Historical Timeline of NNADAP

Year	Milestone
1973	A work group was established by Medical Services Branch (MSB) of National Health and Welfare or NH&W (now Health Canada), the Indian and Eskimo Affairs Program of the Department of Indian Affairs and Northern Development or DIAND (now Indian and Northern Affairs Canada or INAC), and the National Indian Brotherhood or NIB (now Assembly of First Nations or AFN) to report the opinions held by Indians (sic) across Canada regarding the most effective way to combat alcoholism.
1974	Based on the above mentioned work group's report, the National Native Alcohol Abuse Program (NNAAP) was approved in December 1974 as a joint initiative between the Department of Indian and Northern Development (now INAC) and Health and Welfare (now Health Canada). The program was intended to support community designed and operated projects "in the areas of native (i.e., registered Indian and Inuit) health and social services for alcohol abuse prevention, treatment and rehabilitation, in order to arrest and reverse the present destructive physical, mental, social and economic trends." NNAAP was the pilot for what later became the National Native Alcohol and Drug Abuse Program (NNADAP).
1975-76	NNAAP was implemented over a three-year period beginning in the 1975-76 fiscal year.
1975	The program's first treatment centre was established in Manitoba – Sagkeeng Alcohol Rehabilitation Centre.
1977	Clive Linklater review of NNAAP completed. This report recommended that NNAAP be continued on a permanent basis, with an initial 5-year period wherein various approaches and implementation structures would be tested and established thereby providing a base for a viable on-going program. It was recommended that the program be established on a national basis, with a central office as well as designated geographical areas which would serve as project areas. Central to the Linklater report was the recommendation that the projects be community controlled, oriented, directed, and operated and that other necessary support services and structures be provided. The report also recommended the development of ways and means to develop and include a strong cultural base to all projects. It further advocated the establishment of special training, training support staff, and other support tools such as a casebook and improved records and report formats as well as a central information and resource centre for the dissemination of project knowledge and results.
1978	In the fall of 1978 DIAND (now INAC) and NH&W (now Health Canada) submitted to the Treasury Board Secretariat a "Framework for the Evaluation of NNAAP".
1979	The "Framework for the Evaluation of NNAAP" was approved by Treasury Board in February 1979.

1979	In the spring of 1979, NNAAP contracted with Hickling-Johnson Management Consultants to conduct an organisational review of NNAAP and to provide direction as to the manner in which the purposes of the evaluation framework should be met. The final report was submitted in July 1979. This report acknowledged many positive aspects of the NNAAP program and its results. The program achieved positive results largely because it responded to an obvious social need; because a very strong personal commitment to the program on the part of both administrators and participants; because of the strong focus on client initiative and community-based delivery; and because of the good cooperation amongst participating agencies. In regions where these characteristics were strongest, the results were most favourable. The Hickling-Johnson report stated that the provisional nature of the program mitigated against a strong bases – a problem which became increasingly apparent as the program was funded on a provisional basis from on year to the next, thus restricting longer-range planning and efforts. The report suggested that the program was too vague and permissive to allow for controlled development testing, and that the organizational structure rendered it vulnerable to political interference since the roles and responsibilities of the various directors and projects managers were not clearly established. Hickling-Johnson also concluded that the program tended to operate as a satellite organization, without adequate support systems and with insufficient resources to deal effectively with the magnitude of the problem. The operation of the program on a “project” basis resulted in the unhealthy situation of individual projects competing for limited funds, without due regard to the relative needs from one community to the next, or the likely effectiveness of a particular project approach.
1979	A significant element affecting the delivery of health services is the federal government's Indian Health Policy, aimed at improving the quality of community life, raising the level of health of Indians and Inuit to that of other Canadians, and increasing participation by Indians and Inuit in the management of their own health care programs. The Policy, adopted by the federal government in September 1979, places emphasis on developing and maintaining an effective relationship between the government and the Indian and Inuit peoples of Canada. Prior to 1979, non-insured health services were provided on the basis of need to status Indians and Inuit living on reserves. In August 1978, in the interest of better fiscal control and in order to confirm existing practices and ensure uniformity in all regions, the Medical Services Branch issued a guideline, "Policy Directive for the Provision of Uninsured Medical and Dental Benefits to Status Indians and Inuit". Strong opposition from Indians resulted. They claimed entitlement to free universal health services under Treaty rights. Their opposition resulted in the federal government declaring a six-month moratorium on the guideline in February 1979, to provide a period for consultation regarding the controls. No meaningful results were achieved. The moratorium ended in September 1979 when the Government withdrew the guideline and announced the present Indian Health Policy. This had the effect of extending non-insured health services to status Indians and Inuit, regardless of ability to pay and, under

	specific circumstances, place of residence.
1980	NNAAP was extended by Treasury Board for 1 year in March 1980 with the understanding that a proposal for a permanent program would be presented to the Social Development Committee in 1981-82, and was to include an evaluation component.
1980	In May 1980, a task force was established to evaluate the effectiveness, efficiency, and economy of the NNAAP which included representatives from NH&W, DIAND, NIB, Inuit Tapirisat Canada, Native Women's Association of Canada and private consultant experts in the area of alcohol abuse. This tasks force, known as the Evaluation Core Group (ECG) reported back to NH&W and DIAND in September 1980. This report recommended establishing NNAAP as a permanent, on-going program with adequate levels of funding in each region to meet its objective of arresting and reversing the destructive physical, mental, social, and economic trends that are the outcome of the abuse of alcohol and other drugs. In doing so, the report advocated that the program allow for maximum participation by Native people. The report recommended that the program continue as a separately identifiable program, under the administration of the Medical Services Branch of the Department of Health and Welfare (now Health Canada). With respect to organizational changes, the report recommended the decentralization of authority, responsibility and accountability for the program to the regional level – with due regard to the varying degrees of preparedness on the part of each region in assuming responsibility for administering the program. In this regard, the report recommended that a process be established to permit regions to first, justify their readiness for authority to manage a Regional Native Alcohol Abuse Program, second, demonstrate ability to manage the decentralized program, and third, to establish at the regional level a non-profit organization to assume full authority, responsibility and accountability for facilitating the provision of alcoholism services to the Indian and Inuit people of the region. The ECG report recommended that a Review and Implementation Team be established at the national level to review regional submissions according to established guidelines and to grant approval for decentralization to the Region at such time as the criteria and conditions are met. The report recommended the immediate disbandment of the National Advisory Board on Native Alcohol Abuse, ant that the National Secretariat exists only until such time as regions have attained decentralized authority for program management and administration. Instead, the report recommended the creation of a National Council on Native Alcoholism and Drug Abuse, for the purpose of advising Ministers (or their delegates) regarding government policy related to native alcoholism programs.

	In addition, the ECG report made numerous recommendations related to the administration of the proposed permanent program, including items dealing with the roles of Regional Directors, allocation of person-year resources, and training and information support activities. A major element of the proposed ECG permanent alcohol abuse program is the focus on improved cooperation with provincial and territorial agencies and programs, including provisions for the use of "seed monies" to promote the extension of existing services for improved targeting to native peoples.
1982	The Cabinet Discussion Paper on NNADAP dated February 17, 1982 was submitted to the Treasury Board.
1982	The Cabinet Discussion paper on NNADAP was approved on April 5. The purpose of NNADAP was "to support community designed and operated projects in the areas of alcohol abuse prevention, treatment and rehabilitation in order to arrest and reverse the present destructive physical, mental, social and economic trends." It was originally developed as a 5-year $154 million program, and has gone through a life cycle which has seen a growth phase, a period of maturity, and a devolution of the program into community based control. The program to replace the original NNAAP concepts was to include: • Non-medical treatment services that were described as post detoxification primary care and counselling intended to focus on social and cultural rehabilitation. The treatment services are also described as involving intensive psychological and therapeutic counselling oriented toward social and cultural rehabilitation typically offered in a 28-day program. In examining potential program elements it was envisioned by the authors of the document that treatment elements would include inpatient residential treatment facilities, halfway houses and community based (outpatient) treatment services. • Prevention and maintenance activities including professional and paraprofessional counselling. It is pertinent that the original design of NNADAP Prevention and Maintenance programs included a wide range of activities including "advocative, educational and counselling services, provided on either a community-wide or on an individual case basis". The community services included "maintenance" which was to include counselling, self-help and individual and group therapy. The Treasury Board Submission also included reference to "complementary" services, which were to be targeted to family and friends of abusers. In discussing approaches, Alcoholics Anonymous and native cultural and spiritual practices were described as the range of anticipated services. • Support activities such as training, research and development, organizational support, capital, and departmental operation and maintenance.
1982	The National Native Association of Treatment Directors (NNATD) was formed

	in 1982 with funding from NNADAP. The general mandate of the NNATD was the promotion of high quality alcohol and drug treatment services through the utilization of support agencies and the development of new resources to insure effective networking.
1982	The National Native Advocacy Council on Alcohol and Drug Abuse (NNACADA) was formed as a result of the Evaluation Core Group's May 1980 report recommendation for the "creation of a National Council on Native Alcoholism and Drug Abuse, for the purpose of advising Ministers (or their delegates) regarding government policy related to native alcoholism programs." The national board was comprised of one representative from each regional advisory board and facilitated and funded the selection of regional research projects upon the recommendations of the regional advisory boards.
1984	The Society of Aboriginal Addictions Recovery (SOAAR) was created. This organization represented NNADAP prevention/frontline workers. The main purpose of the organization was to provide an environment to allow information sharing and also created assessment tools and procedures, developed mechanisms for recognizing workers, identified and developed training opportunities and worked on early certification and accreditation models.
1984	The National Native Role Model Program, administered by Kahnawake and funded by Health Canada began. The program would be administered by different communities and organizations over its first twenty years. The role models are Native individuals from across Canada who show leadership in their communities. They show in their words and their deeds the seven traditions of wisdom, love, respect, bravery, honesty, humility and truth. The program's first role model was Alwyn Morris, who won gold and bronze medals in kayaking in the 1984 Olympics. John Kim Bell, an internationally known and respected symphony conductor and, the president and founder of the Canadian Native Arts Foundation, was the program's second role model.
1984	The NNATD hosted a workshop on Therapeutic Recreation and Physical Development counselling techniques with participants arriving at the conclusion that the area in most need of development in most treatment settings was in leisure and recreation counselling techniques. From this observation the Therapeutic Recreation and Physical Development research project unfolded.
1984	Hollow Water and its surrounding communities of Manigotan, Aghaming, and Seymourville began the long-term process of recovery by launching a Resource Team which would lead to the creation of the S.A.F.E. Training Program, and the Community Holistic Circle Healing (CHCH) Model.
1984/85	The Treatment Activity Report System (TARS) was created. This system was the first system that captured information on occupancy rates and other treatment program data. Input of client and program data was mandatory for each NNADAP treatment centre.
1985/86	In 1985 the film, "The Honour of All: The Story of Alkali Lake," was released. The film includes in-depth personal interviews collected from some 80 community members in 1984/85 detailing the community approach that Alkali

	Lake took in its battle toward healing and away from alcohol addiction from 1972 to the present day of 1984/85. In 1985, Alkali Lake hosted the first of several international conferences focused on the healing of indigenous communities in which 1,200 people attended. In 1986, a second conference attracted approximately 2,500 people from across North America and around the world.
1987	In May 1987, the federal government announced a $210-million, five-year action plan to curb drug abuse. The National Drug Strategy (NDS), *Action on Drug Abuse*, was launched by the then Minister of National Health and Welfare, who was the lead Minister in the federal effort to curb drug abuse. Several other departments also participated in the first interdepartmental attempt to co-ordinate Canada's response to its drug abuse problem. It was believed that there was a need for a coordinated, strategic approach to the problem of drug abuse in Canada. The overall objective of the NDS was "to reduce the harm to individuals, family and communities from the abuse of alcohol and other drugs through a balanced approach that is acceptable to Canadians." Other partners included provincial and municipal governments, business, law enforcement agencies, and professional and voluntary organizations. The government identified six core components of the NDS: education and prevention; enforcement and control; treatment; international cooperation; research and information; and national focus.
1987	The National Native Association of Treatment Directors produced their first research project in September 1987 titled "Therapeutic Recreation and Physical Development-Counsellors' Manual". This manual demonstrated that recreation and physical development are integral components to the total recovery of alcoholics.
1987	In October of 1987, the Minister of Health and Welfare Canada (now Health Canada), proclaimed the third week of November of each year as Drug Awareness Week or National Addiction Awareness Week (NAAW). The purpose of NAAW is to create an awareness of addictions which affect people across Canada.
1988	NNADAP funding was transferred to the Government of the Northwest Territories as per the 1988 Northwest Territories Health Transfer Agreement. Annually, Health Canada transfers additional funds to both territories in support of treatment and training activities.
1988	The community of Alkali Lake, Nechi Institute and Four Worlds Development Project released the paper titled "New Directions" to be used as part of community healing processes, particularly those that deal with sexual abuse disclosure. This training would be accessed by Aboriginal communities in Canada, the United States as well as Internationally.
1989	In February 1989, the National Native Association of Treatment Directors published "In the Spirit of the Family: Native Alcohol & Drug Counsellor's Family System Treatment Intervention Handbook. The Handbook was developed specifically for facilitating the recovery approach to alcohol and drug abuse. Extensive training was done across Canada based on this handbook.
1989	National Addictions Awareness Week (NAAW) was launched by Nechi

	Training, Research and Health Promotions Institute with funding from Medical Services Branch (now First Nations and Inuit Health Branch or FNIHB) in 1989 to promote activities at the national level. The purpose of NAAW is to provide information, materials and promote activities that serve to raise awareness of addictions and promote healthier lifestyles in both official languages.
1989	On June 29, 1989, Treasury Board approved the financial authorities and resources to support pre-transfer planning and to fund community health management structures. This was the first step toward achieving community control over the administration of health services in community.
1989	The Three Wise Men project began whereby 3 (and later 4) individuals provided clinical support, and advice to NNADAP treatment programs. The information gained through the experiences of the Three/Four Wise Men also contributed to national policy development and program oversight policies.
1990	After much lobbying, the International Congress on Alcohol and Addictions (ICAA) included a special track on Indigenous addiction issues at its Berlin Conference. Attended by Indigenous peoples from Canada, New Zealand and Australia, this forum led to a discussion that became the foundation for what would later become Healing Our Spirit Worldwide.
Mid 1990s	In the mid-1990s, MSB funded the establishment of National and Regional Prevention and Treatment Standards for NNADAP.
1991	MSB's treatment centre funding formula was established. The formula was focussed entirely on in-patient programs, using an annual budget per bed space as a base allocation, then adjusted by size (to reflect economies of scale) and costs associated with additional transportation costs of material purchases (i.e., remoteness indices).
1991	Through a request for proposal process administered by NNADAP, the Nechi Institute and the National Native Association of Treatment Directors were selected to be the first hosts of Healing Our Spirit Worldwide (HOSW).
1992	The first HOSW gathering was held in Edmonton, AB and attracted 3,300 people from 17 countries. The second gathering was held in Sydney, Australia in 1994 and a third gathering, held in Rotorua, Aotearoa (New Zealand), followed in 1998. HOSW firmly established itself as an international cultural and spiritual movement celebrating the tenacity and resilience of Indigenous peoples around the world in the struggle against alcohol and drug abuse. After the third gathering, HOSW was held every four years.
1993	Although the Federal Government Cabinet approved the health transfer policy framework on March 16, 1988, the first NNADAP treatment centre program transfer didn't occur until 1993. The primary goals of the Transfer approach are: • to enable communities to design health programs, establish services and allocate funds according to community health priorities; • to ensure that communities have flexibility in the delivery of health programs and services; • to ensure that public health and safety are maintained through the provision of mandatory health and treatment programs; and

	• to strengthen and enhance the accountability of community leaders to community members. The Transfer process in FNIHB provides the flexibility for communities to take control of their health services at a pace that best suits their needs. It also provides the flexibility to change direction from one approach to another. Communities can move from the Integrated Community-Based Health Services approach to the Health Services Transfer approach (in Pre-Transfer Planning or Bridging Phases) and vice versa, subject to some conditions.
1993	In October 1993, Health Canada completed the First Nations and Inuit Community Youth Solvent Abuse Survey and Study.
1994	In late 1994, Treasury Board approved the financial authorities and resources to support the Integrated Community-Based Health Services approach. A community that chooses the Integrated approach gains less control than with Transfer but greater control than if they continued to operate under General Contribution Agreements. A community operating with the Integrated approach sets up its own health management structure but shares responsibility for delivering services with FNIHB. As long as mandatory health services are provided, communities have the flexibility to change the objectives and activities of a program, increase the resources dedicated to one service and reduce resources for another according to community priorities. The objectives of the Integrated Community-Based Health Services approach are: • to support First Nation and Inuit communities in enhancing their capacity to direct and take control of health resources; and • to facilitate and promote community involvement in planning and implementing health programs and services.
1995	In 1995, Health Canada, through the Brighter Futures/ Solvent Abuse Initiative, began the development phase for several First Nations Treatment Centres geared toward adolescent Solvent Abuse. Six centres were initially awarded, (with one already in existence) in various regions of Canada. The goal of the National Youth Solvent Abuse Program (NYSAP) is to improve the quality of life and the functional abilities of persons addicted to solvents, by minimizing the effects and risks associated with solvent use. NYSAP also includes an outreach program that educates community workers and families on solvent abuse and provides follow-up with clients and their families. MSB began the establishment and implementation phase for six (6) new solvent treatment centres, as announced by the Minister of Health in May 1995. This announcement identified 90 new beds in addition to funding the Sagkeeng Solvent Treatment centre up to a maximum of $3.3M per year. The six new solvent centres and Sagkeeng will form a national system of solvent treatment services providing services to First Nations and Inuit youth across Canada.
1995	In 1995, the federal government announced the Inherent Right to Self-Government Policy which introduced a third option for communities to further increase their control of health services.

	The main features of the Policy include: • recognition that the inherent right is an existing Aboriginal right under Section 35 of the Constitution; • inherent right will be exercised within the existing constitutional framework, harmonized with other jurisdictions and worked out through negotiations; • provinces and territories must be involved in negotiations where matters affecting their jurisdiction are being discussed; • financing should be a shared responsibility among federal, provincial, territorial and Aboriginal governments.
1996	In July 1996, First Nations and Inuit Health Branch began the establishment and implementation phase for the permanent NYSAP treatment sites.
1996	The Royal Commission on Aboriginal Peoples (RCAP) issued its final report in November 1996. The five-volume, 4,000-page report covered a vast range of issues; its 440 recommendations called for sweeping changes to the relationship between Aboriginal and non-Aboriginal people and governments in Canada. Although alcohol and drug abuse were not specifically mentioned, an emphasis was placed on health in general and specifically the legacy of residential schools.
1996	In 1996, the General Review of NNADAP was initiated. The mandate of the national review was to determine the overall effectiveness of the program; to guide the development of strategic recommendations to strengthen programming; and to support the more effective application of the program at the community level.
1997	On April 1, 1997, Yukon Territory resumed the administration and delivery of Universal health programs (which had previously been the responsibility of Health Canada since October 1954) by mutual agreement of both governments. The Council of Yukon First Nations was a party to the agreement. Earlier, in April, 1993, Health Canada transferred the operation of the Whitehorse General Hospital to the Yukon Territorial Government.
1996/ 97	“Solvent Abuse Funding Rational” was created. Regions were experiencing a gap in solvent abuse problems and did not have easy access to treatment services. Quality assurance was to be addressed by implementing and enforcing an accreditation process. Program standards relevant to youth treatment services that all solvent treatment centres must be achieved to receive full funding.
1998	In 1998, there were additional fiscal resources set aside, adding an additional three treatment centres to the NYSAP network.

1998	On 7 January 1998, then Minister of Indian Affairs and Northern Development Honourable Jane Stewart issued a 'Statement of Reconciliation' and unveiled the government's response to the RCAP report titled "Gathering Strength: Canada's Aboriginal Action Plan" This report set out a policy framework for future government action which included the following actions related to the legacy of residential schools and health: • Renewing the Partnership: this commitment included an initial Statement of Reconciliation acknowledging historic injustices to Aboriginal peoples and establishment of a $350-million "healing fund" to address the legacy of abuse in the residential school system. Other elements related to, inter alia, the preservation and promotion of Aboriginal languages; increased public understanding of Aboriginal traditions and issues; inclusion of Aboriginal partners in program design, development and delivery; government willingness to explore how existing systems might be improved; and addressing the needs of urban Aboriginal people more effectively, enhanced data collection and information exchange. • Supporting Strong Communities, People and Economics: this objective entailed devoting resources to improving living standards in Aboriginal communities with respect to housing, water and sewer systems; welfare reform to reduce dependence and focus on job creation; a five-year Aboriginal Human Resources Development Strategy; expansion of the Aboriginal Head Start program; education reform; increased focus on health-related needs and programs; improved access to capital; and establishment of urban youth centres.
1998	On March 31, 1998, the Aboriginal Healing Foundation (AHF) was established by the Government of Canada, in response to the Royal Commission on Aboriginal Peoples and in keeping with the Gathering Strength initiative. It was given an eleven year mandate ending March 31, 2007 to encourage and support, through research and funding contributions, community-based Aboriginal directed healing initiatives which address the legacy of physical and sexual abuse suffered in Canada's Indian Residential School System, including inter-generational impacts. Many AHF funded projects would address alcohol and drug abuse by partnering with existing NNADAP treatment centres: St. Paul Treatment Centre, Tsow-Tun Le Lum, Wilp Si'satxw House of Purification Society, Native Addiction Council of Manitoba, Nelson House Medicine Lodge, Salteaux Healing and Wellness Centre Inc. Alcohol and drug abuse was also addressed through the development of resources through AHF –led research: Addictive Behaviours Among Aboriginal People in Canada, FAS Among Aboriginal People in Canada: Review and Analysis of the Intergenerational Links to Residential Schools.
1998	The Youth Solvent Abuse Committee (YSAC) was formed at which time YSAC began the development of a formal accreditation model and began the

	development of best/promising practice guidelines. YSAC is a supportive network that excels at information sharing and providing the National Youth Solvent Abuse Program with informed and respected representation at the national level. YSAC is also a leader at the international level, having made linkages with numerous organizations that are seeking guidance or best practices in the field of solvent abuse treatment.
1998	The NNADAP General Review document, describing the findings and 37 recommendations of the Review, was completed in 1998.
1998	A National Partnership Committee was established in response to the national General Review of NNADAP report of 1998, as were Regional Partnership Committees. The National Partnership Committee included First Nations, Inuit, and Health Canada. Representation from all Regional Committees comprised the core membership of the national committee. The mandate of the National Partnership Committee was to oversee the implementation of the recommendations of the General Review.
1999	NNADAP funding was transferred to the Government of Nunavut as per the creation of Nunavut in 1999. Annually, Health Canada transfers additional funds to both territories in support of treatment and training activities.
1999	In 1999, MSB circulated a policy paper, The Policy on the Transfer of Treatment Programs for Alcohol, Other Drugs and Youth Solvent Abuse describing the terms under which NNADAP-funded, non-medical treatment programs providing national and regional services could be transferred to First Nations' control. The policy guidelines also apply to the National Youth Solvent Abuse Programs (NYSAP). The terms include the following: • Both NNADAP treatment centres and National Youth Solvent Abuse Centres must be accredited by a recognized national accreditation body if they are entering into Transfer arrangements. • Treatment centres must be incorporated and their boards must represent more than one community or, at a minimum, an entire catchment area, presumably in which one First Nation has many reserve settlements that include a large population dispersed over an extremely wide geographic area or in which the community is so remote that shared ownership with other communities or client access to external centres operated by several communities is not practical. • Band Council Resolutions are required by all communities represented in the Transfer. • The Centres must formally report annually to First Nation communities, conduct a comprehensive audit, and supply a report on mandatory programs to MSB (i.e., the Minister of Health) that includes data drawn from an acceptable management information system (the Substance Abuse Information System [SAIS]) or its equivalent, and occupancy rates over the year). • Core programming funds are to be used for non-medical residential treatment, which is viewed as mandatory. MSB stipulated that, only if occupancy rates of 80% or more are maintained over the year can adjunct services also be paid for, such as outreach and

	aftercare. • Pre-transfer planning would only require a review of the Centre's operation plan and its policies and procedures rather than a full transfer planning process similar to community transfers. The requirement for an emergency preparedness plan would be waived in favour of an emergency evacuation plan. • In 1999 the First Nations and Inuit Health Branch (FNIHB) established a National Advisory Group to consider the need for a National First Nations and Inuit Registry of Substance Abuse Treatment. In keeping with the recommendations of the General NNADAP Review, the Group recommended the development of a program registry containing information on the availability to First Nations and Inuit peoples of services occupying any position on a full continuum of prevention, care and follow-up. • Also in 1999, the First Nations and Inuit Health Programs unit commissioned a study of Treatment Outcome Measures and Data Collection Methods for First Nations and Inuit Substance Abuse Programs.
1999	Accreditation: The first cohort of First Nations surveyors was trained and, in November, the first pilot sites where chosen (Nimkee, Sagkeeng and White Buffalo).
2000	On January 31, 2000, the National Partnership Committee (which began its work in 1998) was incorporated as the National Native Addictions Partnership Foundation Inc (NNAPF).
2000	Establishment of 3 new NYSAP treatment centres (Charles J. Andrew (ATL), White Swan (AB), Eagle's Path (SK)
2000	November 29, 2000, The CBC airs "I'll never stop sniffing gas" on the National, highlighting gas sniffing within the youth population of Davis Inlet and Sheshatshiu, Labrador.
2000	In November 2000, Chiefs Rich (Sheshatshiu Innu) and Tshakapesh (Mushuau Innu) requested help from the federal and provincial governments to address a crisis of children abusing solvents in their communities. The Minister of Health committed to: • bring the at-risk children from the two communities to a safe and protected environment to begin medical and psycho-social assessment and detoxification; • support the Innu to develop and implement family-centered treatment programs; • establish a Labrador Aboriginal detoxification center; and • explore other long-term initiative to repair the cultural and social fabric of the two communities.
2000	Following a series of federal/provincial/Innu meetings a communiqué was released on November 26th 2000, and an agreement signed on December 12th 2000, at the Ministerial and officials level. These documents committed Health Canada to working cooperatively with the Province of Newfoundland and Labrador on the following regarding the Innu:

	• bring the at-risk children from the two communities to a safe and protected environment to begin medical and psycho-social assessment and detoxification; • support the Innu to develop and implement family-centered treatment programs; • establish a Labrador Aboriginal detoxification centre; and • explore other long-term initiatives to repair the cultural and social fabric of the two communities. In the interests of the Innu, both in terms of the crisis response and also in the development of supportive opportunities and sustainability of a healing environment, a comprehensive and collaborative federal/provincial approach with direct Innu involvement and participation has been developed. A joint federal/provincial/Innu technical working group has been established to develop action plans that respond to the immediate crisis and to develop long term solutions, supported by a team of professional experts for advice and validation of processes and plans.
2001	In May 2001, a working group was established to provide recommendations to Health Canada to deal with the reallocation of funds to proactively improve and renew the NNADAP system. A working group of stakeholders included representatives from the National Native Addictions Partnership Foundation, the Manitoba regional working group, the Youth Solvent Abuse Committee and Health Canada. Among the recommendations was the provision for the Sagkeeng First Nation to provide family addictions treatment services.
2001	In June 2001, Cabinet approved a multi-disciplinary approach to respond to the Labrador Innu crisis. This approach includes increased access to a range of health and healing services in the communities, the provision of enhanced policing services, registration of the Innu as Status Indians under the Indian Act, and the creation of Innu reserves. The LICHS is a horizontal initiative involving three federal departments: Indian and Northern Affairs Canada (INAC - lead), Health Canada, and Public Safety and Emergency Preparedness Canada (PSEPC) / RCMP. Health Canada received $20.07 million over three years (2001/02 to 2003/04) to implement a comprehensive community health strategy that addresses prevention and health promotion (maternal/child health), symptoms (addictions), and underlying causes (mental health problems such as trauma and loss). The strategy provides a continuum of health services by supporting community-based programs with professional teams, and by integrating federal health services with provincial health services. The Province of Newfoundland and Labrador has the primary role in delivering social services and primary health care to the Innu, and is working with the federal government and the Labrador Innu to carry out the joint commitments made in November and December of 2000.
2001	Non transferred NNADAP treatment centres were designated funding for their accreditation process – centres were to use 5% or their 10% Evaluation

	allocation.
2002	In early 2002, Health Canada approved the Addictions Renewal Advisory Committee recommendation for the establishment of a family treatment centre at Sagkeeng First Nation to be housed in the now defunct Virginia Fontaine Memorial Centre.
2003	In May 2003 it was that FNIHB would receive a 5 year funding allocation from Canada's Drug Strategy (CDS) in the amount of $5.3 million. The main objectives of this funding was to provide accessible certified training programs for First Nations and Inuit addictions workers with the goal to certify up to two- thirds of the addictions workforce over a five year period, the improvement of "quality of care" in addictions services, and the provision of orientation courses to all new addictions workers.
2004	Following a 2001 evaluation of the National Native Role Model Program, the program name was changed to the National Aboriginal Role Model Program and was redesigned to be more national in scope and more representative of the 3 groups of Aboriginal people in Canada. The National Aboriginal Health Organization (NAHO) was chosen to administer the National Aboriginal Role Model Program for a 5 year period through a request for proposal process beginning in 2004.
2004	The recommended option of the Memorandum to Cabinet, which was approved in principle by Cabinet committee in December 2004, proposed enhancing the Labrador Innu Comprehensive Healing Strategy (LICHS) to make it more comprehensive. The Record of Decisions directed the Ministers to return to Cabinet in 2009 to report on implementation and evaluation results and seek approval for ongoing funding.
2004-05	A call for proposals was initiated and regions submitted proposals outlining certified training options for NNADAP addictions workers. Each region received $55,000 for training based on regional priorities. Examples of regional activities included training for Prevention of Youth Substance Abuse, Aboriginal Addictions/Wellness Worker Certification Board Development, Tobacco Addictions Specialist Certification and Methadone Maintenance, and Case Management, Communication and Education Protocols for Detoxification. CDS commissioned an environmental scan of NNADAP affiliated treatment centres looking at regional staffing standards, certification, training and service delivery needs. The results highlighted the importance of addressing the introduction of new drugs (i.e. crystal meth) and the recognition of co-occurring disorders that have preceded or are the consequences of addiction. The results cited a need for a human resource strategy that is integrated and interdisciplinary with sustainable funding to provide opportunities for training, certification, salary increases, employment incentives, and potential for advancement in the addictions field.
2005	In February 2005, the federal government committed an additional $40 million over two years to the Aboriginal Healing Foundation, extending its mandate until March 31, 2009. This additional 40 million dollars enabled the Foundation to extend about 24% of active projects for another two years.

2005	The first Mental Wellness Advisory Committee (MWAC) meeting was held in June 2005. MWAC's mandate is to develop a Strategic Action Plan to improve the mental wellness outcomes of First Nations and Inuit and guide mental wellness policy and program development over the next 3-5 years.
2006	On May 10, 2006, the Indian Residential School Settlement Agreement received cabinet approval. Part of the Settlement Agreement included a $125 million commitment to the Aboriginal Healing Foundation. This funding extends the mandate of the AHF to September 2012.
2006	A draft strategic action plan was presented to MWAC in February 2006 and was to be presented to MWAC for a final review on June 23, 2006
2008	FNIHB sends an email to regions on March 6, 2008 requesting expressions of interest for Mental Wellness Teams (MWTs). MWTs are community-based, client-centred, multi-disciplinary teams that provide a variety of culturally safe mental health and addictions services and supports to First Nations and Inuit communities. Mental wellness teams are owned, defined and driven by the community and will include Aboriginal traditional, cultural, and Western clinical approaches to mental wellness services, spanning the continuum of care from prevention to after-care. The MWT concept supports an integrated approach to services delivery (multi-jurisdictional, multi-sectoral). Given Federal/Provincial/Territorial jurisdiction, participation and commitment of provincial services/agencies/authorities is important.
2008	On May 8, 2008 the Minister of Health announced $30.5 million over five years, and $9.1 million ongoing, under the National Anti-Drug Strategy (NADS) Treatment Action Plan to strengthen the quality, effectiveness and accessibility of First Nations and Inuit addiction services, particularly for youth, women and families. FNIHB's NADS investment has targeted four key areas: 1) Workforce Development 2) Expanding and Strengthening Addiction Services 3) Mental Wellness Teams 4) Addictions Information Management System (AMIS)
2008	The first meeting of the First Nations Addictions Advisory Panel (FNAAP) took place in Edmonton, Alberta in May of 2008. The mandate of FNAAP is to contribute to the development of a renewed national NNADAP framework to ensure the provision of culturally-appropriate and effective addictions services to First Nations in the coming years.
2009	The NNADAP Renewal/Mental Wellness Research Forum was held in Ottawa on February 23, 2009. The purpose of this forum was to enhance collaboration and consensus between researchers working on the NNADAP Renewal Papers. Participants at the workshop included five researchers connected to NNADAP Renewal/Mental Wellness teams, representatives from the AFN, NNAPF and the First Nations and Inuit Health Branch of Health Canada.
2009	Branch Accreditation Policy Framework and Funding Formula was approved by the Branch Executive Committee with the mission of promoting continuous

	quality improvement through accreditation in First Nations and Inuit health services.
2009	The Regional Needs Assessments contracted by Health Canada regions are completed in the summer of 2009. The Regional Needs Assessments are a key source of information on the status of NNADAP gained via extensive participatory process and which included engagement with individuals at the community level.
2010	The Assembly of First Nations (AFN), the National Native Addictions Partnership Foundation (NNAPF) and the First Nations and Inuit Health Branch (FNIHB) of Health Canada co-hosted the NNADAP Renewal National Forum on January 12-13, 2010 in Ottawa. The forum brought together a broad range of NNADAP partners (approx. 70 people), including community members, service providers, AFN Health Technicians, FNAAP members and representatives from national mental health and addictions initiatives, to discuss the ongoing NNADAP Renewal efforts in light of the completed regional needs assessments. The objectives of the Forum were to: 1. Identify key national program and policy renewal priorities for NNADAP based on the findings of the regional needs assessments, and other culturally-relevant and mainstream evidence; 2. Create an environment where there is collaboration and problem solving amongst partners on key NNADAP challenges; 3. Strengthen working relationships among NNADAP partners through a collaborative working environment; 4. Increase engagement and support of the NNADAP Renewal Process amongst partners; 5. Discuss appropriate approaches for engagement and validation for the Renewed Program Framework for NNADAP; and 6. Establish a network of NNADAP partners to move the Renewal Process forward.
2010	The NNADAP Renewal website is launched April 15, 2010. The web site is designed to facilitate clear and collaborative communication as work continues toward the creation of a renewed NNADAP Framework.