the importance of acknowledging and addressing historical and intergenerational trauma in Aboriginal communities.

Nadmadwin Mental Health Clinic (2008) Nadmadwin Mental Health Clinic pamphlet.

This pamphlet provides the location and hours of the clinic along with programs/services provided.

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National Indian and Inuit Community Health representative Organization (2007) Aboriginal Healing Perspectives: Weaving science and traditions, Helping Aboriginal communities reduce prescription drug abuse.

This 118 paged report discusses: reducing risk factors for addiction; abstinence and harm reduction; education and intervening with individuals and historical trauma, addiction and healing among others.

National Institute on Drug Abuse (2003). Preventing Drug Abuse among Children and Adolescents: A Research-Base Guide for Parents, Educators, and Community Leaders. 2nd ed. U.S. Department of Health and Human Services

This 49 paged document is a discussion of how to prevent substance abuse among youth. Topics in the report include: risk and prevention factors, planning for drug abuse prevention on the community, applying prevention principles to drug abuse prevention programs, and examples of research-based drug abuse prevention programs.

Ngwaagan Gamig Recovery Centre Inc. (2008) Ngwaagan Gamig Recovery Centre Inc. Program / Centre pamphlet.

This pamphlet gives the contact information of the centre along with program / treatment descriptions.

Ngwaagan Gamig Recovery Centre Inc. (2008) Summer 2008 Newsletter – August.

This newsletter includes the vision and mission statements of the centre along with news stories, updates about programs at the centre and poems submitted by the community.

North West LHIN (2008) Aboriginal Health Forum. “Elements of Change” Summary Report.

This 45 paged document provides the results of a two day conference (March 27 and 28, 2008) held in Thunder Bay. The document contains the agenda, questions discussed along with the findings.

O'Donaghey, Pamela M. (n.d.) Healing at Home: A First Nations Guide Home Detox.

This 132 paged document provides the readers with a guide on how one can complete detox at home with a cultural component.

O'Gorman, Karen (2008). Evidence Based Treatment Enhancement Options: Dilico Adult Treatment Centre. Final report for: Dilico Anishabek Family Care Mental Health and Addiction Services.

This 39 paged document reviews a study completed for the Dilico Anishabek Family Care Mental Health and Addiction Services. The study completed a literature review, scan of services and programs, and key informant interviews. The report outlines the best practices identified and the suggestions for the development of a next step work plan among others.

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Oxycontin Task Force (2004). Final Report. Submitted to the Department of Health and Community Services, Department of Education and the Department of Justice

This 64 paged document discusses: an overview of the task force activities; overview of oxycontin; preventing oxycontin abuse; oxycontin detoxification; oxycontin treatment; and harm reduction.

Planning Committee Meeting: Chiefs' Forum on Social Issues (August 19-29, 2008). Briefing Note.

This six page document provides an overview of the planning committee meeting. It includes the meeting goal, strategic planning process, along with specific strategies developed. It also discussed a forum to take place February 23-27 2009.

Preparing For Strategic Planning Community Environmental Scanning Survey (2008).

This two page document gives the results of a survey question regarding the current trends/issues of substance abuse/addiction in the community (same question as above, different years).

Preparing For Strategic Planning Community Environmental Scanning Survey (2007).

This three page document includes the results of a survey regarding the current trends/issues of substance abuse/addictions in the community. The document also includes three other survey questions (no answers).

Quinn, Ashley (2007) Reflection on Intergenerational Trauma: Healing as a Critical Intervention. First Peoples Child and Family Review, Vol.3, No. 4, pp. 72-82

The author argues that healing from the trauma of colonization is a critical component of an intervention on repairing. Recommendations for government, professionals, and for academic institutions, are provided.

Regional Opiate Task Force (2008). Terms of Reference.

This two page document outlines the mandate, goals and objectives, accountability, decision making, membership and meetings of the task force.

ROM (Tuesday, June 3, 2008). Regional Opiate Task Force.

This 3 paged ROM lists the numerous updates and reports from members of the task force.

ROM (Tuesday, March 4, 2008). Regional Narcotics Task Force.

This two page document records the inaugural meeting by this task force. Some concerns of the members included no uniformity with physician prescribing habits, people "taking" narcotic medication from elderly family members and the quickness of addiction to certain narcotics among others.

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Sioux Lookout First Nations Health Authority (2007-2008) Annual report.

This 54 paged book provides an overview of the operating year of 2007-2008 for the Sioux Lookout First Nations Health Authority. The document includes vision/mission statements, health services provided, financial statements, staff/board of directors, partners and funders, and the communities in which the Health Authority serves.

Sioux Lookout First Nation Health Authority (Sept. 5, 2007) Sioux Lookout Zone Chiefs Meeting Resolution 07/07 Forum of Social Issues.

This one page document provides issues and the resolutions to these issues that the Chiefs in this zone created. One issue includes “incidences related to manufactured intoxicant usage are increasing”

Sioux Lookout First Nation Health Authority (2006), The Anishinabe Health Plan

This 245 paged document provides a very detailed account of the Anishinabe Health Plan. Sections include background, community health needs assessment, The NAN Chief's model, the five areas of the NAN chief's model, service delivery system, Human resource management, governance and management, roles and responsibilities, financial planning, and system supports among others.

Sioux Lookout First Nation Health Authority (unknown). Sioux Lookout First Nation Health Authority Organizational Chart

This one page document is a flow chart describing the organization of the health authority

Sutherland, Mariette and Marion Maar (2008). Northern Superior Regional AHWS Renewal Consultation. A report based on Union of Ontario Indian Aboriginal Healing and Wellness Strategy Renewal Consultation with Anishinabek First Nation Communities in The Northern Superior Region.

This 12 page document reports on a two day session with nine (9) health care workers from communities within the area of the health board. Areas discussed include critical needs and health issues in local First Nations, how AHWS programs have been helpful, and areas for improvement among others.

Sutherland, Mariette and Marion Maar (2008). Regional AHWS Renewal Consultation Report. Based on the Union of Ontario Indians Aboriginal Healing and Wellness Strategy Renewal Consultations with First Nation Communities within Anishinabek Territory.

This 31 page document reviews regional meetings that occurred with key informants within Anishinabek communities. The report includes backgrounds on the strategy, overview of AHWS programs, and a summary of priorities among others.

TAPE Educational Services Inc. (2008) Testimonials

This two page document provides testimonials from those that have already completed TAPE training programs.

TAPE Educational Services Inc. (2008). Cognitive Behavioural Therapy: A Customized Certificate Program for front-line staff working at Anishnabie Naadmaagi Gamig Substance Abuse Treatment Centre.

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This ten page document outlines the Cognitive Behavioural Therapy training program to be taking by members of the centre.

Thibodeau, Janice (2008). Proposal For Program Framework for Supportive Housing for People with Problematic Substance Use.

This is a proposal written by the Executive Director of the Anishnabie Naadmaagi Gamig Substance Abuse Treatment Centre. The proposal aims to receive funding for a home in Blind River to house beds for those in recovery. The letter is addressed to Jamie Adams, Zone Director.

United Nations (2004). A Strong Start: Good practices in using a local situation assessment to begin a youth substance abuse prevention project. United Nations Office on Drugs and Crime.

This 54 paged document provides a worldwide perspective on what initiatives can be done on a local level to deal with and prevent youth substance abuse locally. Topics discussed include; preparing for the local situation assessment; conducting the local situation assessment; and mobilizing youth and others to support your project.

Unknown (2009) Prescription Drug Abuse Prevention and Promotion: Recommendations and Best Practices. Presentation.

This presentation discusses: multi-disciplinary approach to addressing underlying addictive behaviours; culturally appropriate prevention strategies; follow-up to long term strategies; skill building for individuals and families; prescription drugs education; and collaboration of community and organizations among others.

Unknown (unknown)...Healing the legacy of the residential schools – Intergenerational...

This two page document was obtained from an unknown website. It discusses the impact that intergenerational survivors face on a day-to-day basis.

Unknown (Unknown) Intergenerational Trauma in Native American Communities: A Framework for Healing. PowerPoint Presentation

This 10 page printout of a PowerPoint presentation discusses the impacts of trauma and ideas for healing.

Unknown (unknown) Alcohol, Solvent and Drug Abuse in Out First Nation Communities.

This four page document appears to be a letter addressed to no one in particular and sign by no one. It discusses the problems of alcohol abuse in particular.

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White Bison, Inc. (May 23, 2005) Wellbriety! White Bison's Online Magazine. Vol. 6, No. 6.

This 8 page document is an online magazine. Its headline and topic of discussion is "From Intergenerational Trauma to Intergenerational Healing". It discusses the conference, the Fifth Annual White Bison Wellbriety Conference in Denver, Colorado. The keynote talk was given by Dr. Maria Yellow Horse Brave Heart.

White Bison, Inc. (May 30, 2005) Wellbriety! White Bison's Online Magazine. Vol. 6, No. 7.

This 6 page document is an online magazine. Its headline is "The Grassroots Speaks...About Intergenerational Trauma". The article discusses the speech given by Theda New Breast and her Top Ten Solutions from the Intergeneration Trauma Circle.

Wilson, Rodgers M. (n.d.) Adolescents and Prescription Drug Abuse. Arizona Department of Health Services. Presentation.

This presentation discusses various aspects of prescription drug abuse in youth. Topics includes impacts on health and development, trends in abuse prevalence, accessibility and availability, gender differences, age trends, and treatment options.

Windigo First Nation Council (2008) First Nation Information.

This seven page document provides descriptions of seven different First Nation communities. On each page describing each first nation there is, hand writing, is a persons name with associated and in some cases contact information. The First Nations include Slate Falls, Bearskin Lake, Sachigo Lake, North Caribou Lake, Cat Lake, Koocheching and Whitewater Lake.

Appendix D: Glossary of Terms

Aboriginal Culture as Healing model

There are now many examples of effective community-based addictions prevention and intervention programs. One of the groundbreaking Aboriginal community healing models is that of Alkali Lake, British Columbia. This community healing model inspired other communities, such as Hollow Water in Manitoba, to become leaders in their own right of a holistic and integrated response.

Treatment centres such as Round Lake in British Columbia, Poundmaker's Lodge in Alberta and Enahtig Healing Lodge in Ontario are examples of addictions program models that have broken new ground in a culture as healing approach to addictions recovery. The culture as healing model is grounded in an understanding of the impacts of residential school abuse and colonization. Culture as healing counters these impacts through strategies of cultural revitalization.

Abstinence

The term refers to the act of refraining from alcohol or other drug use, whether for health, personal, social, religious, moral, legal or other reasons.

Someone who is currently abstinent may be called an "abstainer", a "total abstainer", or, an old-fashioned term relating only to alcohol, a "teetotaler". The term "current abstainer" is sometimes used for research purposes and is usually defined as a person who has not used drugs for a specified period of time, for example, 3, 6 or 12 months. In some studies, persons who drink or use other drugs only once or twice per year are also classified as abstainers.

Abuse

This term is in wide use but of varying meaning. In international drug control conventions "abuse" refers to any consumption of a controlled substance no matter how infrequent. In the Diagnostic and Statistical Manual of Mental Disorders (DSMIV, American Psychiatric Association, 1994), "psychoactive substance abuse" is defined as "a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following within a 12 month period: (1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home; (2) recurrent substance use in situations in which it is physically hazardous; (3) recurrent substance-related legal problems; (4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance". It is a residual category, with dependence taking precedence whenever applicable.

The term "abuse" is sometimes used disapprovingly to refer to any use at all, in particular of illicit drugs. Because of its ambiguity, the term is only used in the

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ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines (WHO, 1992) for non-dependence producing substances. “Harmful” and “hazardous use” are the equivalent terms in WHO usage, although they usually relate only to effects on health and not to social consequences. The term “abuse” is also discouraged by the Centre for Substance Abuse Prevention in the United States, although the term “substance abuse” remains in wide use and refers generally to problems of psychoactive substance use. The term “drug abuse” has also been criticized as being circular when it is used without reference to specific problems arising from drug use. See also: Drug abuse.

Accreditation

The process of recognition that a programme meets specific operational and organizational standards that have been established to ensure the quality of services within a particular region or treatment system. Accreditation is usually awarded by an external professional body on the basis of a review or audit and is usually for a specific period.

Addiction

One of the oldest and most commonly used terms to describe and explain the phenomenon of long-standing alcohol and drug abuse. In some professional circles it has been replaced by the term “alcohol or drug dependence”. According to the WHO Lexicon of Alcohol and Drug Terms, “addiction” is defined as: the repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means.

Key indicators of “addiction” have traditionally been thought to be tolerance and experience of a withdrawal syndrome, that is, it is often equated with physical dependence. More recently, some drug researchers have suggested that “compulsion to use drugs” is a more central indicator of addiction. Addiction is otherwise regarded by the self-help or “recovery” movement as a discrete disease, a debilitating and progressive disorder rooted in the pharmacological effects of the drug for which the only cure is total abstinence. That view is most notably associated with the “self-help” or “recovery” movement, for example, Narcotics Anonymous and Alcoholics Anonymous. In the 1960s, WHO recommended that the term “addiction” be abandoned in favour of dependence, which can exist in various degrees of severity as opposed to an “all or nothing” disease entity.

Addiction is not a diagnostic term in the ICD-10, but continues to be very widely employed by professionals and the general public alike.
See also: Dependence, Dependence syndrome.

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Advice services

The range of information and non-medical treatment services which can variously provide drug information, details of services available, referral to other agencies, and direct clinical casework or psychotherapy. Services may be provided in a direct face-to-face setting or indirectly by telephone to individuals, families, groups, other workers or agencies. The term “advice” is usually reserved for the provision of factual information on specific issues. It also incorporates brief and specific advice to change behaviour, for example in brief interventions (see below). Advice is usually distinguished from “counselling” where the emphasis is more on assisting individuals to evaluate their own situation and reach their own decisions about how to cope.

See also: Brief intervention, Counselling and psychotherapy, Treatment.

Aftercare

A broad range of community-based service supports designed to maintain benefit when a structured treatment has been completed. Aftercare may involve a continuation of individual or group counselling and other supports, but usually at a lower intensity and often by other agencies. Self-help groups such as Alcoholics Anonymous and Narcotics Anonymous are an important provider of aftercare.

See also: Self-help group.

AIDS

The common abbreviation for a fatal viral condition known as acquired immunodeficiency syndrome in which the immune system is weakened and unable to combat infectious diseases. The sharing of injecting equipment among injecting drug users is a major route of transmission for human immunodeficiency virus (HIV). That is the virus that causes AIDS, and in many countries has led to programmes discouraging injecting and to the establishment of programmes to make clean injecting equipment more readily available for injecting drug users in order to reduce the likelihood of transmission of the virus through the sharing of used needles and other equipment.

See also: Harm reduction, Needle exchange, Risk reduction, Safer use.

Amphetamines/Methamphetamines

Amphetamines are synthetic psychoactive drugs that stimulate or increase the action of the central nervous system. Amphetamines may be smoked, injected, inhaled, or taken orally as a capsule or tablet. Methamphetamine is the primary form of amphetamine seen in the United States making up 94 percent of all amphetamine treatment admissions reported to the Treatment Episodes Data Set in 1999. Methamphetamine was developed from its parent drug, amphetamine and is similar in its chemical makeup, but it has more pronounced effects on the central nervous system. Street methamphetamine is referred to by names, such as speed, meth, and chalk. Methamphetamine hydrochloride, clear chunky crystals resembling ice, which can be inhaled by smoking, is referred to as ice, crystal, and glass.

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Benzodiazepines

Benzodiazepines are a group of CNS depressants which are closely related in their chemical structures. They are among the most frequently prescribed medicines worldwide (for daytime anxiety relief and to promote sleep). Individual benzodiazepines differ in speed of onset, duration of action and potency. About 2,000 benzodiazepines have been synthesized by the pharmaceutical industry. Benzodiazepines encountered on the illicit market are usually diverted from legitimate trade rather than synthesized in clandestine laboratories.

Brief intervention

A treatment strategy in which structured therapy of a limited number of sessions (usually one to four) of short duration (typically 5-30 minutes) is offered with the aim of assisting an individual to cease or reduce the use of a psychoactive substance or (less commonly) to deal with other life issues. It is designed, in particular, for general practitioners and other primary health care workers.

Cannabis (Marijuana / Hash)

Cannabis is the dried flowering tops of hemp plants (*Cannabis sativa*), which have euphoric principles (tetrahydrocannabinols); classified as a hallucinogen and prepared as bhang, ganja, hashish, and marihuana.

Care coordination

The process of oversight and practical management of patients within a particular treatment and across different treatments over time. For a particular patient, care coordination can involve assessment, referral, progress monitoring and review activities. In some treatment systems, the care coordinator has some degree of authority over the system that pays for the treatment of patients.

Cocaine/Crack

Cocaine is a powerfully addictive stimulant drug. The powdered hydrochloride salt form of cocaine can be snorted or dissolved in water and injected. Crack is cocaine base that has not been neutralized by an acid to make the hydrochloride salt. This form of cocaine comes in a rock crystal that is heated to produce vapors, which are smoked. The term “crack” refers to the crackling sound produced by the rock as it is heated.

Cognitive-behavioural techniques

A type of psychotherapy that stresses that the way in which people think about a problem is instrumental in causing feelings and behaviours that are unwanted. Cognitive-behavioural techniques (CBT) therefore aims to help a patient replace those unhelpful thoughts with others that lead to more desirable reactions.

In the substance abuse field the CBT therapist helps a patient to acquire new skills to alter or maintain changes in their behaviour. In that respect, relapse prevention programmes may contain a CBT element to help patients resist urges to use substances.

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Cognitive behavioural therapy

Cognitive behavioural therapy suggests that how we think about a situation influences how we act. In turn, our actions can influence how we think and feel. It is therefore necessary to change both cognition (the act of thinking) and behaviour at the same time.

Community-based treatment

Any treatment that is based in a non-residential setting. Outpatient treatments (day attendance-based services provided from a hospital) are often bracketed with community based treatments. Examples of community-based treatments are opioid substitution programmes; counselling programmes and aftercare services.

Community empowerment

Interventions which encourage a community (for example, people in a locality, drug injectors, sex workers) to develop collective ownership and control over health-related choices and activities. To achieve that result, the community may also need to gain collective control of the wider social, political and economic factors which influence their access to health. “Empowerment” is a process of increasing personal, interpersonal or political power so that individuals can take action to improve their lives.

Co-occurring disorders

A person diagnosed as having an alcohol or drug abuse problem in addition to some other diagnosis, usually psychiatric, for example, mood disorder or schizophrenia. Making differential diagnoses is often complicated by overlapping signs and symptoms of dependence and diagnostic entries, for example, anxiety is a prominent feature of drug withdrawal. A further complication is with shared or reciprocal casual processes, for example, a mild disorder of mood leads to some drug use which eventually leads to an exacerbation of the mood disturbance, to further drug use, dependence and severe mood disturbance.

Counselling and psychotherapy

Counselling is an intensive interpersonal process concerned with assisting normal people to achieve their goals or function more effectively. Psychotherapy is generally a longer-term process concerned with reconstruction of the person and larger changes in more fundamental psychological attributes such as personality structure. Psychotherapy is often restricted in conception to those with pathological problems.

Court diversion

A programme of treatment, re-education or community service for individuals referred from criminal courts (criminal diversion) after being charged with driving under the influence of alcohol (drinking-driver diversion) or another drug, with the sale or use of drugs (drug diversion), or with another crime. Individuals are assigned to diversion programmes in lieu of prosecution, which is usually held in abeyance pending successful completion of the diversion programme. Pre-charge diversion refers to the systematic referral of those

detected by the police to an alternative programme without arrest. In some countries, the term “custody diversion” is used to make explicit that in many diversion schemes the individual may attend court but be diverted away from custody into a programme of treatment or re-education.

Crystal Meth

Crystal Meth is one of the street names used for methamphetamine. It is also known as “speed,” “meth” or “chalk.” In its smoked form, it can be referred to as “ice,” “crystal,” “crank,” and “glass.” Methamphetamine belongs to a family of drugs called amphetamines— powerful stimulants that speed up the central nervous system. The drug can be made easily in clandestine laboratories with relatively inexpensive over-the-counter ingredients. Methamphetamine is a drug with high potential for widespread abuse.

Dependence, dependence syndrome

According to the WHO Lexicon of Alcohol and Drug Terms, “dependence, dependence syndrome” is defined as follows: as applied to alcohol and other drugs, a need for repeated doses of the drug to feel good or to avoid feeling bad. The terms “dependence” and “dependence syndrome” have gained favour with WHO and in other circles as alternatives to addiction since the 1960s.

In the DSM-IV, dependence is defined as “a cluster of cognitive, behavioural and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems”.

See also: Addiction.

Detoxification

The process by which a person who is dependent on a psychoactive substance ceases use, in such a way that minimizes the symptoms of withdrawal and risk of harm. While the term “detoxification” literally implies a removal of toxic effects from an episode of drug use, in fact it has come to be used to refer to the management of rebound symptoms of neuroadaptation, that is, withdrawal and any associated physical and mental health problems.

Drug abuse

Current international drug control treaties do not define drug abuse but make reference to a variety of terms, including abuse, misuse and illicit use. In the context of international drug control, drug abuse constitutes the use of any substance under international control for purposes other than medical and scientific, including use without prescription, in excessive dose levels, or over an unjustified period of time.

Drug substitution

Treatment of drug dependence by prescription of a substitute drug for which cross-dependence and cross-tolerance exist. The term is sometimes used in reference to a less hazardous form of the same drug used in the treatment. The goals of drug substitution are to eliminate or reduce use of a particular substance, especially if it is illegal, or to reduce harm from a particular method of

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administration, the attendant dangers to health (for example, from needle sharing), and the social consequences. Drug substitution is often accompanied by psychological and other treatment.

Early intervention

A therapeutic strategy that combines early detection of hazardous or harmful substance use and treatment of those involved. Treatment is offered or provided before such time as patients might present of their own volition and in many cases before they are aware that their substance use might cause problems. It is directed in particular at individuals who have not developed physical dependence or major psychosocial complications.

Eligibility criteria

A set of medical, social and psychological conditions that are used to judge the appropriateness of a treatment for a particular individual. Eligibility criteria usually take into account the severity of patients' problems, their personal motivations or readiness for treatment, and the nature and extent of their social supports and stressors in terms of their suitability for a particular treatment. Use of eligibility criteria is part of a commitment to matching patients to the best or more appropriate treatment in the context of two or more alternatives.

Evaluation

The systematic and scientific process of determining the extent to which an action or sets of actions were successful in the achievement of predetermined objectives. It involves measurement of adequacy, effectiveness and efficiency of programmes or services. Evaluation is to be distinguished from assessment and appraisal: both terms are used as more general terms than evaluation, connoting the drawing of conclusions from the examination of a situation or its elements. Evaluation, then, is a particular type of assessment.

Family liaison worker

A professional counsellor, social worker or nurse whose role is to support the family (dependants and carer(s) of a patient). The worker assists family members who are affected by a substance abuse problem and may provide information, supportive counselling and referral services. Helping the family understand and provide support to a member with a substance abuse problem is a core function.

Focus group

A discussion-based, qualitative research data gathering method designed to explore a topic of interest and generate a range of opinions. A small number of members of a particular group meet together and their discussion is facilitated by a researcher known as a “moderator”.

Half-way house

Often, a place of residence that acts as an intermediate stage between an inpatient or residential therapeutic programme and fully independent living in the community. The term applies to accommodation for alcohol- or drug-dependent individuals endeavouring to maintain their sobriety (compare

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therapeutic community). There are also half-way houses for individuals with psychiatric disorders and for individuals who are leaving prison.

Hallucinogens

Hallucinogens under international control include LSD, phencyclidine (PCP), hallucinogenic amphetamines, mescaline (the active principle of the peyote cactus), psilocybin (naturally occurring in certain mushrooms) and some tryptamines.

Hallucinogens produce altered states of consciousness with different degrees of auditory and/or visual perceptions that are not shared by observers; they are also referred to as “psychedelics”, i.e. they act as catalysts to further feelings and thoughts (not merely hallucinogenic).

Harm reduction

In the context of alcohol or other drugs, harm reduction refers to policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or other drugs, both to the individual and the larger community. This system would extend itself toward people who do not appear to want or to benefit from established programs of care. They do not have an immediate or perhaps even a long-term goal of changing their addictive behaviours. They nonetheless are the most vulnerable to harmful effects from addiction problems. They often have high rates of co-occurrence for both mental and physical health problems. The term is used in particular for policies or programmes that aim to reduce the harm without necessarily requiring abstinence. Some harm reduction strategies designed to achieve safer drug use may, however, precede subsequent efforts to achieve total abstinence. Examples of harm reduction include needle/syringe exchanges to reduce rates of needle sharing among injecting drug users.

Harmful use

According to the WHO Lexicon of Alcohol and Drug Terms, “harmful use” is defined as follows: a pattern of psychoactive substance use that is causing damage to the health of the drug user. The damage may be physical (for example, hepatitis following injection of drugs) or mental (for example, depressive episodes secondary to heavy alcohol intake). Harmful use generally has adverse social consequences as well. The term was introduced in the ICD-10 and supplanted “nondependent use” as a diagnostic term. The closest equivalent in other diagnostic systems (for example, in the DSM-IV) is substance abuse, which usually includes social consequences.

Health Centre

Staffed by a community health nurse and support staff; the focus is on community health programs and is based on prevention and promotion of health; most health centres are found in the more urban settings in non-isolated communities/First Nations.

Heroin

Heroin is a highly addictive and rapidly acting opiate (a drug that is derived from opium). Specifically, heroin is produced from morphine, which is a principal component of opium. Opium is a naturally occurring substance that is extracted from the seedpod of the opium poppy. <http://www.usdoj.gov/ndic/pubs3/3843/index.htm>. Heroin is made from morphine that has been chemically processed. Injection use is commonly found with heroin.

Inhalants

Inhalants are a broad range of drugs in the forms of gases, aerosols, or solvents which are breathed in and absorbed through the lungs. Most inhalant drugs which are used non-medically are ingredients in household or industrial chemical products which are not intended to be concentrated and inhaled, including organic solvents (found in cleaning products, fast-drying glues, and nail polish removers), fuels (gasoline (petrol) and kerosene) and propellant gases such as freon and compressed hydrofluorocarbons which are used in aerosol cans such as hairspray and non-stick cooking spray. A small number of recreational inhalant drugs are pharmaceutical products which are used illicitly, such as anaesthetics (ether and nitrous oxide) and volatile anti-angina drugs (alkyl nitrites).

Integrated treatment system

An integrated treatment system is one that contains several treatment services, both specialist and generic, that operate in a structured and organized way. Most integrated treatment systems will contain community-based and residential services and have established referral and patient transfer arrangements.

Intoxication

According to the WHO Lexicon of Alcohol and Drug Terms, “intoxication” is defined as follows: a condition that follows the administration of a sufficient amount of a psychoactive substance and which results in disturbances in the level of consciousness, cognition, perception, judgement, affect, behaviour, or other psychophysiological functions and responses. The disturbances are related to the acute pharmacological effects of, and learned responses to, the substance and resolve with time, with complete recovery, except where tissue damage or other complications have arisen. The term is most commonly used with regard to alcohol use.

Mandated treatment

A characterization of treatment, sometimes called coercive treatment, that is organized by the criminal justice system. Typically, a court (or other criminal justice body) orders that an individual enters a therapeutic programme (sometimes as an alternative to a custodial sentence). Treatment is mandated in the sense that failure to enter the programme or comply with its rules and regulations may result in the individual receiving the criminal justice penalty that would normally be invoked.

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Methadone

A synthetic opiate drug used in maintenance therapy for those dependent on opioids. It has a long half-life, and can be given orally once daily with supervision. It is the most widely used treatment for opioid dependence in the developed world. When given in an adequate dose to opioid dependent individuals, methadone tends to reduce desire to use heroin and other opiates, eliminates opioid withdrawal and blocks the euphoric effects of the other opioid drugs.

Modality

A categorization of a specific type of drug abuse treatment. A given treatment modality can be described in terms of its specific therapeutic approach or philosophy and purpose. In the United Kingdom, for example, the following treatment modalities are available: residential rehabilitation; inpatient stabilization and detoxification; community specialist prescribing; community general practitioners prescribing; structured counselling and structured day services.

Morphine

Morphine is a narcotic that directly effects the central nervous system. Morphine activates the brain's reward systems. The promise of reward is very intense, causing the individual to crave the drug and to focus his or her activities around taking morphine. The ability of morphine to strongly activate brain reward mechanisms and its ability to chemically alter the normal functioning of these systems can produce an addiction. Morphine effects also reduce a person's level of consciousness, harming the ability to think or be fully aware of present surroundings

Motivational enhancement therapy

Motivational enhancement therapy seeks to evoke from clients their own motivation for change and to consolidate a personal decision and plan for change. The approach is largely client centered, although planned and directed. The counsellor seeks to develop a discrepancy in the client's perceptions between current behaviour and significant personal goals.

<http://www.drugabuse.gov/adac/ADAC9.html>

Mutual-help group

A group in which participants support each other in recovering or maintaining recovery from personal problems. Those groups are often associated with alcohol and other drug dependence problems; however, they also operate in the context of other issues such as depression and various compulsive behaviours. Membership is usually established on a voluntary and confidential basis, with meetings organized with a prescribed format and time.

Narcotic drug

A chemical agent that can induce stupor, coma, or insensibility to pain. The term usually refers to opiates or opioids, which are called narcotic analgesics. In common parlance and legal usage it is often used imprecisely to mean illicit

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drugs, irrespective of their pharmacology. For example, narcotics control legislation in Canada, the United States and several other countries includes cocaine and cannabis as well as opioids. It is also a term adopted by the Single Convention on Narcotic Drugs, 1961.

Needle exchange

Provision to reduce the transmission of infectious diseases by the repeated use and sharing of needles in order to reduce the transmission of blood-borne viruses. It was first developed in response to the advent of HIV/AIDS and quickly spread to many countries in which injecting drug use was experienced as a problem. The concept involves the provision of clean needles in exchange for used needles which are then safely disposed of. In practice, an “exchange” is not always required and clean injecting equipment is provided on demand, sometimes for a small payment.

See also: AIDS, Harm reduction.

Needs assessment

A systematic approach to determining the nature and extent of substance abuse problems in a target population or community that seeks to identify which (or how many) specific interventions should be made available to specific groups of people or how existing interventions and services can be better provided.

Non-isolated First Nation

A zone where a First Nation is located within 90km from the nearest service centre having year-round road access.

Nursing Station

A field unit usually located in a remote isolated or isolated community/First Nation; the nursing station is staffed by community health nurse(s) and supports the nurses and support staff organize and carry out community health programs; these programs include ambulatory and emergency treatment, short term in-patient care and emergency medical transportation.

Opiate

According to the WHO Lexicon of Alcohol and Drug Terms, “opiate” is defined as follows: one of a group of alkaloids derived from the opium poppy (*Papaver somniferum*) with the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma and respiratory depression. The term opiate excludes synthetic opioids such as heroin and methadone.

Opioid

According to the WHO Lexicon of Alcohol and Drug Terms, “opioid” is defined as follows: the generic term applied to alkaloids from the opium poppy (*Papaver somniferum*), their synthetic analogues, and compounds synthesized in the body, which interact with the same specific receptors in the brain, have the capacity to relieve pain, and produce a sense of well-being (euphoria). The opium alkaloids and their synthetic analogues also cause stupor, coma and respiratory depression in high doses.

Outcome evaluation

Outcome evaluation measures the extent to which a programme achieves its immediate objectives. It focuses on outputs and outcomes, including unintended effects, to judge the programme effectiveness. It may also assess the programme process to understand how the outcomes are produced. For UNDCP, outcome evaluations often address the effectiveness of immediate project objectives and the process through which they are achieved. The time horizon for outcome evaluation is usually with the life of the programme or project.

Outcome measure

A direct or indirect observation or record that concerns a specific patient's behaviour or cognition that is relevant to their problems and to the objectives of a treatment or rehabilitation programme. Outcome measures are usually drawn from a set of domains spanning substance abuse behaviours and cognitions; physical and psychological health symptoms and conditions and various aspects of personal, social and economic functioning, including relationship difficulties, housing and accommodation problems; education, training and employment problems; and illegal activities. Commonly, outcome measures are recorded for a suitable period immediately prior to a patient commencing treatment and recorded again at one or more follow-up points and changes in scores on the pairs of measures and then attributed to the treatment provided.

Outcome monitoring

The recording, communication and application of information about the impact or benefit of treatment that is used to judge the value of the intervention and for the purpose of improving its operation and effectiveness.

Outreach

A community-based activity with the overall aim of facilitating improvement in health and reduction of drug-related risk or harm for individuals and groups not effectively reached by existing services or through traditional health education channels. Outreach can be “detached”, “peripatetic”, or “domiciliary” or “peer”. Detached outreach takes place outside of an agency or organizational setting in public places such as the streets, public transport stations, nightclubs, hotels and cafes.

Peripatetic outreach focuses on organizations (for example, half-way houses, needle exchanges, youth clubs, schools and prisons) rather than individuals. Domiciliary outreach takes place in people's homes. Peer (or indigenous) outreach projects use current and former members of the target group (such as injecting drug users) as volunteers and paid staff.

Overdose

According to the WHO Lexicon of Alcohol and Drug Terms, “overdose” is defined as follows: the use of any drug in such an amount that acute adverse physical or mental effects are produced. Deliberate overdose is a common means of suicide and attempted suicide. Overdose may produce transient or lasting

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effects, or death; the lethal dose of a particular drug varies with the individual and with circumstances.

See also: Intoxication.

Oxycodone

A prescription painkiller found in the Opioids family, commonly known as OxyContin®.

Peer intervention

Essentially, a treatment that is delivered by a trained individual who is close in gender or age group or other socio-economic category to the target group. Peer interventions are usually, but not always, brief in duration and target individuals at risk of substance abuse problems or who have problems of moderate severity.

Peer support

At one level, one of the components of a peer outreach relationship where the outreach worker provides some form of assistance to a peer. The assistance is usually ongoing rather than a single discrete episode. The term “peer support group” is used to describe collectives or self-organizations of members of a community for the purpose of representing their shared interests at a socio-political level. These informal resources provide support for change and motivation for maintaining healthier behaviours.

Prevention

An intervention designed to avoid or substantially reduce risk for the acquisition or further development of adverse health and interpersonal problems. Drug abuse prevention programmes vary widely in content and philosophy. The most effective programmes are multidimensional and contain a mixture of straight-talking education sessions about drugs and drug abuse; skills to deal with stress and personal and relationship problems; and drug resistance skills. The specific content of a programme can be specifically adapted to the nature and needs of the target population.

Primary health-care workers

The doctors, nurses, psychologists and support personnel who work from community locations and who essentially provide general health-care services to the local population.

Psychoactive substance

According to the WHO Lexicon of Alcohol and Drug Terms, “psychoactive substance” is defined as follows: a substance that, when ingested, alters mental processes, that is, thinking or emotion. That term and its equivalent, psychotropic drug, are the most neutral and descriptive terms for the whole class of substances, licit and illicit, of interest to drug policy. “Psychoactive” does not necessarily imply dependence-producing.

Psychological dependence

A term for a largely discredited concept but which is still used in some quarters. It refers to dependence upon a drug in the absence of the development of either tolerance or withdrawal symptoms. Most modern uses of the term “dependence” avoid a strict distinction between “psychological” and “physical” dependence. If that phenomenon exists at all, it is likely to be a characteristic of the user and not a property of the drug.

See also: Dependence, Dependence syndrome.

Psychosocial treatment

Interventions based on psychological principles and methods involving individual and group counselling and therapy designed to modify problematic substance-related cognitions and behaviours.

Rehabilitation

According to the WHO Lexicon of Alcohol and Drug Terms, “rehabilitation” is defined as follows: in the field of substance use, the process by which an individual with a drug-related problem achieves an optimal state of health, psychological functioning and social well-being.

Rehabilitation typically follows an initial phase of treatment in which detoxification and, if required, other medical and psychiatric treatment occurs. It encompasses a variety of approaches including group therapy, specific behaviour therapies to prevent relapse, involvement with a mutual-help group, residence in a therapeutic community or half-way house, vocational training, and work experience. There is an expectation of social reintegration into the wider community.

See also: Recovery, Treatment.

Relapse

According to the WHO Lexicon of Alcohol and Drug Terms, “relapse” is defined as follows: a return to drinking or other drug use after a period of abstinence, often accompanied by reinstatement of dependence symptoms. Some writers distinguish between relapse and lapse (“slip”), with the latter denoting an isolated occasion of alcohol or drug use. The rapidity with which signs of dependence return is thought to be a key indicator of the degree of drug dependence.

See also: Relapse prevention.

Relapse prevention

According to the WHO Lexicon of Alcohol and Drug Terms, “relapse prevention” is defined as follows: a set of therapeutic procedures employed in cases of alcohol or other drug problems to help individuals avoid or cope with lapses or relapses to uncontrolled substance use. The procedures may be used with treatment based on either moderation or abstinence, and in conjunction with other therapeutic approaches. Patients are taught coping strategies that can be used to avoid situations considered dangerous precipitants of relapse, and

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shown, through mental rehearsal and other techniques, how to minimize substance use once a relapse has occurred.

See also: Relapse.

Remote/isolated First Nation

A zone where a First Nation is located over 350 km from the nearest service centre having year-round road access.

Residential treatment

Programmes that provide ancillary residential services on the same site as treatment services. The programmes generally strive to provide an environment free of substance abuse, with an expectation for compliance in a number of activities such as detoxification, assessment, information/education, counselling, group work, and the development or recovery of social and life skills.

Risk reduction

Risk reduction describes policies or programmes that focus on reducing the risk of harm from alcohol or other drug use. Risk reduction strategies have some practical advantages in that risky behaviours are usually more immediate and easier to objectively measure than harms, in particular those harms which have a low prevalence. For example, it may be more practical to measure reduced sharing of needles and other injecting equipment than indices of harm such as the incidence of HIV.

See also: Harm reduction, Safer use.

Risky behaviour

In relation to drug use, risky behaviour refers to behaviours that place persons at risk of some drug-related harm. Although most often used in relation to behaviours, such as sharing needles or other injecting equipment (spoon, water, tourniquet, etc.) which place drug injectors at risk of transmission of blood-borne viruses such as HIV or hepatitis C, the term can be applied to any drug and to any risk of harm to livelihood, relationships, legal sanctions, or health.

Ritalin

Methylphenidate (MPH), which is manufactured under the brand name of Ritalin, is a stimulant. Ritalin produces pharmacological effects similar to those of cocaine and amphetamines, and it is prescribed to treat attention-deficit/hyperactivity disorder (ADHA), attention deficit disorder (ADD) and other conditions. Unlike other stimulants, however, MPH has not been produced by drug dealers in homemade labs, likely because it is an inexpensive, readily available medication with a prescription, even though it is a controlled substance.

A growing number of incidents of abuse have been associated with teens and young adults using MPH for its stimulant effects: appetite suppression, wakefulness, increased attentiveness, increased focus and euphoria. It is being used for appetite suppression in many teenagers; college students are taking advantage of its stimulant affects to help them stay focused and awake for those

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long nights of studying. The drug has street names such as "Vitamin R," "R-Ball" and the "Smart Drug."

Safer use

Most drugs may be used in a way in which risk of adverse consequences is reduced by means of a combination of safer preparation, low dose, safer route of administration and in safer settings. For example, the risk of adverse consequences from using heroin, or the extent to which a drug use episode is life threatening, is greatly determined by whether injecting equipment is shared; whether a new batch of heroin is tested first in a small dose in case it is unusually pure; or whether it is used concomitantly with other central nervous system depressants such as benzodiazepines and alcohol. In most cases it is possible to identify drug-using practices which reduce, though usually not eliminate, the risk of serious adverse consequences.

See also: Harm reduction, Risk reduction.

Screening

A rapid procedure designed to detect individuals who have a substance abuse problem.

Self-help group

Groups that offer programmes of recovery on a voluntary basis principally through a twelve-step process for personal change. Those programmes often include participation in meetings to share histories of problems, obtain help and support from other members in dealing with challenges that have led to relapses, and seeking a member who will serve as a sponsor or mentor to provide help in times of crisis.

Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) make up a significant sector of the self-help groups concerned with substance dependence, while Al-anon, Alateen and Adult Children of Alcoholics (ACOA) attract family members trying to reconcile and resolve current or past personal problems associated with substance abuse in the family. Numerous other groups also operate in a similar fashion within and outside the field of substance abuse.

Semi-isolated First Nation

A zone where a First Nation is located between 90km and 350km from the nearest service centre having year-round road access.

Service accreditation

A system within quality assurance that indicates that a treatment service or programme meets a set of organizational, operational, clinical and professional performance standards and relevant legal requirements for its operation. There are currently no internationally agreed standards for service accreditation, but a wide range of countries have developed national standards and accreditation processes.

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Specialist service

A social, welfare or health-care service that has the treatment of people with substance abuse problems as its primary purpose. Stakeholders are the set of individuals in a community with an investment or expectation in the efficient and effective operation of a treatment service or system. That can include patients, carers/family members, treatment providers, planners and those providing financial support for service costs.

Structured treatment

Structured treatment describes a programme of therapeutic care that has several components that are organized in a logical or sequential way and are based on an initial patient assessment, and personalized treatment plan. Those components may include short and longer stay residential care and community/outpatient settings and involve the provision of medical and/or psychosocial interventions and/or aftercare. Naturally, there is variation in the intensity and duration of the components and their goals and objectives.

Substance abuse

A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems.

Substance dependence

A cluster of cognitive, behavioural and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal and compulsive drug-taking behaviour.

Substance use disorder

A generic term used in international systems (DSM-IV and ICD-10) for classifying diseases for various conditions and illnesses associated with the use of any psychotropic drug. It includes both problematic and dependent drug use. Any mental or behavioural disorder resulting from the use of one or more psychoactive substances, whether or not medically prescribed. The substances specified are alcohol, opioids, cannabinoids, sedatives or hypnotics, cocaine, other stimulants (including caffeine), hallucinogens, tobacco, and volatile solvents. The clinical states that may occur include acute intoxication, harmful use, dependence syndrome, withdrawal state, withdrawal state with delirium, psychotic disorder, late-onset psychotic disorder and amnesic syndrome.

Therapeutic community

A structured environment in which individuals with drug-related problems live while undergoing rehabilitation. Such communities are often specifically designed for drug-dependent people; they operate under strict rules, are run mainly by people who have recovered from dependence, and are often geographically isolated. Therapeutic communities are also used for management

of patients with psychotic disorders and anti-social personalities. Therapeutic communities are characterized by a combination of “reality testing” (through confrontation of the individual's drug problem) and support for recovery from staff and peers. They are usually closely aligned with mutual-help groups such as Narcotics Anonymous.

Tolerance

A term for the well established phenomenon of reduced drug effects following repeated drug administrations. Tolerance develops fastest with more frequent episodes of use and with larger amounts per occasion. It is useful to distinguish between metabolic tolerance and functional tolerance. Metabolic tolerance arises usually as a consequence of an induction of liver enzymes which result in the faster metabolism of a given drug dose, thereby reducing the level and duration of blood-drug levels. Functional tolerance refers to diminished effects of a given blood-drug level. That is thought to occur both by virtue of neuroadaptation, as well as by the user learning to anticipate and accommodate intoxicating effects.

Treatment

According to WHO (WHO Expert Committee on Drug Dependence Thirtieth Report, Technical Report Series) the term “treatment” refers to “the process that begins when psychoactive substance abusers come into contact with a health provider or any other community service and may continue through a succession of specific interventions until the highest attainable level of health and well being is reached”. More specifically, treatment may be defined “... as a comprehensive approach to the identification, assistance, ... (and) ... health care ... with regard to persons presenting problems caused by the use of any psychoactive substance”.

Essentially, by providing persons, who are experiencing problems caused by their use of psychoactive substances, with a range of treatment services and opportunities which maximize their physical, mental and social abilities those persons can be assisted to attain the ultimate goal of freedom from drug dependence and to achieve full social reintegration. Treatment services and opportunities can include detoxification, substitution/ maintenance therapy and/or psychosocial therapies and counselling.

Additionally, treatment aims at reducing the dependence on psychoactive substances, as well as reducing the negative health and social consequences caused by, or associated with, the use of such substances.

Twelve-step group

A mutual-help group organized around the twelve-step programme of Alcoholics Anonymous (AA) or a close adaptation of that programme. AA's programme of twelve steps involves admitting one is powerless over one's drinking and over one's life because of drinking, turning one's life over to a “higher power”, making a moral inventory and amends for past wrongs, and offering to help other alcoholics.

Withdrawal

A term used to refer to either the individual symptoms of, or the overall state (or syndrome), which may result when a person ceases use of a particular psychoactive drug upon which they have become dependent or after a period of repeated exposure. The level of central nervous system arousal and the accompanying mood state is usually directly opposite to the direct action of the drug.

See also: Withdrawal syndrome, Dependence syndrome.

Withdrawal syndrome

According to the WHO Lexicon of Alcohol and Drug Terms, “withdrawal syndrome” is defined as follows: a group of symptoms of variable severity which occur on cessation or reduction of drug use after a prolonged period of use and/or in high doses. The syndrome may be accompanied by signs of both psychological and physiological disturbance.

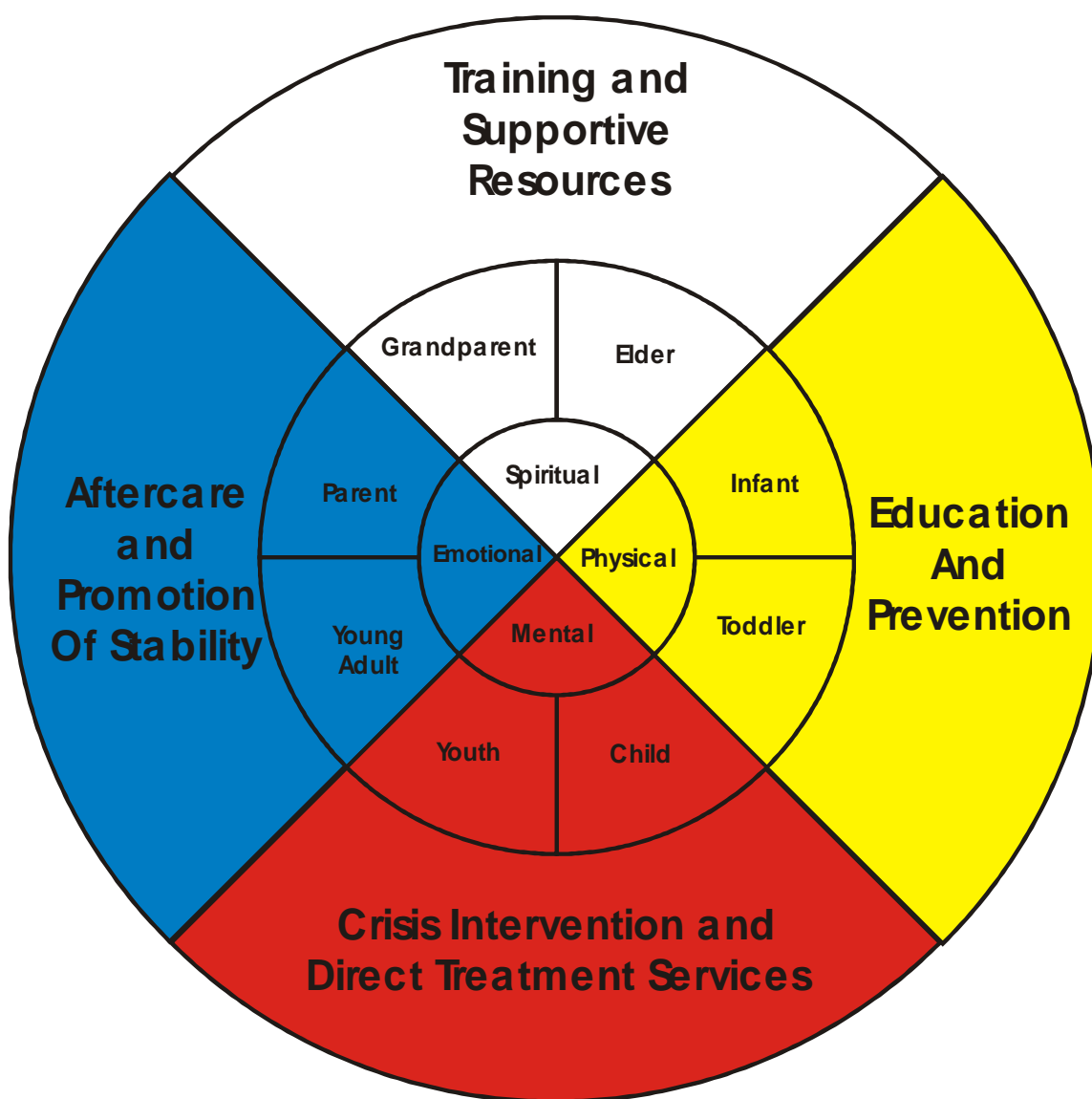
A withdrawal syndrome is one of the indicators of a dependence syndrome. It is also the defining characteristic of the narrower psycho-pharmacological meaning of dependence.

See also: Withdrawal, Dependence syndrome.

Appendix A: Detailed Methodology

In this section, we will be discussing findings from focus groups and key informant interviews during the twelve site visits, key informant interviews as well as survey findings from 38 First Nation communities and eighty nine participants at the NNADAP conference on November 28, 2008. This section of the report provides quantitative and qualitative information from the participants. Each discussion of participant findings is followed by a summary of what the relevant literature has to add to the findings.

In addition to the questions asked of the participants through the different lines of inquiry, Williams Consulting provided a four quadrant model to help focus discussion within a continuum of care and throughout all ages and stages of life.



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The following twelve site visits were completed a total of 198 focus group participants and 29 key informant interviews :

- October 27-28, 2008 at Ngwaagan Gaming Recovery Centre (Rainbow Lodge), Wikwemikong. Four focus groups were held with 22 participants in total and three key informant interviews. Types of stakeholders included: NNADAP workers, staff, Board of Directors, Community Specialist, Chief and Councillors, Mental Health workers and Child Welfare.
- October 28-29, 2008 at Anishnabie Naadmaagi Gamig Treatment Centre, Blind River. Four focus groups were held with 21 participants in total and one key informant interview. Types of stakeholders included: NNADAP workers, staff, Board of Directors and referral programs.
- October 30-31, 2008 at Sagashtawao Healing Lodge, Moosonee. Four focus groups were held with 22 participants in total and one key informant interview. Types of stakeholders included: NNADAP workers, clients, staff, Board of Directors, doctors and service providers.
- November 3-4, 2008 at Dilico Anishinabek Family Care, Thunder Bay. Four focus groups were held with 39 participants in total and eight key informant interviews. Types of stakeholders included: staff, community service providers and clients.
- November 5-6, 2008 in Sioux Lookout. Six key informant interviews were held. Types of stakeholders included: Sioux Lookout First Nation District Health Authority and community service providers.
- November 6, 2008 at Eagle Lake Health Centre, Eagle Lake. One focus group was held with 16 participants. Types of stakeholders included: staff, councillors and clients.
- November 7, 2008 at Migisi Alcohol and Drug Treatment Centre, Kenora. One focus group was held with 17 participants. Types of stakeholders included: staff and Board of Directors.
- November 10, 2008 at Native Horizons Treatment Centre, Hagersville. Two focus groups were held with seven participants in total and two key informant interviews. Types of stakeholders included: NNADAP workers, staff and Board of Directors.
- November 11-12, 2008 at Nimkee Niepigaioagan Healing Centre, Muncey. Three focus groups were held with 16 participants in total and two key informant interviews. Types of stakeholders included: clients, staff and Board of Directors.
- November 13, 2008 at New Directions, Six Nations of the Grand Territory. Three focus groups were held with 18 participants in total and two key informant interviews. Types of stakeholders included: clients, staff and community partners.
- November 18, 2008 at Reverend Tommy Beardy Memorial Family Treatment Centre, Muskrat Dam. Two focus groups were held with 15 participants in total. Types of stakeholders included: clients and staff.
- November 20-21, 2008 at Curve Lake First Nation. One focus group was held with 5 participants in total and 8 key informant interviews. Types of stakeholders included: staff, Chief, Anishnawbek Police and youth.

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Key Informants were held with forty individuals including

- Completed eight interviews with First Nations and Inuit Health Ontario Region
- Completed four interviews with Provincial Territorial Organizations (PTO's)
- Completed ten interviews with Ontario Regional Addictions Partnership Committee (ORAPC)
- Completed nine interviews with Treatment Centre Directors
- Completed one interview with Chiefs on matrix, but others participated in site visits
- Completed five interviews with First Nations representatives.

The charts depicted in this section illustrate quantitative findings from surveyed communities:

Aamjiwnaang First Nation	Dokis First Nation	Ojibway of the Pic River First Nation
Alderville First Nations	Fort Severn	Oneida Nation of the Thames
Algonquin of Golden Lake	Garden River First Nation	Onigaming First Nation
Anishinaabeg of Naongashiing	Ginoogaming First Nation	Sandy Lake First Nation
Aroland First Nation	Hiawatha First Nations	Sheguiandah First Nation
Bingwi Neyaashi Anishinaabek	Longlake #58 First Nation	Six Nations of the Grand River
Cat Lake First Nation	Mohawks of Akwesasne	Slate Falls First Nation
Chippewa's of Georgina Island	Naotkamaygwenning	Thessalon First Nations
Chippewa's of Saugeen	Nibinamik First Nation	Wahta Mohawks
Constance Lake First Nation	Nipissing First Nation	Walpole Island First Nation
Curve Lake First Nation	North Caribou Caico F.N	Webequie First Nation
Delaware Nation	North Spirit Lake	Whitefish River First Nation
		Winnamin Lake First Nation

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As well as NNADAP workers from the following areas:

Alderville First Nation	Hiawatha First Nation	Ojibways of Onigaming
Anishinaabeg of Naongashiing	Iskatewizaagegan #39	Oneida of the Thames
Aroland First Nation	Keewaywin First Nation	Rama First Nation
Attawapiskat First Nation	Kenora	Sandy Lake First Nation
Batchewana First Nation	Kingfisher Lake First Nation	Shawanaga First Nation
Cape Croker	Longlake #58 First Nation	Sheguiandah First Nation
Cat Lake	M'Chigeeng First Nation	Six Nations of the Grand River
Chippewa of the Thames	Matawa First Nation	Thunder Bay
Chippewas of Georgina Island	Mississauga First Nation	Tyendinaga First Nation
Chippewas of Saugeen	Mohawk Council of Akwesasne	Wabaseemoong Band
Christian Island, Beausoleil First Nation	Moose Deer Point	Wahta Mohawks
Curve Lake First Nation	Moose Factory	Walpole Island
Dokis First Nation	Moosonee	Walpole Island First Nation
Eabametoong First Nation	Muskrat Dam First Nation	Wannamin Lake
Eagle Lake	Nippising First Nation	Webaganie First Nation
Garden River First Nation	North Constance Lake First Nation	Whangosig First Nation
Ginoogaming First Nation	North Spirit Lake	Whitefish River First Nation
Gold Lake First Nation	Northwest Angle 37 First Nation	Wikwemikong First Nation
Henry Inlet First Nation	Ochiicha Gw'e Babigo'ining	

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Appendix C: Document Review

AA Meetings.

This single page document lists the days and times in which numerous centres/groups will be having there AA meetings.

Aiken, Mike (2008). Youth lead traffic stops at Wabaseemoong. Daily Miner and News, Tues, September 30, 2008

This newspaper article discusses the recent action taken by youth council members to help change the drug abuse problems in there community. The youth were stopping cars at the entrance of the community searching cars for intoxicants. The youth sick of what is happening in there community wanted change. Treaty 3 police joined the youth and eventually took over the searches.

Amazon.com (2008) Book listing for: Focused Genograms: Intergenerational Assessment of Individuals, Couples and Families.

This one page document is a listing for a book from amazon.com

Anishnabie Naadmaagi Gamig Substance Abuse Treatment centre (2008). Pamphlet.

A pamphlet describing the program of the treatment centre.

Anishnabie Naadmaagi Gamig Substance Abuse Treatment Centre (2008). Welcome to Our Centre.

This 41 page bound document contains all information regarding the centre. It includes services offered, description of facilities, centre mandate, the referral process of patients, program description/schedule, and organization of the centre.

Assembly of First Nations (2009) Canadian Human Rights Complaint: Information Sheet (Letter to Chiefs, PTOs and Tribal Councils)

This one paged information sheet discusses the updates on Human Rights Complaint regarding Child Welfare.

Bergman, Stanley (2008) Email communication to Janice Thibodeau re: CBT Certificate Program – Training Program.

This email was sent to the executive director of Anishnabid Naadmaagi Gamig Substance Abuse Treatment Centre to discuss the Cognitive Behavioural Therapy Certificate Program training for those working at the centre. Program Testimonials and a Proposal where attached in the email.

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Bressette, Nora (2007/2008) Nimkee NupiGawagan Health Centre Inc. Annual Report 2007/2007.

This 41 paged report provides background on the centre including vision statement, mission statement, goals, program descriptions, and governance and management. The report goes on to present and discuss statistics of 2007/2008 including client profile, chemical use, and education level among others

Campbell, Ida (2008). Letter to Chief Isadora Bebamash of M'Chigeeng First Nation re: Non-insured Health Benefits Program.

This document from Health Canada provides the Drug Utilization Reports from 2004-2008 for the community of M'Chigeeng First Nation. Annex A of the report contains numerous charts and tables which provides additional information of the drug utilization trends in the community.

Canadian Centre on Substance Abuse (2008). Prescription Drug Abuse: FAQs.

This 20 paged document provides the reader with frequently asked questions and there answers. All questions and answers were prepared by medical doctors.

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

This 51 paged document discusses the situation in Canada regarding youth substance abuse. Topics covered in the report include: substance abuse and harm to youth; what substance are being use by the youth; the governments response to youth substance abuse; a neuroscience perspectives; gaps in approaches to youth substance abuse and a call to action.

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

This 47 paged document discusses the current situation in Canada regarding substance abuse. Topics covered include: new directions in alcohol policy; harm reduction; drugs and driving; availability and use of evidenced-based treatment; abuse of prescription drugs and alternative sanctions for cannabis use and possession.

Centre for Addiction and Mental Health (2008) Methadone Saves Lives.

This pamphlet provides information regarding Methadone Maintenance treatment (MMT)

Centre for Addiction and Mental Health (2008) Opioid Dependence Treatment Certificate Program

This one paged document provides information on the opioid certificate program. Laying out the courses and workshops that are required.

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Centre for Addiction and Mental Health (2005). Beyond the Label: An educational kit to promote awareness and understanding of the impact of stigma on people living with concurrent mental health and substance abuse problems.

This 119 paged report discusses stigma busting activities that can be held in a group setting held by a facilitator.

Chansonneuve, Deborah (2007). Addictive Behaviours among Aboriginal People in Canada. The Aboriginal Healing Foundation Research Series. Prepared for: the Aboriginal Healing Foundation

This 125 paged document discusses: addictive behaviour and residential school abuse; using the wisdom of culture to promote healing and promising practices.

Chief Arthur Moore (2009) Prescription Drug Abuse (Speaking notes for presentation given in Feb 10, 2009 in Thunder Bay, ON at the Chiefs Forum on Social Issues)

Concurrent Disorders Policy Network (2006). Concurrent Disorders Policy Framework

This 39 paged document discusses: a provincial context of concurrent disorder policy; prevalence and impact of concurrent disorders; a vision for Ontario; goal statement; framework objectives and guiding principles.

Copping, Valerie (unknown). Intergenerational Trauma Treatment Model.

This booklet discusses the Intergenerational Trauma Treatment Model (ITTM) program that is offered by the author.

Crosbie, Lorena and Amber McCart. (unknown) Intergenerational Trauma Treatment Model – Implementation considerations. PowerPoint Presentation.

This 8 page document is a print out of the slides of a PowerPoint presentation discussing the ITTM program developed by Valerie Copping.

Dell, Colleen Anne (2008). Informing Next Steps: A Review of Health Promotion and Intervention Strategies Addressing Prescription Drug Abuse among First Nations in Canada

This 90 paged document discusses: the extent of prescription drug abuse; responses to prescription drug abuse; health promotion; cultural relevance and health promotion; education and awareness; harm reduction and treatments.

Dell, Colleen Anne and Tara Lyona (2007). Harm reduction policies and programs for persons of Aboriginal decent In: Harm Reduction for Special Populations in Canada. Canadian Centre on Substance Abuse.

This 20 paged article discusses the implementation and policies and programs of harm reduction and Aboriginal Communities.

Dilico Anishinabek Family Care (2008). Youth Outreach (YOW) Services pamphlet.

This pamphlet describes the YOW programs and the services that they provide.

Dilico Anishinabek Family Care (2008). District Mental Health and Addiction Services: A Holistic Approach to Recovery, pamphlet.

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This pamphlet describes the different services available and provides a map of the locations of the programs along with the head and district offices.

Dilico Anishinabek Family Care (2008). Day Treatment School-Based Services, pamphlet.

This pamphlet describes the program for youth that have social, emotional and behavioural concerns.

Dilico Anishinabek Family Care (2008). Infant /Child Development Services, pamphlet.

This pamphlet describes the program for children 6 and under. The programs aim is the help parents develop healthy mental, physical, emotional and spiritual development.

Dilico Anishinabek Family Care (2008). Family Preservation Services, pamphlet.

This pamphlet describes the program for families and the services that are provided. Services include effective parenting, behaviour management, anger management, problem solving, and communication.

Dilico Anishinabek Family Care (2008). Mental Health and Addictions Services, booklet.

This 11 paged booklet provides an overview of the services provided for those with mental health and addiction problems. Services are provided to children, families and adults.

Dilico Anishinabek Family Care (2008). Well-being and Balance for Anishinabek Children, Families and Communities, booklet.

This booklet contains the health and welfare services provided by the centre for children, families and the whole community.

FCC Niagara (2008) Intergenerational Trauma Treatment Model.

This one page document is a print out from the FCC Niagara website (www.fccniagara.on.ca). It discusses the ITTM program for those that have experience trauma.

First Nations and Inuit Health – Ontario Region (2009) Trends in Opiate and Benzodiazepine Prescription Use in Sioux Lookout Zone. For the Chiefs Forum on Social Issues. Thunder Bay, ON, February 10, 2009

This 8 paged handout provides the reader with an overview of the trend in opiates and benzodiazepines drug use in the Sioux Lookout area.

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Grand Chief Stan Beardy (2009) Speaking notes for the Chiefs Forum on Social Issues. Thunder Bay, ON. February 10, 2009

Health Canada (2006). Best Practices: Early Intervention, Outreach and Community Linkages for Women with Substance Abuse Problems. Canada's Drug Strategy.

In this 120 paged report topics discussed include: gender difference, barriers to accessing intervention services for problems substance use; specific client-related considerations and needs; early intervention, outreach,; community linkages and key informant and focus group interviews.

Health Canada (2001). Preventing Substance Use Problems Among Young People: A Compendium of Best Practices.

This 294 report looks at the substance abuse problems among the young in Canada and the best practices that are use to treat the addictions. Topics discussed include: substance use patterns of Canadian youth; principles of youth substance use problems prevention; exemplary programs from the scientific literature and exemplary Canadian programs.

Health Canada (2000). Straight Facts about Drugs and Drugs Abuse

This 64 paged document discusses topics including: the harmful consequences of drugs; Canada's drug strategy; Canada's drug laws and the types of drugs that are prevalent in Canada.

Health Canada (1999). Best Practices: Substance Abuse Treatment and Rehabilitation.

This 97 paged report discusses the best practices that are seen in treatment and rehabilitation for substance abuse problems. Topics discussed include: the effectiveness of specific treatment approaches; matching clients with treatments and therapists; the influence of other factors on treatment effectiveness; social populations; services delivery systems; economic benefits of substance abuse treatments and issues and limitations concerning research.

Herie, Marilyn et. al. (2007) Addiction: An information guide. Centre for Addiction and Mental Health.

This 30 paged report discusses: what addictions are; what causes addictions; FAQs about addictions; help for people with addictions; change, recovery and relapse prevention; help for partners and families and explaining addiction to children

Johnson, Autumn (2008). Addiction Counsellors Training Survey: Ontario Regional Addictions Partnership Committee. Final Report.

The report summarized the results of the Addiction Counsellor Training Survey. The survey was administered by ORAPC at the NNADAP conference in November 2007. The report provides demographics, level of training, certification maintenance, type of NNADAP program, and recent training among others

Johnson, Jan (2007) Shared Places: An Introduction to Tribal Histories and Cultures. Part 2: Indigenous Aesthetics / Expressive Culture: Historical Trauma.

This two page document is a printout of class notes from the University of Idaho. It discusses the historical trauma that Native Americans have faced, the six phases of unresolved grief and coping strategies among others

Keewaytinook Okimakanak Research Institute (KORI) (2006). Impacts of Prescription

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Narcotic Use, Misuse and Abuse in the Robinson Superior Treaty Area. Report to the Dilico Ojibway Child and Family Services Strategy Committee.

This documents primary focus is regarding prescription narcotics especially oxycotin in Northwestern communities. The report includes an environmental scan, literature review, and surveys completed by community members.

Maxwell, Jane Carlisle (2006). Trends in the Abuse of Prescription Drugs. The Gulf Coast Addiction Technology Transfer Centre (GCATTC)

This 14 paged document discusses drug abuse problems throughout different cities in the United States of America, and the National trends for the years 2002-2005

Migisi Alcohol and Drug Treatment Centre (2008).

This four page document gives the four week schedule of a patient in the treatment center.

Migisi Alcohol and Drug Treatment Centre (2006). Mobile Community-Base Aftercare Treatment Support Program.

This document is a pilot project for a proposed regional aftercare services infrastructure. The proposal includes the statement of need, goals, program description, work plan and budget among others.

Mitchell, Terry L. and Dawn T. Maracle (2005) Healing the Generations Post-Traumatic Stress and the Health Status of Aboriginal Populations in Canada. Journal of Aboriginal Health. March 2005. pg 14-24

The authors of this publication discuss the inequalities between Aboriginal and non-Aboriginal people in Canada and it's relation to and importance of post-traumatic stress disorder/response. They also note the importance of acknowledging and addressing historical and intergenerational trauma in Aboriginal communities.

Nadmadwin Mental Health Clinic (2008) Nadmadwin Mental Health Clinic pamphlet.

This pamphlet provides the location and hours of the clinic along with programs/services provided.

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National Indian and Inuit Community Health representative Organization (2007) Aboriginal Healing Perspectives: Weaving science and traditions, Helping Aboriginal communities reduce prescription drug abuse.

This 118 paged report discusses: reducing risk factors for addiction; abstinence and harm reduction; education and intervening with individuals and historical trauma, addiction and healing among others.

National Institute on Drug Abuse (2003). Preventing Drug Abuse among Children and Adolescents: A Research-Base Guide for Parents, Educators, and Community Leaders. 2nd ed. U.S. Department of Health and Human Services

This 49 paged document is a discussion of how to prevent substance abuse among youth. Topics in the report include: risk and prevention factors, planning for drug abuse prevention on the community, applying prevention principles to drug abuse prevention programs, and examples of research-based drug abuse prevention programs.

Ngwaagan Gamig Recovery Centre Inc. (2008) Ngwaagan Gamig Recovery Centre Inc. Program / Centre pamphlet.

This pamphlet gives the contact information of the centre along with program / treatment descriptions.

Ngwaagan Gamig Recovery Centre Inc. (2008) Summer 2008 Newsletter – August.

This newsletter includes the vision and mission statements of the centre along with news stories, updates about programs at the centre and poems submitted by the community.

North West LHIN (2008) Aboriginal Health Forum. “Elements of Change” Summary Report.

This 45 paged document provides the results of a two day conference (March 27 and 28, 2008) held in Thunder Bay. The document contains the agenda, questions discussed along with the findings.

O'Donaghey, Pamela M. (n.d.) Healing at Home: A First Nations Guide Home Detox.

This 132 paged document provides the readers with a guide on how one can complete detox at home with a cultural component.

O’Gorman, Karen (2008). Evidence Based Treatment Enhancement Options: Dilico Adult

Treatment Centre. Final report for: Dilico Anishabek Family Care Mental Health and Addiction Services.

This 39 paged document reviews a study completed for the Dilico Anishabek Family Care Mental Health and Addiction Services. The study completed a literature review, scan of services and programs, and key informant interviews. The report outlines the best practices identified and the suggestions for the development of a next step work plan among others.

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Oxycontin Task Force (2004). Final Report. Submitted to the Department of Health and Community Services, Department of Education and the Department of Justice

This 64 paged document discusses: an overview of the task force activities; overview of oxycontin; preventing oxycontin abuse; oxycontin detoxification; oxycontin treatment; and harm reduction.

Planning Committee Meeting: Chiefs' Forum on Social Issues (August 19-29, 2008). Briefing Note.

This six page document provides an overview of the planning committee meeting. It includes the meeting goal, strategic planning process, along with specific strategies developed. It also discussed a forum to take place February 23-27 2009.

Preparing For Strategic Planning Community Environmental Scanning Survey (2008).

This two page document gives the results of a survey question regarding the current trends/issues of substance abuse/addiction in the community (same question as above, different years).

Preparing For Strategic Planning Community Environmental Scanning Survey (2007).

This three page document includes the results of a survey regarding the current trends/issues of substance abuse/addictions in the community. The document also includes three other survey questions (no answers).

Quinn, Ashley (2007) Reflection on Intergenerational Trauma: Healing as a Critical Intervention. First Peoples Child and Family Review, Vol.3, No. 4, pp. 72-82

The author argues that healing from the trauma of colonization is a critical component of an intervention on repairing. Recommendations for government, professionals, and for academic institutions, are provided.

Regional Opiate Task Force (2008). Terms of Reference.

This two page document outlines the mandate, goals and objectives, accountability, decision making, membership and meetings of the task force.

ROM (Tuesday, June 3, 2008). Regional Opiate Task Force.

This 3 paged ROM lists the numerous updates and reports from members of the task force.

ROM (Tuesday, March 4, 2008). Regional Narcotics Task Force.

This two page document records the inaugural meeting by this task force. Some concerns of the members included no uniformity with physician prescribing habits, people "taking" narcotic medication from elderly family members and the quickness of addiction to certain narcotics among others.

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Sioux Lookout First Nations Health Authority (2007-2008) Annual report.

This 54 paged book provides an overview of the operating year of 2007-2008 for the Sioux Lookout First Nations Health Authority. The document includes vision/mission statements, health services provided, financial statements, staff/board of directors, partners and funders, and the communities in which the Health Authority serves.

Sioux Lookout First Nation Health Authority (Sept. 5, 2007) Sioux Lookout Zone Chiefs Meeting Resolution 07/07 Forum of Social Issues.

This one page document provides issues and the resolutions to these issues that the Chiefs in this zone created. One issue includes “incidences related to manufactured intoxicant usage are increasing”

Sioux Lookout First Nation Health Authority (2006), The Anishinabe Health Plan

This 245 paged document provides a very detailed account of the Anishinabe Health Plan. Sections include background, community health needs assessment, The NAN Chief's model, the five areas of the NAN chief's model, service delivery system, Human resource management, governance and management, roles and responsibilities, financial planning, and system supports among others.

Sioux Lookout First Nation Health Authority (unknown). Sioux Lookout First Nation Health Authority Organizational Chart

This one page document is a flow chart describing the organization of the health authority

Sutherland, Mariette and Marion Maar (2008). Northern Superior Regional AHWS Renewal Consultation. A report based on Union of Ontario Indian Aboriginal Healing and Wellness Strategy Renewal Consultation with Anishinabek First Nation Communities in The Northern Superior Region.

This 12 page document reports on a two day session with nine (9) health care workers from communities within the area of the health board. Areas discussed include critical needs and health issues in local First Nations, how AHWS programs have been helpful, and areas for improvement among others.

Sutherland, Mariette and Marion Maar (2008). Regional AHWS Renewal Consultation

Report. Based on the Union of Ontario Indians Aboriginal Healing and Wellness Strategy Renewal Consultations with First Nation Communities within Anishinabek Territory.

This 31 page document reviews regional meetings that occurred with key informants within Anishinabek communities. The report includes backgrounds on the strategy, overview of AHWS programs, and a summary of priorities among others.

TAPE Educational Services Inc. (2008) Testimonials

This two page document provides testimonials from those that have already completed TAPE training programs.

TAPE Educational Services Inc. (2008). Cognitive Behavioural Therapy: A Customized

Certificate Program for front-line staff working at Anishnabie Naadmaagi Gamig Substance Abuse Treatment Centre.

This ten page document outlines the Cognitive Behavioural Therapy training program to be taken by members of the centre.

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Thibodeau, Janice (2008). Proposal For Program Framework for Supportive Housing for People with Problematic Substance Use.

This is a proposal written by the Executive Director of the Anishnabie Naadmaagi Gamig Substance Abuse Treatment Centre. The proposal aims to receive funding for a home in Blind River to house beds for those in recovery. The letter is addressed to Jamie Adams, Zone Director.

United Nations (2004). A Strong Start: Good practices in using a local situation assessment to begin a youth substance abuse prevention project. United Nations Office on Drugs and Crime.

This 54 paged document provides a worldwide perspective on what initiatives can be done on a local level to deal with and prevent youth substance abuse locally. Topics discussed include; preparing for the local situation assessment; conducting the local situation assessment; and mobilizing youth and others to support your project.

Unknown (2009) Prescription Drug Abuse Prevention and Promotion: Recommendations and Best Practices. Presentation.

This presentation discusses: multi-disciplinary approach to addressing underlying addictive behaviours; culturally appropriate prevention strategies; follow-up to long term strategies; skill building for individuals and families; prescription drugs education; and collaboration of community and organizations among others.

Unknown (unknown)...Healing the legacy of the residential schools – Intergenerational...

This two page document was obtained from an unknown website. It discusses the impact that intergenerational survivors face on a day-to-day basis.

Unknown (Unknown) Intergenerational Trauma in Native American Communities: A Framework for Healing. PowerPoint Presentation

This 10 page printout of a PowerPoint presentation discusses the impacts of trauma and ideas for healing.

Unknown (unknown) Alcohol, Solvent and Drug Abuse in Out First Nation Communities.

This four page document appears to be a letter addressed to no one in particular and sign by no one. It discusses the problems of alcohol abuse in particular.

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White Bison, Inc. (May 23, 2005) Wellbriety! White Bison's Online Magazine. Vol. 6, No. 6.

This 8 page document is an online magazine. It's headline and topic of discussion is "From Intergenerational Trauma to Intergenerational Healing". It discusses the conference, the Fifth Annual White Bison Wellbriety Conference in Denver, Colorado. The keynote talk was given by Dr. Maria Yellow Horse Brave Heart.

White Bison, Inc. (May 30, 2005) Wellbriety! White Bison's Online Magazine. Vol. 6, No. 7.

This 6 page document is an online magazine. Its headline is "The Grassroots Speaks...About Intergenerational Trauma". The article discusses the speech given by Theda New Breast and her Top Ten Solutions from the Intergeneration Trauma Circle.

Wilson, Rodgers M. (n.d.) Adolescents and Prescription Drug Abuse. Arizona Department of Health Services. Presentation.

This presentation discusses various aspects of prescription drug abuse in youth. Topics includes impacts on health and development, trends in abuse prevalence, accessibility and availability, gender differences, age trends, and treatment options.

Windigo First Nation Council (2008) First Nation Information.

This seven page document provides descriptions of seven different First Nation communities. On each page describing each first nation there is, hand writing, is a persons name with associated and in some cases contact information. The First Nations include Slate Falls, Bearskin Lake, Sachigo Lake, North Caribou Lake, Cat Lake, Koocheching and Whitewater Lake.



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GLOSSARY OF TERMS

NOTE:

This Glossary of Terms heavily relies on terminology found in the United Nations (2003) Drug Abuse Treatment and Rehabilitation Guide; Addiction work compiled by Wayne Skinner (2006) as well as AHF (2007) Addictive Behaviour among Aboriginal People in Canada.

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A Joint Initiative of The Chiefs Of Ontario, Ontario Region First Nations and Inuit Health (FNIH) and the Ontario Regional Addictions Partnership Committee (ORAPC).

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ACRONYMS

Chiefs of Ontario (COO)
First Nations Addictions Advisory Panel (FNAAP)
First Nations and Inuit Health (FNIH)
National Native Alcohol and Drug Abuse Program
(NNADAP)
Ontario Regional Addictions Partnership Committee
(ORAPC)
World Health Organization (WHO)

GLOSSARY OF TERMS

Aboriginal Culture as a Healing Model

There are now many examples of effective community-based addictions prevention and intervention programs. One of the groundbreaking Aboriginal community healing models is that of Alkali Lake, British Columbia. This community healing model inspired other communities, such as Hollow Water in Manitoba, to become leaders in their own right of a holistic and integrated response.

Treatment centres such as Round Lake in British Columbia, Poundmaker's Lodge in Alberta and Enaahdig Healing Lodge in Ontario are examples of addictions program models that have broken new ground in a culture as healing approach to addictions recovery. The culture as healing model is grounded in an understanding of the impacts of residential school abuse and colonization. Culture as healing counters these impacts through strategies of cultural revitalization.

Abstinence

The term refers to the act of refraining from alcohol or other drug use, whether for health, personal, social, religious, moral, legal or other reasons.

Someone who is currently abstinent may be called an "abstainer", a "total abstainer", or, an old-fashioned term relating only to alcohol, a "teetotaler". The term "current abstainer" is sometimes used for research purposes and is usually defined as a person who has not used drugs for a specified period of time, for example, 3, 6 or 12 months. In some studies, persons who drink or use other drugs only once or twice per year are also classified as abstainers.

Abuse

This term is in wide use but of varying meaning. In international drug control conventions "abuse" refers to any consumption of a controlled substance no matter how infrequent. In the Diagnostic and Statistical Manual of Mental Disorders (DSMIV, American Psychiatric Association, 1994), "psychoactive substance abuse" is defined as "a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following within a 12 month period: (1) recurrent substance use resulting in a failure to fulfil major role obligations at work, school or home; (2) recurrent substance use in situations in which it is physically hazardous; (3) recurrent substance-related legal problems; (4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance". It is a residual category, with dependence taking precedence whenever applicable.

The term "abuse" is sometimes used disapprovingly to refer to any use at all, in particular of illicit drugs. Because of its ambiguity, the term is only used in the ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines (WHO, 1992) for non-

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dependence producing substances. "Harmful" and "hazardous use" are the equivalent terms in WHO usage, although they usually relate only to effects on health and not to social consequences. The term "abuse" is also discouraged by the Centre for Substance Abuse Prevention in the United States, although the term "substance abuse" remains in wide use and refers generally to problems of psychoactive substance use. The term "drug abuse" has also been criticized as being circular when it is used without reference to specific problems arising from drug use.

See also: Drug Abuse.

Accreditation

The process of recognition that a programme meets specific operational and organizational standards that have been established to ensure the quality of services within a particular region or treatment system. Accreditation is usually awarded by an external professional body on the basis of a review or audit and is usually for a specific period.

Addiction

One of the oldest and most commonly used terms to describe and explain the phenomenon of long-standing alcohol and drug abuse. In some professional circles it has been replaced by the term "alcohol or drug dependence". According to the WHO Lexicon of Alcohol and Drug Terms, "addiction" is defined as: the repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means.

Key indicators of "addiction" have traditionally been thought to be tolerance and experience of a withdrawal syndrome, that is, it is often equated with physical dependence. More recently, some drug researchers have suggested that "compulsion to use drugs" is a more central indicator of addiction. Addiction is otherwise regarded by the self-help or "recovery" movement as a discrete disease, a debilitating and progressive disorder rooted in the pharmacological effects of the drug for which the only cure is total abstinence. That view is most notably associated with the "self-help" or "recovery" movement, for example, Narcotics Anonymous and Alcoholics Anonymous. In the 1960s, WHO recommended that the term "addiction" be abandoned in favour of dependence, which can exist in various degrees of severity as opposed to an "all or nothing" disease entity.

Addiction is not a diagnostic term in the ICD-10, but continues to be very widely employed by professionals and the general public alike.

See also: Dependence, Dependence Syndrome.

Advice Services

The range of information and non-medical treatment services which can variously provide drug information, details of services available, referral to other agencies, and direct clinical casework or psychotherapy. Services may be provided in a direct face-to-face setting or indirectly by telephone to individuals, families, groups, other workers or agencies. The term "advice" is usually reserved for the provision of factual information on specific issues. It also incorporates brief and specific advice to change behaviour, for example in brief interventions (See Below). Advice is usually

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distinguished from “counselling” where the emphasis is more on assisting individuals to evaluate their own situation and reach their own decisions about how to cope.

See also: Brief Intervention, Counselling and Psychotherapy, Treatment.

Aftercare

A broad range of community-based service supports designed to maintain benefit when a structured treatment has been completed. Aftercare may involve a continuation of individual or group counselling and other supports, but usually at a lower intensity and often by other agencies. Self-help groups such as Alcoholics Anonymous and Narcotics Anonymous are an important provider of aftercare.

See also: Self-Help Group.

AIDS

The common abbreviation for a fatal viral condition known as acquired immunodeficiency syndrome in which the immune system is weakened and unable to combat infectious diseases. The sharing of injecting equipment among injecting drug users is a major route of transmission for human immunodeficiency virus (HIV). That is the virus that causes AIDS, and in many countries has led to programmes discouraging injecting and to the establishment of programmes to make clean injecting equipment more readily available for injecting drug users in order to reduce the likelihood of transmission of the virus through the sharing of used needles and other equipment.

See also: Harm Reduction, Needle Exchange, Risk reduction, Safer Use.

Amphetamines/Methamphetamines

Amphetamines are synthetic psychoactive drugs that stimulate or increase the action of the central nervous system. Amphetamines may be smoked, injected, inhaled, or taken orally as a capsule or tablet. Methamphetamine is the primary form of amphetamine seen in the United States making up 94 percent of all amphetamine treatment admissions reported to the Treatment Episodes Data Set in 1999. Methamphetamine was developed from its parent drug, amphetamine and is similar in its chemical makeup, but it has more pronounced effects on the central nervous system. Street methamphetamine is referred to by names, such as speed, meth, and chalk. Methamphetamine hydrochloride, clear chunky crystals resembling ice, which can be inhaled by smoking, is referred to as ice, crystal, and glass.

Benzodiazepines

Benzodiazepines are a group of CNS depressants which are closely related in their chemical structures. They are among the most frequently prescribed medicines worldwide (for daytime anxiety relief and to promote sleep). Individual benzodiazepines differ in speed of onset, duration of action and potency. About 2,000 benzodiazepines have been synthesized by the pharmaceutical industry. Benzodiazepines encountered on the illicit market are usually diverted from legitimate trade rather than synthesized in clandestine laboratories.

Brief Intervention

A treatment strategy in which structured therapy of a limited number of sessions (usually one to four) of short duration (typically 5-30 minutes) is offered with the aim of assisting an individual to cease or reduce the use of a psychoactive substance or (less commonly)

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to deal with other life issues. It is designed, in particular, for general practitioners and other primary health care workers.

Cannabis (Marijuana/Hash)

Cannabis is the dried flowering tops of hemp plants (*Cannabis sativa*), which have euphoric principles (tetrahydrocannabinols); classified as a hallucinogen and prepared as bhang, ganja, hashish, and marijuana.

Care Coordination

The process of oversight and practical management of patients within a particular treatment and across different treatments over time. For a particular patient, care coordination can involve assessment, referral, progress monitoring and review activities. In some treatment systems, the care coordinator has some degree of authority over the system that pays for the treatment of patients.

Cocaine/Crack

Cocaine is a powerfully addictive stimulant drug. The powdered hydrochloride salt form of cocaine can be snorted or dissolved in water and injected. Crack is cocaine base that has not been neutralized by an acid to make the hydrochloride salt. This form of cocaine comes in a rock crystal that is heated to produce vapors, which are smoked. The term “crack” refers to the crackling sound produced by the rock as it is heated.

Cognitive-Behavioural Techniques

A type of psychotherapy that stresses that the way in which people think about a problem is instrumental in causing feelings and behaviours that are unwanted. Cognitive-behavioural techniques (CBT) therefore aims to help a patient replace those unhelpful thoughts with others that lead to more desirable reactions.

In the substance abuse field the CBT therapist helps a patient to acquire new skills to alter or maintain changes in their behaviour. In that respect, relapse prevention programmes may contain a CBT element to help patients resist urges to use substances.

Cognitive Behavioural Therapy

Cognitive behavioural therapy suggests that how we think about a situation influences how we act. In turn, our actions can influence how we think and feel. It is therefore necessary to change both cognition (the act of thinking) and behaviour at the same time.

Community-Based Treatment

Any treatment that is based in a non-residential setting. Outpatient treatments (day attendance-based services provided from a hospital) are often bracketed with community based treatments. Examples of community-based treatments are opioid substitution programmes; counselling programmes and aftercare services.

Community Empowerment

Interventions which encourage a community (for example, people in a locality, drug injectors, sex workers) to develop collective ownership and control over health-related choices and activities. To achieve that result, the community may also need to gain collective control of the wider social, political and economic factors which influence their access to health. “Empowerment” is a process of increasing personal, interpersonal or political power so that individuals can take action to improve their lives.

Co-Occurring Disorders

A person diagnosed as having an alcohol or drug abuse problem in addition to some other diagnosis, usually psychiatric, for example,

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mood disorder or schizophrenia. Making differential diagnoses is often complicated by overlapping signs and symptoms of dependence and diagnostic entries, for example, anxiety is a prominent feature of drug withdrawal. A further complication is with shared or reciprocal casual processes, for example, a mild disorder of mood leads to some drug use which eventually leads to an exacerbation of the mood disturbance, to further drug use, dependence and severe mood disturbance.

Counselling and Psychotherapy

Counselling is an intensive interpersonal process concerned with assisting normal people to achieve their goals or function more effectively. Psychotherapy is generally a longer-term process concerned with reconstruction of the person and larger changes in more fundamental psychological attributes such as personality structure. Psychotherapy is often restricted in conception to those with pathological problems.

Court Diversion

A programme of treatment, re-education or community service for individuals referred from criminal courts (criminal diversion) after being charged with driving under the influence of alcohol (drinking-driver diversion) or another drug, with the sale or use of drugs (drug diversion), or with another crime. Individuals are assigned to diversion programmes in lieu of prosecution, which is usually held in abeyance pending successful completion of the diversion programme. Pre-charge diversion refers to the systematic referral of those detected by the police to an alternative programme without arrest. In some countries, the term "custody diversion" is used to make explicit that in many diversion schemes the individual may attend court but be diverted away from custody into a programme of treatment or re-education.

Crystal Meth

Crystal Meth is one of the street names used for methamphetamine. It is also known as "speed," "meth" or "chalk." In its smoked form, it can be referred to as "ice," "crystal," "crank," and "glass." Methamphetamine belongs to a family of drugs called amphetamines--powerful stimulants that speed up the central nervous system. The drug can be made easily in clandestine laboratories with relatively inexpensive over-the-counter ingredients. Methamphetamine is a drug with high potential for widespread abuse.

Dependence, Dependence Syndrome

According to the WHO Lexicon of Alcohol and Drug Terms, "dependence, dependence syndrome" is defined as follows: as applied to alcohol and other drugs, a need for repeated doses of the drug to feel good or to avoid feeling bad. The terms "dependence" and "dependence syndrome" have gained favour with WHO and in other circles as alternatives to addiction since the 1960s.

In the DSM-IV, dependence is defined as "a cluster of cognitive, behavioural and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems".

See also: Addiction.

Detoxification

The process by which a person who is dependent on a psychoactive substance ceases use, in such a way that minimizes the symptoms of withdrawal and risk of harm. While the term "detoxification" literally implies a removal of toxic effects from an episode of drug use, in fact it has come to be used to refer to the management of rebound symptoms of neuroadaptation, that is, withdrawal

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and any associated physical and mental health problems.

Drug Abuse

Current international drug control treaties do not define drug abuse but make reference to a variety of terms, including abuse, misuse and illicit use. In the context of international drug control, drug abuse constitutes the use of any substance under international control for purposes other than medical and scientific, including use without prescription, in excessive dose levels, or over an unjustified period of time.

Drug Substitution

Treatment of drug dependence by prescription of a substitute drug for which cross-dependence and cross-tolerance exist. The term is sometimes used in reference to a less hazardous form of the same drug used in the treatment. The goals of drug substitution are to eliminate or reduce use of a particular substance, especially if it is illegal, or to reduce harm from a particular method of administration, the attendant dangers to health (for example, from needle sharing), and the social consequences. Drug substitution is often accompanied by psychological and other treatment.

Early Intervention

A therapeutic strategy that combines early detection of hazardous or harmful substance use and treatment of those involved. Treatment is offered or provided before such time as patients might present of their own volition and in many cases before they are aware that their substance use might cause problems. It is directed in particular at individuals who have not developed physical dependence or major psychosocial complications.

Eligibility Criteria

A set of medical, social and psychological conditions that are used to judge the appropriateness of a treatment for a particular individual. Eligibility criteria usually take into account the severity of patients' problems, their personal motivations or readiness for treatment, and the nature and extent of their social supports and stressors in terms of their suitability for a particular treatment. Use of eligibility criteria is part of a commitment to matching patients to the best or more appropriate treatment in the context of two or more alternatives.

Evaluation

The systematic and scientific process of determining the extent to which an action or sets of actions were successful in the achievement of predetermined objectives. It involves measurement of adequacy, effectiveness and efficiency of programmes or services. Evaluation is to be distinguished from assessment and appraisal: both terms are used as more general terms than evaluation, connoting the drawing of conclusions from the examination of a situation or its elements. Evaluation, then, is a particular type of assessment.

Family Liaison Worker

A professional counsellor, social worker or nurse whose role is to support the family (dependants and carer(s) of a patient). The worker assists family members who are affected by a substance abuse problem and may provide information, supportive counselling and referral services. Helping the family understand and provide support to a member with a substance abuse problem is a core function.

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Focus Group

A discussion-based, qualitative research data gathering method designed to explore a topic of interest and generate a range of opinions. A small number of members of a particular group meet together and their discussion is facilitated by a researcher known as a “moderator”.

Half-Way House

Often, a place of residence that acts as an intermediate stage between an inpatient or residential therapeutic programme and fully independent living in the community. The term applies to accommodation for alcohol- or drug-dependent individuals endeavouring to maintain their sobriety (compare therapeutic community). There are also half-way houses for individuals with psychiatric disorders and for individuals who are leaving prison.

Hallucinogens

Hallucinogens under international control include LSD, phencyclidine (PCP), hallucinogenic amphetamines, mescaline (the active principle of the peyote cactus), psilocybin (naturally occurring in certain mushrooms) and some tryptamines.

Hallucinogens produce altered states of consciousness with different degrees of auditory and/or visual perceptions that are not shared by observers; they are also referred to as “psychedelics”, i.e. they act as catalysts to further feelings and thoughts (not merely hallucinogenic).

Harm Reduction

In the context of alcohol or other drugs, harm reduction refers to policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or other drugs, both to the individual and the larger community.

This system would extend itself toward people who do not appear to want or to benefit from established programs of care. They do not have an immediate or perhaps even a long-term goal of changing their addictive behaviours. They nonetheless are the most vulnerable to harmful effects from addiction problems. They often have high rates of co-occurrence for both mental and physical health problems. The term is used in particular for policies or programmes that aim to reduce the harm without necessarily requiring abstinence. Some harm reduction strategies designed to achieve safer drug use may, however, precede subsequent efforts to achieve total abstinence. Examples of harm reduction include needle/syringe exchanges to reduce rates of needle sharing among injecting drug users.

Harmful Use

According to the WHO Lexicon of Alcohol and Drug Terms, “harmful use” is defined as follows: a pattern of psychoactive substance use that is causing damage to the health of the drug user. The damage may be physical (for example, hepatitis following injection of drugs) or mental (for example, depressive episodes secondary to heavy alcohol intake). Harmful use generally has adverse social consequences as well. The term was introduced in the ICD-10 and supplanted “nondependent use” as a diagnostic term. The closest equivalent in other diagnostic systems (for example, in the DSM-IV) is substance abuse, which usually includes social consequences.

Health Centre

Staffed by a community health nurse and support staff; the focus is on community health programs and is based on prevention and promotion of health; most health centres are found in the more urban settings in non-isolated communities/First Nations.

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Heroin

Heroin is a highly addictive and rapidly acting opiate (a drug that is derived from opium). Specifically, heroin is produced from morphine, which is a principal component of opium. Opium is a naturally occurring substance that is extracted from the seedpod of the opium poppy. <http://www.usdoj.gov/ndic/pubs3/3843/index.htm>. Heroin is made from morphine that has been chemically processed. Injection use is commonly found with heroin.

Inhalants

Inhalants are a broad range of drugs in the forms of gases, aerosols, or solvents which are breathed in and absorbed through the lungs. Most inhalant drugs which are used non-medically are ingredients in household or industrial chemical products which are not intended to be concentrated and inhaled, including organic solvents (found in cleaning products, fast-drying glues, and nail polish removers), fuels (gasoline (petrol) and kerosene) and propellant gases such as freon and compressed hydrofluorocarbons which are used in aerosol cans such as hairspray and non-stick cooking spray. A small number of recreational inhalant drugs are pharmaceutical products which are used illicitly, such as anaesthetics (ether and nitrous oxide) and volatile anti-angina drugs (alkyl nitrites).

Integrated Treatment System

An integrated treatment system is one that contains several treatment services, both specialist and generic, that operate in a structured and organized way. Most integrated treatment systems will contain community-based and residential services and have established referral and patient transfer arrangements.

Intoxication

According to the WHO Lexicon of Alcohol and Drug Terms, "intoxication" is defined as follows: a condition that follows the administration of a sufficient amount of a psychoactive substance and which results in disturbances in the level of consciousness, cognition, perception, judgement, affect, behaviour, or other psychophysiological functions and responses. The disturbances are related to the acute pharmacological effects of, and learned responses to, the substance and resolve with time, with complete recovery, except where tissue damage or other complications have arisen. The term is most commonly used with regard to alcohol use.

Mandated Treatment

A characterization of treatment, sometimes called coercive treatment, that is organized by the criminal justice system. Typically, a court (or other criminal justice body) orders that an individual enters a therapeutic programme (sometimes as an alternative to a custodial sentence). Treatment is mandated in the sense that failure to enter the programme or comply with its rules and regulations may result in the individual receiving the criminal justice penalty that would normally be invoked.

Methadone

A synthetic opiate drug used in maintenance therapy for those dependent on opioids. It has a long half-life, and can be given orally once daily with supervision. It is the most widely used treatment for opioid dependence in the developed world. When given in an adequate dose to opioid dependent individuals, methadone tends to reduce desire to use heroin and other opiates, eliminates opioid withdrawal and blocks the euphoric effects of the other opioid drugs.

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Modality

A categorization of a specific type of drug abuse treatment. A given treatment modality can be described in terms of its specific therapeutic approach or philosophy and purpose. In the United Kingdom, for example, the following treatment modalities are available: residential rehabilitation; inpatient stabilization and detoxification; community specialist prescribing; community general practitioners prescribing; structured counselling and structured day services.

Morphine

Morphine is a narcotic that directly effects the central nervous system. Morphine activates the brain's reward systems. The promise of reward is very intense, causing the individual to crave the drug and to focus his or her activities around taking morphine. The ability of morphine to strongly activate brain reward mechanisms and its ability to chemically alter the normal functioning of these systems can produce an addiction. Morphine effects also reduce a person's level of consciousness, harming the ability to think or be fully aware of present surroundings

Motivational Enhancement Therapy

Motivational enhancement therapy seeks to evoke from clients their own motivation for change and to consolidate a personal decision and plan for change. The approach is largely client centered, although planned and directed. The counsellor seeks to develop a discrepancy in the client's perceptions between current behaviour and significant personal goals. <http://www.drugabuse.gov/adac/ADAC9.html>

Mutual-Help Group

A group in which participants support each other in recovering or maintaining recovery from personal problems. Those groups are often associated with alcohol and other drug dependence problems; however, they also operate in the context of other issues such as depression and various compulsive behaviours. Membership is usually established on a voluntary and confidential basis, with meetings organized with a prescribed format and time.

Narcotic Drug

A chemical agent that can induce stupor, coma, or insensibility to pain. The term usually refers to opiates or opioids, which are called narcotic analgesics. In common parlance and legal usage it is often used imprecisely to mean illicit drugs, irrespective of their pharmacology. For example, narcotics control legislation in Canada, the United States and several other countries includes cocaine and cannabis as well as opioids. It is also a term adopted by the Single Convention on Narcotic Drugs, 1961.

Needle Exchange

Provision to reduce the transmission of infectious diseases by the repeated use and sharing of needles in order to reduce the transmission of blood-borne viruses. It was first developed in response to the advent of HIV/AIDS and quickly spread to many countries in which injecting drug use was experienced as a problem. The concept involves the provision of clean needles in exchange for used needles which are then safely disposed of. In practice, an "exchange" is not always required and clean injecting equipment is provided on demand, sometimes for a small payment.

See also: AIDS, Harm Reduction.

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Needs Assessment

A systematic approach to determining the nature and extent of substance abuse problems in a target population or community that seeks to identify which (or how many) specific interventions should be made available to specific groups of people or how existing interventions and services can be better provided.

Non-Isolated First Nation

A zone where a First Nation is located within 90km from the nearest service centre having year-round road access.

Nursing Station

A field unit usually located in a remote isolated or isolated community/First Nation; the nursing station is staffed by community health nurse(s) and supports the nurses and support staff organize and carry out community health programs; these programs include ambulatory and emergency treatment, short term in-patient care and emergency medical transportation.

Opiate

According to the WHO Lexicon of Alcohol and Drug Terms, "opiate" is defined as follows: one of a group of alkaloids derived from the opium poppy (*Papaver somniferum*) with the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma and respiratory depression. The term opiate excludes synthetic opioids such as heroin and methadone.

Opioid

According to the WHO Lexicon of Alcohol and Drug Terms, "opioid" is defined as follows: the generic term applied to alkaloids from the opium poppy (*Papaver somniferum*), their synthetic analogues, and compounds synthesized in the body, which interact with

the same specific receptors in the brain, have the capacity to relieve pain, and produce a sense of well-being (euphoria). The opium alkaloids and their synthetic analogues also cause stupor, coma and respiratory depression in high doses.

Outcome Evaluation

Outcome evaluation measures the extent to which a programme achieves its immediate objectives. It focuses on outputs and outcomes, including unintended effects, to judge the programme effectiveness. It may also assess the programme process to understand how the outcomes are produced. For UNDCP, outcome evaluations often address the effectiveness of immediate project objectives and the process through which they are achieved. The time horizon for outcome evaluation is usually with the life of the programme or project.

Outcome Measure

A direct or indirect observation or record that concerns a specific patient's behaviour or cognition that is relevant to their problems and to the objectives of a treatment or rehabilitation programme. Outcome measures are usually drawn from a set of domains spanning substance abuse behaviours and cognitions; physical and psychological health symptoms and conditions and various aspects of personal, social and economic functioning, including relationship difficulties, housing and accommodation problems; education, training and employment problems; and illegal activities. Commonly, outcome measures are recorded for a suitable period immediately prior to a patient commencing treatment and recorded again at one or more follow-up points and changes in scores on the pairs of measures and then attributed to the treatment provided.

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Outcome Monitoring

The recording, communication and application of information about the impact or benefit of treatment that is used to judge the value of the intervention and for the purpose of improving its operation and effectiveness.

Outreach

A community-based activity with the overall aim of facilitating improvement in health and reduction of drug-related risk or harm for individuals and groups not effectively reached by existing services or through traditional health education channels. Outreach can be “detached”, “peripatetic”, or “domiciliary” or “peer”. Detached outreach takes place outside of an agency or organizational setting in public places such as the streets, public transport stations, nightclubs, hotels and cafes.

Peripatetic outreach focuses on organizations (for example, half-way houses, needle exchanges, youth clubs, schools and prisons) rather than individuals. Domiciliary outreach takes place in people’s homes. Peer (or indigenous) outreach projects use current and former members of the target group (such as injecting drug users) as volunteers and paid staff.

Overdose

According to the WHO Lexicon of Alcohol and Drug Terms, “overdose” is defined as follows: the use of any drug in such an amount that acute adverse physical or mental effects are produced. Deliberate overdose is a common means of suicide and attempted suicide. Overdose may produce transient or lasting effects, or death; the lethal dose of a particular drug varies with the individual and with circumstances.

See also: Intoxication.

Oxycodone

A prescription painkiller found in the Opioids family, commonly known as OxyContin®.

Peer Intervention

Essentially, a treatment that is delivered by a trained individual who is close in gender or age group or other socio-economic category to the target group. Peer interventions are usually, but not always, brief in duration and target individuals at risk of substance abuse problems or who have problems of moderate severity.

Peer Support

At one level, one of the components of a peer outreach relationship where the outreach worker provides some form of assistance to a peer. The assistance is usually ongoing rather than a single discrete episode. The term “peer support group” is used to describe collectives or self-organizations of members of a community for the purpose of representing their shared interests at a socio-political level. These informal resources provide support for change and motivation for maintaining healthier behaviours.

Prevention

An intervention designed to avoid or substantially reduce risk for the acquisition or further development of adverse health and interpersonal problems. Drug abuse prevention programmes vary widely in content and philosophy. The most effective programmes are multidimensional and contain a mixture of straight-talking education sessions about drugs and drug abuse; skills to deal with stress and personal and relationship problems; and drug resistance skills. The specific content of a programme can be specifically adapted to the nature and needs of the target population.

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Primary Health-Care Workers

The doctors, nurses, psychologists and support personnel who work from community locations and who essentially provide general health-care services to the local population.

Psychoactive Substance

According to the WHO Lexicon of Alcohol and Drug Terms, “psychoactive substance” is defined as follows: a substance that, when ingested, alters mental processes, that is, thinking or emotion. That term and its equivalent, psychotropic drug, are the most neutral and descriptive terms for the whole class of substances, licit and illicit, of interest to drug policy. “Psychoactive” does not necessarily imply dependence-producing.

Psychological Dependence

A term for a largely discredited concept but which is still used in some quarters. It refers to dependence upon a drug in the absence of the development of either tolerance or withdrawal symptoms. Most modern uses of the term “dependence” avoid a strict distinction between “psychological” and “physical” dependence. If that phenomenon exists at all, it is likely to be a characteristic of the user and not a property of the drug.

See also: Dependence, Dependence Syndrome.

Psychosocial Treatment

Interventions based on psychological principles and methods involving individual and group counselling and therapy designed to modify problematic substance-related cognitions and behaviours.

Rehabilitation

According to the WHO Lexicon of Alcohol and Drug Terms, “rehabilitation” is defined as follows: in the field of substance use, the process by which an individual with a drug-related problem achieves an optimal state of health, psychological functioning and social well-being.

Rehabilitation typically follows an initial phase of treatment in which detoxification and, if required, other medical and psychiatric treatment occurs. It encompasses a variety of approaches including group therapy, specific behaviour therapies to prevent relapse, involvement with a mutual-help group, residence in a therapeutic community or half-way house, vocational training, and work experience. There is an expectation of social reintegration into the wider community.

See also: Recovery, Treatment.

Relapse

According to the WHO Lexicon of Alcohol and Drug Terms, “relapse” is defined as follows: a return to drinking or other drug use after a period of abstinence, often accompanied by reinstatement of dependence symptoms. Some writers distinguish between relapse and lapse (“slip”), with the latter denoting an isolated occasion of alcohol or drug use. The rapidity with which signs of dependence return is thought to be a key indicator of the degree of drug dependence.

See also: Relapse Prevention.

Relapse Prevention

According to the WHO Lexicon of Alcohol and Drug Terms, “relapse prevention” is defined as follows: a set of therapeutic procedures employed in cases of alcohol or other drug problems to help individuals avoid or cope with lapses or relapses

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to uncontrolled substance use. The procedures may be used with treatment based on either moderation or abstinence, and in conjunction with other therapeutic approaches. Patients are taught coping strategies that can be used to avoid situations considered dangerous precipitants of relapse, and shown, through mental rehearsal and other techniques, how to minimize substance use once a relapse has occurred.

See also: Relapse.

Remote/Isolated First Nation

A zone where a First Nation is located over 350 km from the nearest service centre having year-round road access.

Residential Treatment

Programmes that provide ancillary residential services on the same site as treatment services. The programmes generally strive to provide an environment free of substance abuse, with an expectation for compliance in a number of activities such as detoxification, assessment, information/education, counselling, group work, and the development or recovery of social and life skills.

Risk Reduction

Risk reduction describes policies or programmes that focus on reducing the risk of harm from alcohol or other drug use. Risk reduction strategies have some practical advantages in that risky behaviours are usually more immediate and easier to objectively measure than harms, in particular those harms which have a low prevalence. For example, it may be more practical to measure reduced sharing of needles and other injecting equipment than indices of harm such as the incidence of HIV.

See also: Harm Reduction, Safer Use.

Risky Behaviour

In relation to drug use, risky behaviour refers to behaviours that place persons at risk of some drug-related harm. Although most often used in relation to behaviours, such as sharing needles or other injecting equipment (spoon, water, tourniquet, etc.) which place drug injectors at risk of transmission of blood-borne viruses such as HIV or hepatitis C, the term can be applied to any drug and to any risk of harm to livelihood, relationships, legal sanctions, or health.

Ritalin

Methylphenidate (MPH), which is manufactured under the brand name of Ritalin, is a stimulant. Ritalin produces pharmacological effects similar to those of cocaine and amphetamines, and it is prescribed to treat attention-deficit/hyperactivity disorder (ADHA), attention deficit disorder (ADD) and other conditions. Unlike other stimulants, however, MPH has not been produced by drug dealers in homemade labs, likely because it is an inexpensive, readily available medication with a prescription, even though it is a controlled substance.

A growing number of incidents of abuse have been associated with teens and young adults using MPH for its stimulant effects: appetite suppression, wakefulness, increased attentiveness, increased focus and euphoria. It is being used for appetite suppression in many teenagers; college students are taking advantage of its stimulant affects to help them stay focused and awake for those long nights of studying. The drug has street names such as "Vitamin R," "R-Ball" and the "Smart Drug."

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Safer Use

Most drugs may be used in a way in which risk of adverse consequences is reduced by means of a combination of safer preparation, low dose, safer route of administration and in safer settings. For example, the risk of adverse consequences from using heroin, or the extent to which a drug use episode is life threatening, is greatly determined by whether injecting equipment is shared; whether a new batch of heroin is tested first in a small dose in case it is unusually pure; or whether it is used concomitantly with other central nervous system depressants such as benzodiazepines and alcohol. In most cases it is possible to identify drug-using practices which reduce, though usually not eliminate, the risk of serious adverse consequences.

See also: Harm Reduction, Risk Reduction.

Screening

A rapid procedure designed to detect individuals who have a substance abuse problem.

Self-Help Group

Groups that offer programmes of recovery on a voluntary basis principally through a twelve-step process for personal change. Those programmes often include participation in meetings to share histories of problems, obtain help and support from other members in dealing with challenges that have led to relapses, and seeking a member who will serve as a sponsor or mentor to provide help in times of crisis.

Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) make up a significant sector of the self-help groups concerned with substance dependence, while Al-anon, Alateen and Adult Children of Alcoholics (ACOA) attract family

members trying to reconcile and resolve current or past personal problems associated with substance abuse in the family. Numerous other groups also operate in a similar fashion within and outside the field of substance abuse.

Semi-Isolated First Nation

A zone where a First Nation is located between 90km and 350km from the nearest service centre having year-round road access.

Service Accreditation

A system within quality assurance that indicates that a treatment service or programme meets a set of organizational, operational, clinical and professional performance standards and relevant legal requirements for its operation. There are currently no internationally agreed standards for service accreditation, but a wide range of countries have developed national standards and accreditation processes.

Specialist Service

A social, welfare or health-care service that has the treatment of people with substance abuse problems as its primary purpose. Stakeholders are the set of individuals in a community with an investment or expectation in the efficient and effective operation of a treatment service or system. That can include patients, carers/family members, treatment providers, planners and those providing financial support for service costs.

Structured Treatment

Structured treatment describes a programme of therapeutic care that has several components that are organized in a logical or sequential way and are based on an initial patient assessment, and personalized treatment plan. Those components may include short and longer stay residential care and community/

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outpatient settings and involve the provision of medical and/or psychosocial interventions and/or aftercare. Naturally, there is variation in the intensity and duration of the components and their goals and objectives.

Substance Abuse

A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. There may be repeated failure to fulfil major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems.

Substance Dependence

A cluster of cognitive, behavioural and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal and compulsive drug-taking behaviour.

Substance Use Disorder

A generic term used in international systems (DSM-IV and ICD-10) for classifying diseases for various conditions and illnesses associated with the use of any psychotropic drug. It includes both problematic and dependent drug use. Any mental or behavioural disorder resulting from the use of one or more psychoactive substances, whether or not medically prescribed. The substances specified are alcohol, opioids, cannabinoids, sedatives or hypnotics, cocaine, other stimulants (including caffeine), hallucinogens, tobacco, and volatile solvents. The clinical states that may occur include acute intoxication, harmful use, dependence syndrome, withdrawal state, withdrawal state with delirium, psychotic

disorder, late-onset psychotic disorder and amnesic syndrome.

Therapeutic Community

A structured environment in which individuals with drug-related problems live while undergoing rehabilitation. Such communities are often specifically designed for drug-dependent people; they operate under strict rules, are run mainly by people who have recovered from dependence, and are often geographically isolated. Therapeutic communities are also used for management of patients with psychotic disorders and anti-social personalities. Therapeutic communities are characterized by a combination of "reality testing" (through confrontation of the individual's drug problem) and support for recovery from staff and peers. They are usually closely aligned with mutual-help groups such as Narcotics Anonymous.

Tolerance

A term for the well established phenomenon of reduced drug effects following repeated drug administrations. Tolerance develops fastest with more frequent episodes of use and with larger amounts per occasion. It is useful to distinguish between metabolic tolerance and functional tolerance. Metabolic tolerance arises usually as a consequence of an induction of liver enzymes which result in the faster metabolism of a given drug dose, thereby reducing the level and duration of blood-drug levels. Functional tolerance refers to diminished effects of a given blood-drug level. That is thought to occur both by virtue of neuroadaptation, as well as by the user learning to anticipate and accommodate intoxicating effects.

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Treatment

According to WHO (WHO Expert Committee on Drug Dependence Thirtieth Report, Technical Report Series) the term “treatment” refers to “the process that begins when psychoactive substance abusers come into contact with a health provider or any other community service and may continue through a succession of specific interventions until the highest attainable level of health and well being is reached”. More specifically, treatment may be defined “... as a comprehensive approach to the identification, assistance, ... (and) ... health care ... with regard to persons presenting problems caused by the use of any psychoactive substance”.

Essentially, by providing persons, who are experiencing problems caused by their use of psychoactive substances, with a range of treatment services and opportunities which maximize their physical, mental and social abilities those persons can be assisted to attain the ultimate goal of freedom from drug dependence and to achieve full social reintegration. Treatment services and opportunities can include detoxification, substitution/ maintenance therapy and/or psychosocial therapies and counselling.

Additionally, treatment aims at reducing the dependence on psychoactive substances, as well as reducing the negative health and social consequences caused by, or associated with, the use of such substances.

Twelve-Step Group

A mutual-help group organized around the twelve-step programme of Alcoholics Anonymous (AA) or a close adaptation of that programme. AA's programme of twelve steps involves admitting one is powerless over one's drinking and over one's life because of

drinking, turning one's life over to a “higher power”, making a moral inventory and amends for past wrongs, and offering to help other alcoholics.

Withdrawal

A term used to refer to either the individual symptoms of, or the overall state (or syndrome), which may result when a person ceases use of a particular psychoactive drug upon which they have become dependent or after a period of repeated exposure. The level of central nervous system arousal and the accompanying mood state is usually directly opposite to the direct action of the drug.

See also: Withdrawal Syndrome, Dependence Syndrome.

Withdrawal Syndrome

According to the WHO Lexicon of Alcohol and Drug Terms, “withdrawal syndrome” is defined as follows: a group of symptoms of variable severity which occur on cessation or reduction of drug use after a prolonged period of use and/or in high doses. The syndrome may be accompanied by signs of both psychological and physiological disturbance.

A withdrawal syndrome is one of the indicators of a dependence syndrome. It is also the defining characteristic of the narrower psychopharmacological meaning of dependence.

See also: Withdrawal, Dependence Syndrome.

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