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National Native Addictions Partnership Foundation Inc.

NNADAP RENEWAL FRAMEWORK

For Implementing the Strategic Recommendations of the 1998,
General Review of the National Native Alcohol and Drug Abuse Program

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Draft, Working Paper— Prepared For Discussion Purposes Only

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1.0 INTRODUCTION

This document sets out a framework of purpose, values and principles to guide a renewal and capacity-building process for the National Native Alcohol and Drug Abuse Program (NNADAP). It also identifies some of the more significant deficiencies in NNADAP and the ends and means required to strengthen the program. Prepared by the Framework Sub-committee of the National Native Addictions Partnership Foundation(NNAPF) Inc., the *NNADAP Renewal Framework*, as outlined below, is intended for use as the primary reference guide for a co-ordinated, integrated approach to program renewal.

The Renewal Framework offers up the Partnership Foundation's vision of NNADAP in the future. It is not only crafted as an abstract statement of direction; in summary form, the Framework also offers very practical direction regarding the "who, what, why, when, where and how" such a vision can and should materialize.

The document is intended to promote and facilitate the implementation of the spirit and much of the substance of the 1998 national review. As a follow-up to the (national) *General Review*, the Framework specifies priority strategies for program upgrading, the fundamental program components that will comprise NNADAP and the roles and responsibilities of stakeholders.

The partnership implementing the strategic response to the NNADAP Renewal Framework will lay the basis for extending NNADAP's continuum of care, expanding its capital and operational resources, improving its prevention and intervention methods, and bolstering the skills of the people who deliver services. The proposed renewal process includes a reaffirmation and strengthening of much of NNADAP's existing infrastructure; it also calls for a number of substantial changes and enhancements of the program's policies, procedures, personnel qualifications and methodologies.

The aim of the NNADAP renewal process is to significantly enhance the performance capacity of the substance abuse and addictions programming serving the First Nations and Inuit peoples of Canada. Once fully realized, the renewed NNADAP will include a network of high quality services that will be readily accessible to people from all First Nations and Inuit communities in Canada.

1.1 - CONTENTS OF THE DOCUMENT

The Framework begins by briefly describing the background context of the substance abuse and addictions issues in First Nations and Inuit communities. It also provides a summary description of the prevention and intervention services developed by Health Canada to respond to those issues.

The document outlines the major events in the history of NNADAP that have impacted upon or directly shaped its progress. It then goes on to describe how a series of substantive program evaluations, each of which called for significant upgrading and change, led to the national, General Review of the program.

A synopsis is provided of the organizational and planning activities undertaken to date in response to the General Review by First Nations and Inuit representatives and Health Canada. In anticipation of a systematic, strategic implementation process, this framework document has grown directly out of those activities.

After establishing the background context of the preparation of the Renewal Framework, the document proceeds to describe NNADAP's renewed mandate, the vision of the National Native Addictions Partnership Foundation, and the mission, values and guiding principles that will animate the renewal of the human and physical infrastructure of the program.

In keeping with the principles enunciated by the Royal Commission on Aboriginal Peoples in its publication, *Gathering Strength: Canada's Aboriginal Action Plan*, *1997*, the renewal of NNADAP will achieve far greater success by working pro-actively through partnerships. We believe that, when compared with our current, primarily "go-it-alone/one-track" approach to service provision, the program can have much greater impact on reducing substance abuse rates in our communities if we strike a number of strategic partnerships. A renewed NNADAP will improve and intensify internal working relationships within the NNADAP infrastructure. It will also develop effective partnerships with external organizations with partially overlapping mandates.

In the latter segments of the Framework, a brief, summary outline is provided of the roles and responsibilities of the various stakeholders and potential partners. In addition to the First Nations and Inuit peoples generally and service clients specifically, these stakeholders and partners include:

- **Organizations and Personnel Dedicated Primarily to Addressing Substance Abuse and Addictions Issues**
  - Program clients: Community members (all of whom are, ostensibly, prevention program clients) and substance abusers who are clients of intervention programs
  - Community Prevention Program Personnel (i.e., NNADAP-funded Workers) and the Health Boards/Committees they report to and the Community Health Service Teams they work with
  - Treatment Program Management and Staff
  - The National Native Addictions Partnership Foundation Inc.
  - The National Youth Solvent Abuse Program (NYSAP)
  - First Nations and Inuit Health (FNIH) Branch (Health Canada)
  - Regional Working Groups (linked to the National Partnership)
  - Provincial and Territorial Addictions Intervention Organizations
  - Metis Substance Abuse and Addictions Organizations

- **Area and Community Governing Councils**
  - Area Councils

- Chiefs and Councils

❑ **Family Support and Early Childhood Development**

- First Nations Child and Family Services
- Community Early Childhood Development Programs
- Headstart Programs

❑ **Educational Institutions and Organizations**

- School Authorities
- Teachers
- Non-government Educational Organizations

❑ **Mental Health Service Organizations**

- The National Working Group on First Nations and Inuit Mental Health Services
- The Aboriginal Healing Foundation
- Regional First Nations and Inuit Mental Health Service Coordinating Bodies
- Mental Health Counsellors serving First Nations and Inuit Communities

❑ **Justice and Police Service Organizations**

- The Department of Justice
- Corrections Services Canada
- Provincial and Territorial Justice and Corrections' Authorities
- Police Services

❑ **Adult Training and Economic Development Authorities**

A summary description of the principal gaps in NNADAP is then provided, as are the strategic solutions and basic program components required to fill those gaps and thus renew and adequately upgrade the program.

2.0 BACKGROUND: FIRST NATIONS AND INUIT SUBSTANCE ABUSE AND ADDICTIONS PROGRAMMING

Alcohol and drug abuse and addictive behaviours have been implicated as causes and effects of the relative underdevelopment of First Nations and Inuit health since the inception of contact with European newcomers. In the areas of North America that are now a part of Canada, these problems originated in the inexperience of Aboriginal peoples with the alcoholic beverages that Europeans brought with them. The indigenous cultures simply had no protective social norms in place to moderate or set limits upon the amount of alcohol consumed or to define the limits of safe, socially acceptable behaviour to accompany its use.

In the late 19th century the substance abuse problems for indigenous peoples intensified dramatically. In that period and continuing on well into subsequent post-contact history, the economic exchange systems in which Aboriginal peoples were either primary players (e.g., fishing; horticulture; hunting and gathering) or full partners — i.e., inland exploration; the fur trade; the buffalo hunt and north-south trade — were displaced by economic development and nation-building policies founded upon the recruitment of European settlers and workers. Displaced from their roles in the outgoing economy as either/or both subsistence producers and full trading partners, Aboriginal peoples were essentially left on the sidelines to watch the emergence of a newly developing economy and society. After losing their traditional economies, indigenous peoples have been especially vulnerable to the health and social problems that are virtually characteristic of economically marginalized members of all industrial and post-industrial societies. With tragic consistency and across all ethnic backgrounds, those problems include crippling alcohol and drug abuse patterns.

2.1 OVERVIEW AND INDICATORS OF THE PROBLEM

There are a variety of substances abused by disproportionate numbers of First Nations and Inuit peoples: alcohol, including alcohol-based solvents ingested as either inhalants (gas or glue) or as a drink (e.g., shaving lotion); "street" drugs, including intravenous injection drugs and "designer" (manufactured substitutes for organic) drugs; medically prescribed drugs used inappropriately; and addictive, non-nutritious and unhealthy food products. A selection of research evidence indicating the existence and disproportionate distribution of these problems in First Nations and Inuit communities is summarized below.

2.1.1 - ALCOHOL ABUSE

There are various approaches to studying the existence of a mental or physical health problem. Included are two commonly used approaches, one being the gathering of the observations and opinions of specially informed observers of a particular problem, such as health workers. Another involves surveying the opinions and relevant, self-declared behavioural facts provided by community members. Most of the research evidence using these two approaches indicate that the relative numbers of alcohol users in First Nations and Inuit communities has declined substantially in recent decades, settling in at levels well below national averages. However, amongst those who do continue to drink, problem

drinking and accompanying, self- and socially-destructive behaviours and alcoholism (i.e., Alcohol Dependency Syndrome [ADS]) are commonplace. Further, despite the hopeful trends suggested by the research showing increasing numbers of Aboriginal abstainers, there is some evidence that alcohol abuse is becoming more frequent among Aboriginal youth. Obviously, if the trend of youthful alcohol use is real and it is sustained as these early drinkers mature, then the gains made in recent decades towards sobriety as a norm will gradually be reversed.

While the progress made in the reduction of alcohol users in Aboriginal communities must be recognized and applauded, we must not lose sight of the fact that alcohol abuse remains a major personal and social health problem of enormous magnitude. It would not be overstating the case to suggest that normative drinking styles amongst our peoples quite literally carry with them thousand of ever-present disasters waiting to happen.

The impact of high risk drinking styles is indicated in the fact that the rate of death due to alcohol use by Aboriginal people is 43.7 per 100,000 people, which is almost twice that of the general population, for which the death rate is 23.6 per 100,000 (Single, Robson and Scott, 1997).

Rates of hospitalization, deaths due to injury and poisoning and suicide rates are all closely related with impairment from alcohol and other psycho-active drugs.

First Nations and Inuit hospitalization rates for alcohol are well above national and regional rates for the general population (Single, Robson and Scott, 1997).

The age-standardized injury and poisoning rate for First Nations is strikingly higher than it is for the general population; in fact, some studies have found the First Nations injury and poisoning rate to be almost 4 times higher. According to Single, Robson and Scott, Aboriginal suicide rates are 6-8 times the national average.

2.1.2 - Abuse of Illicit, Non-Medical Drugs

Drugs used for non-medical purposes are a growing concern for NNADAP personnel, who confront a somewhat bewildering and ever-changing array of mood-modifying substances entering the communities in which they work. The workers are especially concerned about the use of drugs by youth.

Studies undertaken in various parts of Canada indicate that indigenous Canadians, as a group, also experience disproportionately high rates of non-medical drug abuse (Scott, 1997). A study of Treatment Activity Reporting System (TARS) data in the early 1990s showed a trend of increasing use of narcotics by NNADAP clients.

It is true that the primary substance abuse or addiction problem identified by clients in NNADAP treatment centres is still alcohol (58.4%). It is also true that over 20% identify other drugs, including 12.2% of clients identifying the abuse of narcotics as one of or the primary substance abuse problems and 8.6% identifying hallucinogens (NNADAP program reports, 2000).

The rate of death due to illicit drugs is almost three times higher than the general population.

According to Single, Robson and Scott, the Aboriginal rate is 7.0 per 100,000 compared to 2.6 deaths per 100,000 in the general population due to illicit drug use.

Community studies conducted as a part of the Federal Government's *Health Transfer Initiative* have indicated that the availability of marijuana and hashish is commonplace on reserves and that single communities often have as many as fifteen individuals actively "dealing" drugs for profit. A 1996 Health Promotion Survey in the Northwest Territories found that cannabis, in the "hash" or "grass" form, was used 3 times more frequently by Aboriginals than by the general population (Health Canada, 1996). A Manitoba study found Aboriginal drug abuse rates to be consistently higher than the general population in every one of fourteen different drugs studied (Gfellner and Hundleby, 1995). Further, health workers and First Nations' leaders are increasingly being told that the use of harder drugs, such as cocaine, "crack-cocaine," heroine and other intravenous-injection drugs, the trade in methadone and the use of "designer" drugs such as *Ecstasy,* is on the rise among youth.

At various conferences attended by the NNAPF Framework Committee, NNADAP workers have expressed concern about the arrival of hard drugs in communities, and the fact that workers often don't understand the signs of impairment, the nature of the "highs" or the behaviours associated with each of these drugs. Intervention workers also express frustration, even helplessness, not only because they are unfamiliar with many of these drugs but because they simply don't know how to intervene with the young people using them. This frustration was given voice at a Montreal Conference held to respond to the final report of the General Review of NNADAP. As a result of these knowledge and skill limitations of many NNADAP workers, a "generation gap" is developing between NNADAP workers and the youth whom they are expected to serve. According to many key informants, NNADAP workers are often perceived by young people as being irrelevant to their problems.

Many NNADAP workers and community leaders are also concerned about the growth in the sales of alcohol and drugs to minors and the intimate connection between urban drug trafficking, prostitution and juvenile and young adult gang activity.

2.1.3 - Cross-Drug Abuse

Both Canadian and American studies have indicated that Aboriginal peoples are significantly more likely than the general population to be cross-abusers of drugs. A 1991/92 report by the Provincial Government on client characteristics in Saskatchewan's provincial treatment programs indicated that 46% of Aboriginal clients in its programs admitted to abusing both alcohol and other drugs (SADAC). Other studies, based on community surveys, have indicated that the actual incidence of cross-abuse in the general First Nations population is far lower than such client data would suggest.

2.1.4 - Dual Disorders

Clients with dual disorders represent a special challenge for substance abuse interventionists. Researchers in the United States have estimated that psychiatric patients who abused drugs on a regular basis were 250% more likely to be hospitalized than those patients who rarely

or occasionally used them (Kanwischer and Hundley, 1990). One of the complicating factors is that, until the client is detoxified, it is impossible to accurately diagnose the primary psychological disorder. According to one writer (Nathan, 1991), it is necessary for the client to be drug free from 4 to 6 weeks before an accurate diagnosis can be made. Another complicating factor is that some psychological disorders make it difficult for clients to present their problems in an organized way (e.g., a schizophrenic) or in an honest, non-manipulative way (e.g., an individual with a personality disorder, such as a borderline personality or an anti-social personality). In the case of sociopathic personalities, manic-depressives, or schizophrenics, serious safety risk factors cannot be assessed accurately because drug or alcohol impairment often suppresses the appearance or expression of the mental illness. Consequently, the client with the disorder, other program clients and staff, can be placed at considerable risk because of the difficulties of diagnosis. Further, alcohol or drug abuse restricts the possibility of effective treatment for a mental health problem. Both NNADAP treatment and prevention workers frequently express concern about their inability to provide professional, dual diagnostic assessment for clients who might potentially have a dual disorder.

2.1.5 - Prescription Drug Abuse

Prescription drug dependency, especially a dependency on sedatives, pain killers and anxiety-reducing compounds, is consistently considered to be a widespread and potentially increasing problem among First Nations and Inuit peoples, especially women. In fact, a study by Scott (1995) of data from NNADAP's Treatment Activity Reporting System (TARS) suggested that the abuse of prescription drugs is increasing among First Nations and Inuit people who are referred to NNADAP in-patient treatment programs.

Interviews with physicians in many community studies have indicated that First Nations' patients often apply considerable pressure on physicians to give them drugs that have mood-modifying properties, even when the need is questionable because alternatives are readily available. However, the resident surveys undertaken as part of the same studies give clear expression to the view that many doctors prescribe mood-modifying drugs in a promiscuous fashion. Community residents tend to complain that at least one physician in or accessible to their health service area is far too ready to prescribe drugs that have addictive properties.

Health Canada was actually warned in 1997 by the Auditor-General that its First Nations and Inuit clientele were overusing prescription drugs. The Department subsequently developed a watchdog system based on data collected by pharmacists and devised to restrict multiple prescription refills. In November of this year, after reviewing the matter, Auditor-General Denis Desautels criticized Health Canada for not taking stronger action. He concluded that, while Health Canada's watchdog system has met some limited success, its results were disappointing because the adherence of pharmacists had not been sufficiently monitored.

2.1.6 - Solvent Abuse

There is insufficient objective research to determine the scope of solvent abuse as a problem in First Nations and Inuit communities. It is known that the use of inhalants and methyl alcohol in liquid form is commonplace among Aboriginal people counted among the homeless, alcohol-dependents, and residents of urban "skid rows." However, in reserve settings, solvent abuse typically involves youth who experiment with inhalant-sniffing (gas or glue). These are the only available, affordable (i.e., free), "high" producing drug available to most children. Older youth consider solvent inhaling a "kiddy drug practice" and thus it is abandoned and replaced by other substances as children grow through the adolescent years and secure more discretionary income.

While there is evidence from community surveys that experimentation with inhalants is widespread in Aboriginal communities, in some instances — typically in remote, northern communities — the practice takes hold as a defining social activity among children and early teens. The fact is that *any* solvent abuse causes permanent damage to an individual's neurology and a single overdose can prove lethal. Consequently, when it becomes normative for a group, the phenomenon becomes a combined medical emergency and social problem of the highest order of priority.

In response to the solvent abuse problem, the Federal Government has established the National Youth Solvent Abuse Program (NYSAP) and funded ten in-patient centres. Treatment programs have tended to rely upon in-patient methods which require the removal of children from their home communities. However, there is a concensus among treatment professionals that unless various environmental conditions in the families and communities of solvent abusers are addressed, inhalant abusers remain at high risk, even after months of intensive treatment.

2.1.7 - SMOKING RATES

Non-traditional use of tobacco is also a major health problem in Aboriginal communities. Data from both national surveys and community studies of adults in First Nations and Inuit peoples indicate that Aboriginal people are between two and 2.5 times as likely as the general population to be both regular (daily) smokers and occasional (less than daily) smokers. Research findings formerly kept silent by the major tobacco companies have clearly shown that the addictive properties of nicotine in cigarettes are actually enhanced deliberately with other addictive compounds blended into the filter or the tobacco itself. The well-known health risks of smoking include eight different kinds of cancer, heart disease, stroke, fetal damage from the smoking of pregnant mothers, ulcers and a variety of other chronic illness conditions.

2.1.8 - Addictive Behaviour Patterns and Other Unhealthy, compulsive Behaviours: Convenience Food, Problem Gambling, and Relationship Dependencies

Addictive behaviour patterns can become a generalized problem, often enveloping our most basic, essential habits, such as food consumption, our recreational habits, such as gambling, and our sexual and social relationships. There is a widespread view among health workers that addictive behaviour patterns have become generalized in Aboriginal communities, arguably as a kind of "self-medication" for emotional pain associated with residential school abuse, family violence and abandonment issues, often experienced in childhood but never addressed therapeutically.

- **Nutritional Abuse: Junk Food and Convenience Food**: There is increasing evidence that the addiction-like, regular consumption of high cholesterol and high carbohydrate snacks and convenience foods, is replacing alcohol as the most costly substance abuse problem in the Aboriginal population. By replacing nutritious foods with the regular consumption of sub-standard meals, a variety of problems have emerged. Undernourished children who substitute snacks to meet their hunger needs find school performance unnecessarily difficult. Further, child obesity rates and, indeed, obesity in general, is becoming commonplace in Aboriginal communities, and a norm amongst those who are middle-aged. That obesity appears to be triggering a virtual epidemic of late-onset diabetes and, in turn, the extremely serious health risks associated with that diabetes, such as glaucoma and loss of circulation in the limbs, are further elevated by convenience food habits.

- **Problem Gambling**: In recent decades, the standard measure of problem gambling, the *South Oaks Gambling Screen*, has some built-in cultural biases and it has been criticized methodologically by the Addictions Research Foundation (ARF) of Ontario. While a new research instrument has been tested and will be available for use in the near future, virtually all studies of First Nations and Inuit respondents have shown problem gambling rates on the SOGS far higher than the general population. In several community health surveys conducted on Saskatchewan reserves, problem gambling appears to be an affliction of between one-third and more than one-half of the 15 years old and older population.

  The issue of problem gambling in Aboriginal communities is an especially complicated one, even from a moral perspective. Gambling is often seen as a "replacement addiction" for abstaining, former alcoholics, and NNADAP workers who address addictions issues frequently express frustration with the ever-greater access that their former alcoholic clients have to gambling outlets. The workers express discomfort with speaking out against gambling, even though it is very destructive for many of their acquaintances and former clients. That discomfort stems from the fact that casinos and other forms of gambling are playing such a major role in the economic development strategies of their communities. It is not a simple issue because the workers know that gambling operations are creating employment and significant, investment income. NNADAP workers also

know that employment is a major contributing factor to the prevention or termination of substance abuse problems.

- **Relationship Dependencies and Sexual Addictions**: Mental health therapists, NNADAP workers and Community Health Representatives often indicate that disproportionate frequencies of relationship conflict and family violence are caused by overly controlling and/or overly dependent relationships between intimate, adult partners. The dependent nature of such relationships may be an expression of addictive behaviour patterns generally. The frequency of these problems are often thought to originate in troubled family relationships and sexual and emotional abuse experienced during childhood in residential schools.

  Troubled backgrounds of this kind may also be expressed through a consistent substitution of sexual pleasure for meaningful, adult relationships. While "sexual addiction" is a term that has not been consistently accepted as a psychological disorder, the lifestyle that accompanies it is often an expression of compulsive behaviour patterns and can carry significant health risks associated with sexually transmitted diseases.

2.2 OVERVIEW OF THE NATIONAL NATIVE ALCOHOL AND DRUG ABUSE PROGRAM (NNADAP)

The National Native Alcohol and Drug Abuse Program (NNADAP) is the primary, federal funding source for services designed to prevent and overcome alcohol and drug abuse problems in the communities of First Nations and Inuit peoples.

Program revenue support for NNADAP policy development and service quality monitoring are primarily administered by First Nations and Inuit Health Branch (recently renamed from the former "Medical Services Branch") of Health Canada. That process is carried out through a national office and regional infrastructure throughout the country.

Direct NNADAP service delivery is undertaken by First Nations' communities and treatment programs, mostly in-patient, and typically delivered jointly by groups of First Nations through incorporated management structures.

The treatment programs are available to all First Nations people throughout the country but, in the vast majority of cases, clients participating in them are drawn from various resident locations *within* each of the First Nation and Inuit health service regions. Limitations on access to programs outside the Region are set by a policy that requires that clients must access the program closest to their residence that has bed space vacancies available at the time of an intake request.

2.2.1 - PROGRAM HISTORY

The history of NNADAP originates in a national pilot project implemented on a preliminary basis in the mid-1970s. Operated at the outset as a joint program of the (then named)

Department of Indian Affairs and Northern Development (DIAND) and the (then) Department of National Health and Welfare, the National Native Alcohol Program (NNAP) continued for five years beyond its initial 3-year mandate as a demonstration project.

A proposal for a permanent program was submitted to and approved by the (Federal) Treasury Board in 1981-82. A permanent program to inclusively address alcohol *and* drug problems and to be called the National Native Alcohol *and Drug* Abuse Program (NNADAP) was needed, argued the proposal:

- to establish certainty in the program;
- to reduce staff turnover related to that uncertainty, and
- to establish a program that could be integrated and co-ordinated with other programs which would, together, promote community health and environments dominated by sober lifestyles.

The alcohol and drug abuse program was actually established as a permanent program prior to such major community development initiatives as *Pathways*, the Native Economic Development Program (NEDP), self-government legislation, and the community-based health services transfer initiative.

As the *General Review of NNADAP* stated, NNADAP was established and given permanency because of the "urgent and visible nature of alcohol and drug abuse among First Nations and Inuit people."

The program was conceived in the initial submission to Treasury Board as comprising the following elements:

- non-medical treatment services, as well as post-treatment services such as half-way houses and outpatient services;
- prevention and maintenance activities, including professional and paraprofessional counselling; community education; self-help groups; and complementary services, such as support groups for those afflicted and for their families;
- personnel training support;
- research and development;
- regionally-based Indian and Inuit institutions to provide technical assistance, training, research, planning, coordination, service evaluation and funding.

The following potential program elements were excluded from the original program proposal:

- primary prevention (with the exception of health education and financial and technical assistance to help in leveraging the support of other programs to mount comprehensive community prevention strategies)
- medical services were not directly included;

- medical and non-medical detoxification was not directly funded;

Further, professional counselling services in communities was excluded, despite the fact that such services were included as basic program elements in the original program conception, as it was proposed to Treasury Board.

2.2.1.1 - Beyond the Initial Proposal: The Contents of NNADAP

NNADAP now supports an infrastructure managed and delivered by First Nations and Inuit communities and organizations throughout Canada. That infrastructure includes:

- 49 treatment centres, housing 695 treatment beds and outpatient services providing non-medical, post-detoxification treatment;
- over 500 community-based prevention programs employing over 700 workers, almost all employed by First Nations and Inuit communities themselves.

Training funds and research and development funds originally committed to NNADAP have been "rolled into" the general NNADAP contributions budget and, consequently, the existence and potential for a clearly articulated, comprehensive training and research program with regional and national dimensions has been lost.

Operating separately but often in a close working relationship with NNADAP is the National Youth Solvent Abuse Program (NYSAP), which now funds 10 treatment centres across the country, each with a capacity of 12 inpatient beds (although one centre uses funding for two of its allocated bed spaces for outreach clients). The NYSAP is managed through a National Committee of solvent abuse treatment centre representatives. The Committee oversees the development of program standards and the negotiation of partnership protocols for the effective management of the program. The management of the program is independent of NNADAP and other community-based programs.

2.2.1.2 Historical Milestones

The program context can be better understood if its history is set out in terms of events that served as milestones in its development. These milestones are listed below.

- In fiscal year **1975-76 the National Native Alcohol Program (NNAP) was established** as a 3-year pilot project jointly administered by DIAND and the Department of National Health and Welfare. It was subsequently extended until a Treasury Board submission calling for a permanent program achieved Treasury Board approval in 1981/82.
- The renamed and fully conceptualized, permanent National Native Alcohol and Drug Abuse Program **(NNADAP) was established in fiscal year 1982/83**. Health Canada assumed full responsibility for the program. In its first two years, the program primarily funded on-reserve NNADAP prevention projects.

- In **1984/85, resources for a national *treatment* program component of NNADAP were committed** by the Federal Government.

- **By the late 1980s, the program was well established**, and **several years of evaluative activities ensued**, undertaken as collaborations of First Nations and Inuit organizations, Health Canada and independent researchers. Arguably, the most influential of these evaluations was a study undertaken in 1989 by the internationally respected Addictions Research Foundation (ARF). The ARF study was highly critical, finding confusion among workers regarding the definition and mandate of their roles and responsibilities as community workers, under-skilled staff in both prevention and treatment, underdeveloped pre-care and aftercare/outpatient follow-up services, and weak linkages between community dimensions of the program and in-patient treatment programs.

- Several subsequent evaluations at the regional level confirmed the findings of the ARF. However, **the upgrading recommended in these evaluations was generally delayed**. This delay appears to be a direct result of the conjunction of two facts, specifically (1) the concept of Regional First Nations' coordinating bodies that might eventually evolve into Regional policy-making authorities never fully materialized and (2) in the face of a new policy direction, as expressed in the *Health Transfer Initiative*, MSB increasingly withdrew from playing an assertive, "hands on" role at the service delivery level. Consequently there were few "pushes" or "pulls" towards change.

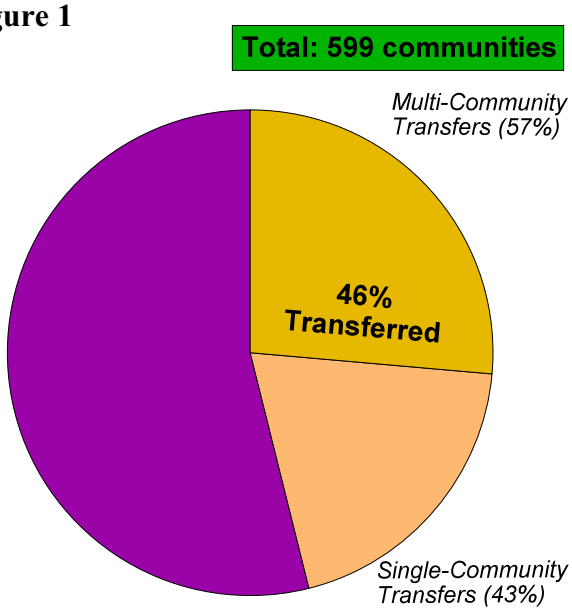
- **In 1989, the Federal Government established the *Health Services Transfer Initiative***, which sought and, in many cases succeeded, in transferring administrative and program revenues, and management and delivery authority, for programming directly to First Nations, either individually or collectively. This initiative provided the basis for long-term (5-year) agreements. It also further reduced the capacity of a regional authority to dictate standardized policy, especially regarding prevention programs, which were folded into individual health transfer agreements.

  A summary of the trend in the take-up of Health Transfer arrangements is provided in Table 1 below.

- In the early 1990s, 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). Critics of the formula believe that the formula has been disadvantageous to smaller centres and, when upward adjustments to correct for these financial limitations have had to be made, they must be drawn from Regional budget envelopes. In some instances this has meant that, in effect, the larger centres have subsidized the smaller centres. The limitations of budget allocations for smaller centres were made all the more obvious when youth solvent abuse treatment centre funding came on stream, amounting to substantially greater per bed space allocations.

Table 1 Transfers by Region/Communities*					
Region	Total Eligible Communities	Transferred as of March 31, 2000		Projected to March 31, 2005	
	Number	Number	% Total	Number	% Total
Atlantic	40	20	50	36	90
Quebec	28	23	82	28	100
Ontario	124	38	31	57	46
Manitoba	62	33	53	52	84
Saskatchewan	83	60	72	68	82
Alberta	58	4	7	10	17
Pacific	204	98	49	109	53
Total	599	276	46	360	60

Figure 1



* This table and pie chart are borrowed from the Health Canada publication, *Ten Years of Health Transfer First Nation and Inuit Control.*

- Also **in the early 1990s, new funding was provided for community programming initiatives** in the areas of family violence prevention and intervention, community mental health, early childhood development, injury prevention, programs to support the care of healthy babies, and solvent abuse intervention. This initiative can be seen, in part, as

growing out of the call in the original NNADAP proposal for NNADAP to "leverage" and work together with other complementary programs to mount primary prevention strategies. It should also be noted that the programming made possible by this funding was also a response to many years of recommendations made by NNADAP workers themselves.

- The First Nations and Inuit Community **Youth Solvent Abuse Survey** and Study, funded by Health Canada, was completed in October, 1993. The study led to the establishment of several solvent abuse treatment centres for youth across the country under a new MSB program entitled the National Youth Solvent Abuse Programs (NYSAP)

- In the mid-1990s, MSB funded the establishment of **National and Regional Prevention and Treatment Standards** for NNADAP. However, subsequent evaluations indicated that the voluntary pursuit of standards-upgrading had been relatively slow. In various aspects of programming, services continued to be below par with the standards guidelines.

- In 1996, the ***Report of the Royal Commission on Aboriginal Peoples*** **(RCAP)** was completed. As the Royal Commission stated in its final report, before the renewal of the relationship can begin, "a great cleansing of the wounds must take place." The third volume of the report, *Gathering Strength*, focussed on social policy. The report included major sections on the importance of a new Aboriginal healing strategy. It emphasized that, to be effective, such a strategy would have to place a major emphasis on not only the individual but also the Aboriginal family and community systems. The importance of an Aboriginal health strategy grounded in a holistic approach, and supported by a human resource development strategy, social housing and cultural renewal, was also a major theme in Volume 3 of the RCAP report.

- Also growing out of and as a follow-up to the RCAP report, an implementation framework entitled ***Gathering Strength: Canada's Aboriginal Action Plan*** was produced in 1997. The plan began with a *Statement of Reconciliation* through which the Government of Canada formally acknowledged and expressed regret for the historic injustices experienced by Aboriginal people. The statement included an official apology for the victimization of Aboriginal people in residential schools through physical and sexual abuse. It made a commitment to assisting in community healing to address the profound impacts of abuse at Residential Schools. The Action Plan set out the following four basic objectives to guide the Federal Government's efforts to translate its declared intentions into actions:

  1. *A Commitment to Renewed Partnerships*. One objective is for the Federal Government to build a renewed set of partnerships with Aboriginal people, other levels of government, and the private sector. An especially significant aspect of this statement of renewal is the emphasis given to the importance of Aboriginal input into the design, development and delivery of programs affecting their lives and communities. Another is an emphasis on restructuring Federal Institutions in a way that will reflect renewed and more symmetrical relationships in policy development and administration in which

Aboriginal people are full partners.

2. *Strengthening of Aboriginal Governance Capacity*. Another objective set out in the Action Plan gave recognition to the need for strong, accountable and sustainable governments and institutions. The document stated: "This means ensuring that Aboriginal governments and institutions have the authority, accountability mechanisms and legitimacy to retain the confidence and support of their constituents and of other government institutions, to govern effectively. It committed the Government of Canada to working closely with Aboriginal people to enhance their capacity to govern and to enlist provincial and territorial governments in partnerships that will help make this ideal a reality.

3. *Creating New Fiscal Relationships*. Through the Gathering Strength Action Plan, the Government of Canada also made a commitment to working in partnership with Aboriginal governments and organizations in developing a new fiscal relationship that will provide more stable and predictable financing, is accountable, and which maximizes the internal generation of own-source revenue.

4. *Supporting Strong Communities, People and Economies*. The Action Plan also committed the Federal Government to working closely with and providing tangible support to Aboriginal people in their efforts to *improve the physical and social infrastructures* of their communities. It also made a commitment *pro-actively supporting healthy communities* through an administrative *transfer strategy* to enhance community control and a *program strategy* to address priority service gaps in such areas as mental health and solvent abuse. Also of relevance to substance abuse and addictions programming was through the creation of an *Aboriginal Health Institute*, a *Headstart* program and a *human resource development* strategy.

- Throughout the 1990s, increasing numbers of First Nations entered into **Transfer Agreements**, most of which included NNADAP funded program and personnel funding.
- **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. A formal report describing the findings and recommendations of **the Review was completed in 1998**.
- In **early1998, the Aboriginal Healing Foundation was established**, at least partially as a response to the Royal Commission on Aboriginal Peoples. The Foundation's mission is *to encourage and support Aboriginal people in building and reinforcing sustainable healing processes that address the legacy of physical and sexual abuse in the residential school system, including intergenerational impacts.* Residential school abuse was identified in the RCAP report and several other studies as having a significant influence on the disproportionate levels of substance abuse and addictions in First Nations and Inuit communities. The Foundation funds projects submitted by Aboriginal

organizations, groups and communities (including communities of interest) which are designed to:

- promote healing within the community
- empower Aboriginal women
- develop and enhance the capacity of traditional and professional Aboriginal care-givers to promote healing in their communities
- intervene in current personal or family problems caused directly or indirectly by residential school abuse in order to restore balance in the future
- record and share the history of residential school abuse in order to honour the suffering and learn from that history and to avoid the repetition of similar abuse between parents and children.

Several other events have taken place since 1998 that have direct implications for NNADAP. These events have been directly influenced by the national review of the program completed in 1998.

- In **1999, MSB circulated a policy paper 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**.

- The First Nations and Inuit Health Branch is currently working in partnership with the Assembly of First Nations and the Inuit Tapirisat of Canada on the development of a national, **comprehensive mental health program** that aims to provide equitable, sustainable and accessible mental health services to all First Nations and Inuit communities. The program is intended to complement current and emerging programs, including addictions programs. A recent environmental scan produced by the national working group on First Nations and Inuit mental health services drew the following conclusions:

  - A clear mandate for mental health services dedicated to First Nations and Inuit is lacking.

  - Mental health services for Aboriginal people struggling with substance abuse, sexual abuse, family violence and suicide are sharply curtailed by the federal government's approach, which it describes as "bits and pieces" initiatives, short-term expedient reactions to political pressure—*not* a program."

  - In many Aboriginal communities in remote areas of the country, there is either poor or no access to acute psychiatric treatment, long-term therapy or rehabilitation services.

  The report recommended that all levels of government should immediately resolve issues of jurisdiction and, within six months of submission of the report, draft a 5-year national mental health program for First Nations and Inuit peoples.

- 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.

- In 1999, a federal non-profit corporation — **the National Native Addictions Partnership Foundation Inc (NNAPF)** — was created to better enable the National Working Group to fulfill its mandate. A Board of Directors of the Foundation has now assumed responsibility for developing a strategic approach to the implementation of the report's recommendations.

2.3 THE GENERAL REVIEW OF N.N.A.D.A.P, 1998: OVERVIEW AND GENERAL FINDINGS

Reporting in 1998, the General NNADAP Review called for greater program integration, significant program and human resource upgrading, and specific areas in which new funding was required. It also called for Regional Councils and a national First Nations body to guide the upgrading process. A Steering Committee with MSB and First Nations' representatives had overseen the independently contracted production of the report.

The Review presented data from a survey of 37 randomly selected communities indicating alcohol/drug abuse remains one of the major health concerns in First Nation communities across Canada—and indicated that NNADAP enjoys significant support in most First Nations.

The General Review reported that, nationally, $30 million is spent on prevention (community-based) projects. That expenditure supports a workforce of 729 positions, which are now available in most First Nations' communities. The report indicated that another $28 million is spent in the program annually on 73 treatment centres.

The General Review identified the following key problems:

- There is a lack of integration of community programming and treatment centres.
- The program lacks an integrated network/system of services.
- There is a lack of differentiation and specialization of program interventions.
- Lack of relevant information to make decisions.
- Prevention staff work in isolation from colleagues and professional supervision.
- There is a high turnover of staff.
- The program faces increasing financial challenges.
- There is inconsistent training content and accessibility to training across jurisdictions.
- There is a lack of adequately trained personnel both in prevention and treatment.
- There is a lack of specialized services for families, children and youth.

- Most treatment centres do not operate according to a set of standards nor do they implement quality assurance programs.
- High drop-out rates are blamed by treatment staff on lack of pre-care in communities and other factors, including self-discharge because of motivational and situational factors.
- Lack of adequate aftercare is a major problem.
- A systems approach to the entire program is lacking and is needed.
- Regions must work on ways of integrating addictions services with other community-based programs and treatment centres and prevention efforts must be more closely linked and coordinated.
- Due to federal fiscal reduction, NNADAP has had no incremental increases for several years and is therefore at a financial disadvantage.
- Provincial health reforms have reduced or eliminated other services available to NNADAP, including detoxification services and mental health services.
- The transfer and self-government development process raises the issue of which organization and which process is used to implement standards, information systems, and program evaluation.

The Review and the discussions around it support further development of an integrated, network of services, enhanced human resource development, improvements and uniform application of standards, evaluation/program reviews, and accreditation.

2.4 RECOMMENDATIONS OF THE GENERAL REVIEW OF NNADAP

The General Review made 37 recommendations which, in the view of the NNAPF Board, fall into seven broad categories of enabling functions. These functions are described in the left column below. The Board also identified the implementation goals listed in the right column below, adjacent to each enabling function.

ENABLING FUNCTION	IMPLEMENTATION GOAL
1. Networking	To organize a national network of addictions programs and services through which the knowledge, experience and skills of its members can be universally accessed by clients, workers, managers, policymakers and partners; to ensure that community prevention and Treatment Centre personnel do not function in isolation from their colleagues; and, to develop a partnership between the National Native Addictions Partnership Foundation, the Regional Addictions Partnership Committees and FNIHB.

2. Research & Development	To support the effective operation and development of community prevention and Treatment Centre operations through pure and applied research with a focus on identifying individual, family and community need and improving programs and services.
3. Best Practices	To identify the best practices within the extensive base experience of community prevention programs and treatment centres; to capitalize on these experiences by documenting success and providing "hands-on" exposure for Addictions personnel to methods and practices that are effective; and, to establish an accreditation process for community prevention and treatment centre programs.
4. Training	To establish a networked training system to support the development of the human resources required to ensure effective and efficient addictions services for Aboriginal people regardless of where they live; and, to establish a national certification program for community prevention and treatment centre personnel.
5. Communications	To develop and implement a national program of communications, using state-of-art methods and technologies that provides timely information related to the addictions field to clients, workers, managers, policymakers and partners within the First Nations and Inuit Addictions network; and, to ensure communications support to Regional Addictions Partnership Committees.
6. Resources/Capital	To establish a funding base that supports an effective and efficient system of programs and services delivered by qualified personnel to Aboriginal people regardless of where they live in Canada (including operational and capital requirements).
7. Continuum of Care	To develop a continuum of care within which services would be available to all Aboriginal people wherever they live in Canada including primary, secondary and tertiary prevention and intervention community services, community development programs, and a complete range of treatment services (detoxification, "first and second stage" treatment programs, specialized treatment services).

A detailed statement of the recommendations is appended to this document (See Appendix A) and is of course available in the final report General Review of NNADAP.

2.5 FROM REVIEW TO ACTION

Since the completion of the Review, specific organizational developments and planning processes have been undertaken to ensure that the national NNADAP Review's major recommendations are translated into reality.

2.5.1 - ESTABLISHMENT OF A NATIONAL AND REGIONAL PARTNERSHIP TO IMPLEMENT THE N.N.A.D.A.P. REVIEW

As indicated above, the report of the General Review of NNADAP (1998) recommended that Regional Committees and a National committee be struck to ensure that the major recommendations of the Review were acted upon. In keeping with this recommendation, partnership committees linking First Nations and Inuit representatives and Health Canada were in fact struck at the Regional and National levels. The partnership is based on a combination of the knowledge and expertise of First Nations and Inuit members who have long worked in the substance abuse field and the resources and secretariat services provided by Health Canada.

An interim National Partnership Committee consisting of First Nations and Inuit members was established and mandated by Health Canada to develop a plan to implement the recommendations in the NNADAP Review throughout Canada. At the same time, Regional Working Groups were formed, composed of prevention and treatment representatives selected by their respective First Nation and Inuit authorities. These Regional Working Groups each officially nominated a representative to sit on the National Partnership Committee.

2.5.1.1 - Incorporation of the Partnership as a Foundation

The Partnership Committee was incorporated as the National Native Addictions Partnership Foundation in January of 2000. The administrative office of the Foundation is on the Muskoday Reserve in Saskatchewan.

The rationale for incorporating the Partnership as a Foundation is that the legal status of such a corporate form legally facilitates the Partnership's capacity to actively pursue other sources of funding.

2.5.1.2 - Board Members of the National Native Addictions Partnership Foundation

Foundation Board members are listed in the table below

Member	Region	Telephone	e-mail
Chief Austin Bear President	National President	(306) 764-1282	Merlecrain@sk.sympatico.ca
Lawrence Jeffries Vice-President	Ontario	(705) 336-3450	shladmin@onlink.net
Wayne Christian Secretary Treasurer	Pacific	(250) 546-3077	wmchristian@roundlake.bc.ca
Marilyn Willier, Member	Alberta	(780) 523-4401	Frank_large@hc-sc.gc.ca
Lou Ann Stacey Member	Quebec	(450) 632-6880	lastacey@hotmail.com
Cindy Ginnish Member	Atlantic	(506) 627-4626	egrs@nbnet.nb.ca
Theresa Yetman Member	Manitoba	(204) 484-2256 Ext 224	
Carol Hopkins Member	Representative of the National Youth Solvent Abuse Program	(519) 264-2277	carolhopkins@hotmail.com
Chief Marie Anne Day-Walker-Pelletier, Member	Saskatchewan	(306) 334-2532	
Vern Jones Member	Northwest Territories/Yukon	(867) 874-6581	vernj@thesundog.net
Ainiak Korgak Member	Nunavut	(867) 793-2839	akorgak@gov.nu.ca
Elsie Casaway, Interim Member	AFN	(613) 241-6789	ECasaway@AFN.ca

2.5.2 - DIRECTION OF THE NATIONAL AND REGIONAL WORKING GROUPS

To date, the Foundation has taken on specific roles and responsibilities, including priority projects taken on in response to key Review recommendations and the facilitation of two National Partnership Conferences.

2.5.2.1 - Purpose of the National Native Addictions Partnership Conferences

The Partnership has facilitated two conferences to date, one held on February 25-27, 2000, in Vancouver and the other in Montreal on October 29-31 of the same year. Their purpose was to bring together the Regional Working Groups and the National Working Group to establish a means of working together in order to proceed with planning a follow-up strategy to the General Review.

It was intended by the partners that the planning conferences would emerge with the rudiments of a common vision and mission statement, a statement of shared values and a set of guiding principles. Conference goals also included an identification of key work areas and recommendations regarding the roles and responsibilities of each committee and stakeholder organization and group in promoting adequate follow-up to the Review.

It was anticipated that, subsequent to gathering input from the Montreal Conferences, the National Working Group would prepare a framework document to guide implementation. The document would reflect the opinions of the National Working Group and a synthesis of the specific inputs of the Regional participants at the second planning conference held in Montreal. While there was substantial variation in the actual representation from First Nations and Inuit Health Regions, *all* Regions were in fact represented.

While there was considerable variation in the numbers of representatives from different First Nations and Inuit Health Regions, all Regions were represented at the Montreal Conference. It was also intended that a completed framework document would be prepared by the Foundation and shared with the Regional Working Groups as the template for future directions.

2.5.2.2 - Outcome of the National Native Addictions Partnership Conferences

While partially incomplete in terms of meeting conference goals in their entirety, overall direction for the implementation strategy was given by the Regional Working Groups, as well as a variety of suggestions that were consistent across all groups. The ideas of each working group were taken into account, and supplemented by additional interpretive and analytical work and references to other, relevant, evaluation studies and reviews. These various sources of input were then synthesized to create the framework described below.

3.0 NNADAP RENEWAL FRAMEWORK

This section outlines a set of guiding, philosophical and theoretical assumptions to steer the NNADAP renewal process. It also identifies the core elements of programming to be carried forward and sustained. A summary is provided of the primary gaps in programming, as indicated in the General Review of NNADAP and other, major evaluation studies, as are a set of program enhancements and initiatives to be taken to fill those gaps. Finally, there is an outline of the continuing roles and invited, future roles and responsibilities of stakeholders and partners, both directly within the NNADAP service circle and in overlapping service-providing circles.

3.1 ADAPTATION OF REVIEW RECOMMENDATIONS

It should be noted that the Framework does not simply reiterate the recommendations of the 1998 Review. While the document does not stray far in either spirit or detail from the General Review, it does reflect references to other evaluative studies and further deliberations and judgements regarding the strengths, weaknesses, missing elements, and priorities of the statement of recommendations in the Review. These adaptations have been made by the National Native Addictions Partnership Foundation, with input from the Regional Working Groups.

3.2 MANDATE OF NNADAP

The existing mandate statement for NNADAP continues to capture the fundamental function of the program and, therefore, with minor revisions, it should be carried forward.

In the original mandate statement, the term "substance abuse" was treated as a problem that was in some way distinguishable from alcohol and drug abuse. That usage is inaccurate and confusing. In the professional literature, the term substance abuse is generally employed as a category that includes the abuse of all psycho-active and physiology-modifying (e.g., steroids) and addictive substances. In short, alcohol and drug abuse are two sub-types of substance abuse.

There was also is no clear distinction between "substance abuse" and "addiction" in the original statement. While it is true that the addictive use of any substance can be appropriately described as substance abuse, all substance abuse is *not* addictive behaviour. In fact, most substance abuse is not addiction; it is experimental or infrequent behaviour but it is often accompanied by significant behavioural risks. The renewed mandate statement therefore reads as follows:

> *The mandate of NNADAP is to support First Nations and Inuit people and their communities with the establishment and effective operation of programs aimed at preventing and reducing high levels of substance abuse and addictions.*

3.3 VISION OF A RENEWED NNADAP

Discussions at the Vancouver and Montreal Conferences touched upon many themes directed at renewing the quality, effectiveness and efficiencies of alcohol and drug abuse programming for First Nations and Inuit peoples. Deliberations of the working groups provided suggestions regarding the type of follow-up strategy to the General Review that would best ensure that its most significant recommendations would be realized in practice.

Conference deliberations also gave further affirmation to the conclusions of the General Review and, when synthesized, they yield a relatively clear conception of what the NNADAP infrastructure *should* look like in the future. Taken together, those parameters form a vision of a renewed and more effectively performing NNADAP—a conceptual picture of an improved and nationally, regionally, sub-regionally, and locally integrated system of prevention and intervention services *and* the intended outcomes of that system of services.

Reflecting the spirit of the General Review of NNADAP, 1998, and confirmed through the consultations at the Conferences hosted by the Partnership, the following statement captures the essence of a guiding vision for the end results we are seeking:

> *Assisted by an integrated national, regional, district and local network of both highly effective and culturally sensitive substance abuse and addictions prevention and intervention programs and highly trained, caring and effective service providers, First Nations and Inuit people will gradually liberate themselves, their families and their communities from the burdens of past and present substance abuse and addictive behaviours.*

3.4 MISSION OF THE NATIONAL NATIVE ADDICTIONS PARTNERSHIP FOUNDATION

The mission of the National Native Addictions Partnership Foundation is captured in the following statement:

> *Building on the national General Review of NNADAP, 1998, and other Regional and individual studies, our challenge is to advocate, develop, facilitate, and monitor strategies designed to continuously upgrade and enhance the quality of ideas, information, program methodologies, financial allocations and skills of service providers comprising the program.*

To achieve the simplicity that is often required by the communication requirements of social marketing strategies, the above statement can be reduced substantially; in its short form, it could read as follows:

> *The National Native Addictions Foundation is committed to promoting a capacity-building strategy to renew NNADAP.*

3.5 MISSION OF THE NATIONAL NATIVE ALCOHOL AND DRUG ABUSE PROGRAM

The mission of NNADAP can be stated as follows:

> *Our mission is to promote healthy spirits and sober lifestyles by providing a high quality, full continuum of culturally-sensitive intervention and prevention services in all First Nations and Inuit Health Regions in Canada.*

3.6 SHARED VALUES

The Conferences identified a set shared values to serve as the foundation for NNADAP. These values should inform the style of work, individual and organizational interactions, and the overall direction taken by the national and regional working groups and their individual members. Most important, these values should provide the moral base for the work of management boards and committees guiding direct service delivery, the workers providing the services, and the clients participating in our programs.

The shared values of the stakeholders represented in the Partnership can be stated as follows:

- ***Respect***: This value is expressed by acknowledging the input of stakeholders, through listening in a non-judgmental fashion, by acknowledging and positively affirming diversity; and by encouraging the free expression of diverse ideas.
- ***Accommodating cultural diversity***: Not only must we be respectful of individual differences between our stakeholders, but we must acknowledge the beliefs, norms and sensibilities of the different First Nations and Inuit cultures represented amongst our communities.
- ***Honesty***: In our efforts to improve the substance abuse and addictions services provided to First Nations and Inuit peoples, we should strive to personally seek the truth and to express the truth as we see it to others. Honesty is achieved when there is no intended gap between our stated intentions and our behaviour: We must always strive to "Walk the talk!"
- ***Compassion***: Our work should be motivated by our compassion and kindness. Our compassion is informed by our empathy and should be reflected in our sincere intentions and actions directed at caring for others, especially those among us who are experiencing great difficulties and hardships.
- ***Trust***: We should be bound by an obligation to act in ways that do not harm others. It is through meeting this obligation that trust is established and wise decisions are made.
- ***Family strength***: Our families are the basis of our existence, the foundations of our strength and the cornerstones of our future—and they are therefore profoundly implicated in our healing. We recognize that our belonging to a family need not be through a biological relationship but can also include family relations expressing traditional and contemporary adoption practices and our intimate social networks. We also acknowledge

that our communities should be understood as our extended families. We should therefore work towards overcoming past differences between families and clans that serve as obstacles to community solidarity.

- ***Humility***: In relation to others, especially those who are suffering, we must strive to be humble. Humility inspires hope in others, whereas arrogance encourages a sense of failure and bitterness in those who are witness to but not party to our success. Our humility is a recognition of ourselves as sacred and equal parts of creation, and the honouring of all other individuals in a fashion that acknowledges that, like us, they too are endowed with the same inherent autonomy, dignity, freedom and equality.
- ***Holistic Approaches reflecting the Interconnectedness of Causes, Consequences and Solutions***: In recognition of the fact that substance abuse and addictions problems originate in many causes, are expressed in many ways and are suffered with varying degrees of intensity, our policies and programming must be holistic. This commitment is in keeping with the spirit of the health-promoting traditions of the First Nations and Inuit. In practical terms, this means that our healing efforts should reflect the interconnected nature of substance abuse and addictions problems. Prevention and intervention should therefore be multi-dimensional, aimed at returning a healthy balance to the various spheres of community, family and personal living. NNADAP activities should also combine and integrate community efforts at promoting personal and social development, spiritual healing, social support and economic development.

3.7 PERSPECTIVE ON HEALTH PROMOTION

The fundamental model of health promotion that lies at the heart of future NNADAP efforts will be the *population health model* rather than the disease model. The shift reflects a greater emphasis being placed on prevention. Rather than being a truly new approach, our reference to the population health model reflects a return to spiritual and philosophical themes that are central to Aboriginal traditions in North America. It signals a greater focus on prevention and intervention strategies that recognize and affirm the need to address the several spheres of human activities charted by the Medicine Wheel.

In developing programs, NNADAP initially followed the lead of other North American substance abuse programs in being heavily influenced by what was variously referred to as the *bio-mechanical*, *medical* or *disease* model of prevention and intervention. The disease perspective insisted on viewing the substance abuse client as a "patient" with a "chronic disease" who needed a "cure" through externally administered or prescribed "treatment," typically in a specialized, residential facility, much like a sick person needs a hospital. In determining a recovery strategy, it was assumed that "The expert always knows best."

The disease model did have the advantage of elevating the professional and public view of substance abusers and addicts above the simplistic, disparaging, moral judgements that had long characterized them as having a fundamentally flawed character or for being "sinners." The disease model considered *all* substance abuse as an addiction, a disease that intensified over time once it was contracted. In fact the disease model is flawed by an underlying view

of the substance abuser based on several assumptions since proven false by scientifically credible research.

Contrary to the disease model, all substance abuse is not addiction; in fact, most substance abusers are *not* addicts and the greatest costs incurred by substance abuse is incurred by impaired but non-addicted substance abusers. Nor does substance abuse follow a specific, inevitable course; its pathways are many and varied in their course and individuals experiencing substance abuse problems do not necessarily move, over time, from one degree of severity to another. It is also true that most potential substance abusers learn to avoid such health-limiting habits and learn to live sober lifestyles, and they do so *without* help from experts. It is doubtful that, for most substance abusers, the belief that one has a chronic disease condition that cannot be overcome is questionable at best and self-defeating at worst.

In effect, the medical/disease model tends to "medicalize" what is really a behavioural problem strongly, often overwhelmingly, influenced by social-environmental factors.[1]

The population health model shifts us away from the assumption in the medical/disease model that puts professional — and often "outside" — "experts in the driver's seat." It moves us to a different ground upon which health promotion workers are assistants to capacity-building processes undertaken by individuals, families and communities. In the population health model, health promotion workers from a variety of specialities, whether physicians, nurses, psychologists, traditional healers and addictions workers, spend most of their time assisting individuals and communities with their attempts to increase control over and to improve their own health. Through personal development support and training, community members are empowered to play a far more active and responsible role in self-care. Through community health development, members, local professionals, traditional healers and community leaders join to build a sobriety-friendly, healthy habitat, and to promote healthy, sober lifestyles and balance in community and personal norms.

From the population health perspective, community health promotion is seen to assist with community development strategies based on local needs identification; community-wide or region-wide, inter-agency planning that targets problems in a multi-dimensional, holistic fashion. It also encourages personal and social coping skill development and self-help groups. Rather than being the least powerful level of a public health delivery system directed by large, remote, centralized bureaucracies, communities become the focal point of health service decision-making and operations.

In the population health model, national and regional organizations are viewed as system-wide enablers of community-based and shared service (e.g., treatment centre) programs.

When providing substance abuse and addictions intervention services for the individual, the

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[1] A cursory review of the literature on the subject would include a reading of the following materials: Stanton Peele's *The Diseasing of America* (Second Ed.: 1995); Stanton Peele and Archie Brodsky's *The Truth About Addiction and Recovery* (1991); and Chapter 1 of the *Handbook of Alcoholism Treatment Approaches: Effective Alternatives* by Reid K. Hester and William R. Miller, which calls for a *Public Health Model* to integrate the various types of contributing factors, potential outcomes and remedial strategies into a single, unifying theoretical model.

population health model emphasizes self-exploratory assessment of both the routine and exceptional challenges posed in different spheres of basic living. It also emphasizes training individuals in *self-efficacy*, the psychological notion that, if individuals believe that they can solve problems, they are far more likely to be successful in meeting their goals than if they live with a persistent sense of pessimism and a lack of self-confidence. In substance abuse and addictions work, the population health model encourages NNADAP workers to training clients in therapy to acquire a broad spectrum of coping and social skills that will enable the individual to live a sober, satisfying lifestyle.

In the population health model, the individual with substance abuse or addiction problems is not a person with a disease, nor is s/he "damaged goods." Instead, the troubled individual is seen to be resilient, having powers within to overcome substance abuse or addictions problems: S/he is a full human being with a variety of strengths to draw from.

3.8 GUIDING PRINCIPLES

In attempting to execute its mission within this values framework, NNADAP policy-makers, service providers and partners will be guided by the following principles:

- ***Clients First***: The planning, development and delivery of services will proceed in a fashion that gives supremacy to the principle that the interests of clients must always be paramount, with all other considerations being secondary.
- ***Client Initiative must be Expected and Respected.*** Before beginning any program of change with hopes of success, a person must be committed to taking responsibility for his or her own healing, sobriety and healthy lifestyle choices. Dependency on others is a path that leads to failure. Personal initiative is required for a person to admit to a problem, overcome it and heal the wounds it has created for self and others. NNADAP workers and other First Nations and Inuit Health workers should recognize that a wide variety of circumstances, typically beyond the individual's control, lead to substance abuse problems. Clients should therefore not be blamed for their problems but they should be encouraged and supported in their efforts to take primary responsibility for their own solutions.
- ***Harm Reduction Support Services are Sometimes Necessary***. Some substance abuse clients have experienced so much damage to their physical and mental health that intervention goals must initially be very modest. Building on the individual's strength is still essential, as it is for all substance abusers. What appear to be minor gains for some can be major, even life-saving, achievements for others.. At times, *harm reduction* is the first, most important, and realistic course of action to be taken. In such instances, healing efforts, rather than being aimed immediately at full recovery, might only be oriented to reducing the risks that the client routinely experiences in his or her normal, everyday environment. Small gains can save lives in the short run and serve as the point of departure on a new, less risky and more healthy path through the future.
- ***Accountability and Transparency***. It is fundamental that both management

organizations overseeing NNADAP and service providers themselves carry out their duties in a way that reflects accountability and transparency.

- ***Communication.*** It is essential that the rationale, process and the outcomes of the implementation of key recommendations for changing NNADAP be communicated with all stakeholders. Further, active and continuous communication of relevant information and opinions from service workers, researchers, and clients should be a vital, integral feature of program operations.

- ***Working through Partnerships.*** The NNADAP Renewal Strategy will draw new strength from placing a greater emphasis on working partnerships. Within the NNADAP network, enhanced working partnerships will forge a truly coordinated and integrated system of services between community, district, regional and national stakeholders. The strategy will establish mechanisms to facilitate closer working relationships between First Nations prevention programs and First Nations' treatment centres, as well as between regional and national First Nations agencies and representative organizations. In keeping with the recommendation of the *Gathering Strength: Canada's Aboriginal Action Plan* (1997), First Nations and Inuit peoples and their program organizations will also work in partnership with the federal government, other levels of government, and with the private sector, to jointly identify and address priorities. The partnership with the Federal Government itself is further emphasized in recognition of continued and renewed fiduciary and Treaty relationships, residual role requirements of the Federal government, and official statements of First Nations and Inuit organizations that express the view that Treaty and Aboriginal rights cannot be diminished as a result of the acquisition of service delivery responsibilities by Aboriginal communities.

- ***Capacity-Building is an Ongoing Need***. Program methodologies and human resource development must be continuously and objectively evaluated and adapted and, when necessary modified, changed or upgraded to reflect the needs of clients for effective services.

- ***A System Sensitive to and Respectful of Both Traditional and Contemporary Approaches to Healing.*** As determined by clients, families and communities, both traditional and contemporary approaches to healing will be respected and valued in the delivery of substance abuse prevention and intervention services to the members of First Nations and Inuit communities.

- ***Demonstrably Effective Prevention and Intervention Methodologies.*** Substance abuse and addictions service methodologies should be demonstrably effective, as indicated by scientific, evaluative research. Research and demonstration projects should be supported that make every effort to provide clear, unbiased evidence of the effectiveness of various prevention and intervention methods used with First Nations and Inuit clients.

- ***Services Delivered by Knowledgeable, Skilled Workers***. Substance abuse and addictions services should be delivered by accredited, highly skilled people dedicated to empowering community members in general by sharing prevention skills, as well as by sharing ideas about healing and sobriety management with substance abusers and addicts.

- ***Service Quality Supported by Sophisticated Information Management***. First Nations' substance abuse and addictions program personnel should have access to relevant, comprehensive and accurate information that can inform a range of decisions. Relevant information should be available to support choices to be made regarding alternative healing methods or secondary support needs for clients with distinctive cultural or linguistic needs or with mental or physical challenges.

Taken together, these principles are expected to guide the development and implementation of the program components listed below.

3.9 PROBLEMS AND SOLUTIONS

The most critical gaps in the NNADAP infrastructure and the program elements needed to fill those gaps are identified below. The selection is based on the *General NNADAP Review* of 1998 and further deliberations of NNAPF. These *Program Renewal Elements* will be considered the priority renewal elements by the Partnership.

IDENTIFIED *NNADAP* PROGRAM GAPS	**PROGRAM RENEWAL ELEMENTS**
Networking Deficit: Lack of a fully developed and integrated "system of services"	The following new program elements should be established: 1. An incorporated, **National Native Addictions Partnership Foundation** to guide and monitor a program renewal strategy from a national perspective. 2. A **National Strategic Program Renewal Action Plan** should be prepared annually by NNAPF. 3. **Program Integration.** All addictions programming in both Health Canada and First Nations and Inuit service delivery organizations should be integrated into a single unit nationally and regionally. 4. **Regional Policy and Program Support Councils** should be funded. They would be funded to develop, promote and support the implementation of Regional Stategic Plans for an entire Region 4. **Regional Forums** should be funded annually to bring NNADAP workers together to network, learn from each other, and form Regional policy statements. 5. **Regional Strategic Frameworks and Annual Action Plans** should be prepared to direct programming at the Regional level in concert with the National strategy. 6. **Case Management** practices should be established as a routine aspect of NNADAP service provision. 7. **Professional Supervision and collegial Support for Community Workers** should be routinely available, through shared service arrangements, such as "service hubs" coordinated through treatment centres or multi-community governing council administrations. 8. **Co-ordinated, Intergovernmental Efforts should be Taken to Address the Use and Sale of Illegal Alcohol and Drug Communities.**

IDENTIFIED *NNADAP* PROGRAM GAPS	**PROGRAM RENEWAL ELEMENTS**
Lack of Dedicated Research and Development Program: Research and development is based on a reactive, piecemeal approach, lacks coherency and has failed to provide adequate data on a variety of incidence levels and specialized prevention and intervention needs;	A **Structured Research Program** should be reinstated to support the substance abuse and addictions programming in the First Nations and Inuit Health Branch (FNIHB), with funding made available to support program coordination both in NNAPF and in Regional coordinating bodies. Initial, priority research projects should be aimed at providing an information base on the incidence, consequences and "best practice" prevention and intervention methods to address the following urgent problems: ▸ Group inhalant abuse behaviour patterns in remote communities ▸ Illegal "street" (including intravenous-injection) drug use ▸ Prescription drug abuse ▸ Prevention and intervention service needs of at-risk and currently substance-abusing youth ▸ Nutritional addictions problems and their contribution to obesity, diabetes, heart disease and other illness conditions. ▸ Problem gambling—through Regional initiatives in partnership with provincial and territorial governments
There is an Absence of Experimentation/Evaluation re: Alternative Prevention and Intervention Models	A **Demonstration Program should be Established to Provide Existing Programs with Funding to Undertake Preparatory and Adaptation processes required to test (a) Alternative Community Prevention Programming (b) the effectiveness of Community Counselling Programs (c) Day/Evening Non-residential Programs Offered as Shared Service for Several Communities and (d) Alternative Residential Intervention Approaches.** Successful programs should be considered as potential **Centres of Excellence** that can provide advice, undertake research and offer training in the alternative they have advanced.
Lack of a comprehensive client information system that conveniently enables client information management, program information management, program evaluation planning by community and treatment centre programs, as well as regional and national coordinating bodies.	Development and operation of a new **First Nations and Inuit Addictions Information System** that will serve as a basis for information sharing within and between treatment programs, for case management, for program planning. The system should have the capacity to track the outcomes of interventions and therefore serve as a basis for evaluating the performance of specific programs as well as types of intervention.

IDENTIFIED *NNADAP* PROGRAM GAPS	PROGRAM RENEWAL ELEMENTS
Underdeveloped service information for referrals. NNADAP & other health workers lack ready access to alternative substance abuse and related social/mental health services. **Service Delivery is Inconsistent with the Best Prevention and Intervention Practices**. The program is not carefully linked nor adaptable, in an ongoing way, to program methodologies identified in the research literature as being most effective.	**Development and Implementation of a Registry of Substance Abuse Services and Relevant Social/mental Health Services** that maintains current, alternative service descriptions and provides information on the current availability of services. The most substantial strategy for upgrading program service quality is for the Native Addictions Partnership Foundation to **Organize and Administer an Accreditation Process** that accomplishes the following: ■ An **Accreditation Development Support Fund** will be made available to both treatment and prevention programs to assist them in preparing for accreditation. Funds should be expended to support assistance provided by **Regional Accreditation Development Specialists** contracted by Regional coordinating bodies. ■ **Mandatory Treatment Program Transfer**. For treatment programs to enter into Transfer Agreements, they must, as a condition of the Agreement, secure program accreditation. ■ **Incentives-based, Voluntary Community Program Accreditation**. While accreditation of prevention programs should be voluntary, for community programs to secure access to **NNADAP Renewal Fund** resources (discussed below), they must seek and secure accreditation. In addition, ■ **Codes of Ethical Conduct** for treatment program boards, NNADAP workers, Regional coordinating bodies and the National Native Addictions Partnership Foundation Board should be prepared and adopted, after appropriate consultations. ■ A **Revised Scope of Practice Duties** for prevention workers should be prepared and introduced to NNADAP community workers. ■ **Best practice prevention and intervention models will be learned and adopted**. This will require preparation of curriculum and the delivery of certified training through appropriate training institutions. On-line and other distance education methods might also be utilized to deliver courses to remote communities and treatment centres, as well as to communities or centres which cannot make other arrangements consistent with their practical needs.

IDENTIFIED *NNADAP* PROGRAM GAPS	PROGRAM RENEWAL ELEMENTS
	■ **Guidelines and program models for providing services to specialized populations will be made available**, with immediate emphasis given to supporting ***youth service initiatives,*** including primary and secondary prevention programming.
Skill levels of NNADAP Personnel are Below Prevention and Intervention Standards in the Field.	To fill the gap between current skill levels and reasonable expectations, the following initiatives are required: A **Human Resource Development Strategy** should be developed with National and Regional components. As part of that strategy: ● program and management skill gaps should be identified; ● funding should be available to First Nations and Inuit education and training institutions to develop curriculum and courses consistent with a personnel certification process; ● a review of current prevention and treatment salaries should be undertaken and a new, national salary grid based upon training, experience and remoteness indices should be established; ● Substance Abuse and Addictions Service Personnel Needs should be included in a **National Health Services Work Force Needs Study;** ● A compiled **List of Accredited Training Institutes** that provide Appropriate Programs should be established as part of the overall accreditation process; ● A **Certification Process for both Prevention Workers and Counsellors Should be Established by NNAPF** as part of the larger accreditation process (*Addictions Counsellor Certification should Include a Core of General Counselling Skills, Supplemented by Specialization in Substance Abuse and Addictions Counsellor Training***).** Current training must also be supplemented by programs to enhance knowledge/skills in the following: - Understanding/counselling re: drug abuse - Intervening with populations with special needs - Cultural heritage training and Traditional Healing Approaches - Broad spectrum skills training, e.g., the Community Reinforcement (CRA) Approach

IDENTIFIED *NNADAP* PROGRAM GAPS	PROGRAM RENEWAL ELEMENTS
Program Communications are Underdeveloped	A **National Social Marketing Strategy** should be prepared and implemented to raise awareness of the results of the NNADAP renewal process. The **NNADAP Renewal Framework** should be circulated to all First Nations and Inuit communities and all stakeholder organizations in Canada The **NNAPF Inc. should Produce a National Addictions Prevention Newsletter *and* Website** **"Best Practice" Models and Methodologies in both Prevention and Intervention should be Circulated** to All First Nations and Inuit Communities and Stakeholder Organizations NNAPF will Prepare and Circulate a **National NNADAP Newsletter** with Region-by-Region Contributions from First Nations and Inuit contributors, as well as FNIHB. **Problem-solving 'Hotlines" and Internet Links** should be established to ensure that NNADAP workers have ready access, when necessary to 24-hour, **professional advice re: addictions problems/solutions and mental health problems/solutions**.
Funding levels are insufficient for small treatment programs, professional counselling services in the community, and for community prevention programming.	**Treatment Program Funding Level Review**. Treatment programs should be reviewed to ensure there is a consistency between the needs served by various types and sizes of centre. **Program Funding Enhancement for Prevention Programming** is critical. Further leveraging strategies should be developed by NNAPF and Regions to enhance healthy, sobriety-promoting, community social, recreational and fitness activities. A **Funding Program for Community Youth Programs** should be established**,** with emphasis on intersectoral support in communities and leveraged revenue-sharing.

IDENTIFIED *NNADAP* PROGRAM GAPS	PROGRAM RENEWAL ELEMENTS
	Health Canada should Provide Adequate Budgetary Support to Implement the Key Elements of NNADAP Renewal. The Department should also facilitate opportunities for contributions from other Federal Government departments and identify potential partnerships and other, available funding sources and fund-raising strategies.
Funding for salaries is often too limited to retain highly qualified staff.	**A Salary Review and Revision** should be undertaken with the understanding that, if appropriate, a *more competitive salary grid* linked to experience and training, the population size of the community, and remoteness and environmental risk indices, should be developed and funding based on that grid should be made available, both to treatment programs and prevention programs.
A manual of facility standards is not in place.	A **Facility Standards Manual** should be prepared and circulated to all Regions, to be used as the primary reference for capital construction and renovation; it would describe appropriate space use, building dimensions; access to utilities and water; segregation from nuisances; light exposure; physical view; site survey; site cost and site development cost guidelines; health and safety requirements; bed-space ratios; privacy regulations; male/female segregation guidelines; adult/youth segregation guidelines; counselling space requirements; classroom space dimensions; boardroom/meeting room space dimensions; bathroom size; office; kitchen; work flow; traffic flow; heating/air conditioning standards, equipment requirements; equipment storage needs, "Med" supplies, equipment storage and waste disposal guidelines; file storage need; standards for maintaining confidentiality of client information; landscaping guidelines; and special requirements.
Some facilities are substandard and upgrading is needed.	**Regional Facilities Reviews** should be undertaken and **New Funding for Capital Upgrading Should Be Introduced**.
	Provide capital needed for upgrading and implement major upgrades.
There is a perception that capital and operational funding formulas are insensitive to the needs of outpatient programs.	Review Capital and Operational Funding to Determine Fairness and Efficiencies and **Make Appropriate Adjustments**.

IDENTIFIED *NNADAP* PROGRAM GAPS	PROGRAM RENEWAL ELEMENTS
A full continuum of care is not available to clients:	
■ Program funding for prevention is inadequate.	**Prevention Resources should be Enhanced through Direct Funding and Joint Funding through Partnerships**
■ Counselling clients often do not have access to detoxification services.	**Medical Detoxification Services should be Assured by Health Canada when such services are appropriate** **A Non-medical Detoxification Program should be established in Service Hubs** serving areas with community populations totalling 7,500 people. These programs could be operated by area treatment centres or through paid, in-home supervisors. A *program organization and policy and procedures manual* should be prepared by Health Canada, along with a training video to be sent to each treatment centre and interested shared service area. Funding would be required to support this program element.
■ Assessment, diagnosis is uneven and inconsistent across communities and treatment programs. Poor screening results in unmotivated clients and high drop-out rates	**Assessment and Diagnostic Instruments Should be Reviewed and Revised** according to state-of-the-art assessment standards. Both initial *intake assessment* methods and *diagnostic/goal-setting* instruments, should be revised and models shared with trainers, who should train both community workers and intervention program counsellors in their use. This training should include *guidelines on how to undertake assessments re: dual disorders.*
■ Pre-care is generally underdeveloped	**A Pre-care Program Model should be Developed and Shared with all Community Programs** that includes the *development of Pre-care Guide Books*, and *training for NNADAP Workers* in providing pre-care services.
■ Medical transportation policies lack consistency with the therapeutic needs of clients (i.e., restricted program referral destinations) and is underfunded.	**Revise Medical Transportation Policy and Provide Adequate Funding** to support the revised policy.

IDENTIFIED *NNADAP* PROGRAM GAPS	**PROGRAM RENEWAL ELEMENTS**
Continuum of care deficits/Cont.'d . . .	
■ Professional, out-patient counselling services for substance abuse and addictions is unavailable in many communities. This leaves residential services as the only alternative for intensive problem-solving and healing.	**Professional Counselling Services in Communities Should be Offered on an Out-patient Basis**. All First Nations and Inuit people with substance abuse and addictions problems should have access to counselling *in* the community from (1) certified counsellors working as NNADAP community workers (2) community mental health counsellors trained in substance abuse and addictions intervention (3) certified counsellors available through service hubs, such as treatment centres or shared health service centres.
■ Programming customized for individuals with special needs is generally absent	**Specialized Community-based and Residential Programs** for: 1) Youth 2) Prescription drug Abusers 3) Families: Family/Couples Intervention, non-residential & residential (4) Communities as a Whole: Multi-systemic Community Therapy or Traditional Community Healing.
■ Support for and access to Traditional Healers is difficult. Liability issues serve as an obstacle and transportation support is inadequate.	A **Joint Task Force on Support for Traditional Healing Should be Struck Between Health Canada, NNAPF Inc., and Traditional Healers** and a **Traditional Healing Funding Support Program** should be established, with protocols established to exempt NNADAP personnel and Health Canada from liabilities associated with supporting an individual's choice to consult with and be administered to by a Traditional Healer.
■ Aftercare and follow-up services are minimal.	**Aftercare/relapse Prevention Services should be made available in all Communities**, either through NNADAP community workers or mental health counsellors. These services should include *individual and family counselling*, access to *support groups* and *assistance with securing sober residential accommodations* prior to full re-entry into a home environment. **Every community should have a worker trained in relapse prevention counselling.** **Refresher/booster Programs Should be Available in *All* Treatment Programs** for ex-clients who are at risk of re-

3.10 CONTINUUM OF CARE FOR A RENEWED NNADAP

Recognition should be given to a variety of types and intensities of substance abuse problems. At least two decades of research have contradicted previous thinking that alcohol and drug abuse *necessarily* develops as one type of "disease" and follows, inevitably, through a specific, predictable, progressive set of stages of intensity. In fact, substance abuse takes many forms and does not necessarily move from one stage to another nor does it consistently worsen and create more intense personal problems over time.

3.10.1 - CONTINUUM OF PROBLEMS

Substance abuse problems do vary widely but can be "typed" in a very general sense. They can legitimately be viewed as following into a number of broad categories, including the following (derived from Lewis, Dana and Blevins, 1988, p.6):

- no- or low-risk clients who do not actually use alcohol or drugs and who have never abused them
- moderate, infrequent drinkers who do not drink (or use other drugs) to the point of impairment
- frequent users of mood-modifying substances who hold their intake to pre-set limits
- episodic drinkers who may consume alcohol or drugs infrequently but who exhibit high-risk, bizarre or anti-social behaviour when they do indulge
- frequent, heavy users with moderate health and personal and interpersonal problems as a result of their chronic, heavy use
- alcoholics (or drug addicts) who are severely dependent and whose addictions pose serious, sometimes life-threatening problems.

Figure 2 **CONTINUUM OF POTENTIAL SUBSTANCE ABUSE PROBLEMS**

0	1	2	3	4	5
Non-use	Moderate, non-problematic use	Frequent User, controlled; normal behaviour	Episodic substance user; sometimes or often bizarre behaviour while using	Chronic, heavy user; moderate problems	Acute dependence; life-threatening health problems

* *NOTE:* Within this continuum, it should also be recognized that, in any population of substantial size, a wide range of individual reactions can be anticipated, including:

- variable physiological reactions to the substances, such as varying speeds of alcohol metabolization, the occurrence/non-occurrence of allergenic reactions;
- variable psychological reactions (e.g., passivity responses, thought distortions, hallucinogenic experiences, or anger reactions); and
- degrees of likely "progressivity" (i.e., predictability that an individual at one point on the continuum may move on to more acute problems).

Note: For a more detailed description of the continuum of problems and the continuum of care, please see Appendix C.

3.10.2 - CONTINUUM OF CARE PROVIDED IN A RENEWED NNADAP

To combat substance abuse and addictions in First Nations and Inuit communities, the National Native Addictions Partnership Foundation will promote a full continuum of care. Each of the various categories across the continuum of problems described above call for particular types of service responses, which are described in Figure 3 below.

Figure 3 SCHEMATIC DIAGRAM OF FULL CONTINUUM OF CARE: FIRST NATIONS AND INUIT SUBSTANCE ABUSE AND ADDICTIONS

Primary Prevention	**Secondary Prevention**	**Assessment & Referral**	**Diagnosis**	**Precare**	**Tertiary Intervention**	**Aftercare**	**Booster Programs**
Target: Non-abusers/non-addicts Approaches:, e.g., Health Education; Community recreation; Culture camps; Life skills & Social Problem-solving skill training; Sobriety-promoting community recreation, socializing, cultural and spiritual activities	Outreach to high-risk and early stage problem drinkers and alcohol abusers e.g., Headstart; Therapeutic Recreation for at-risk teens; Impaired driver & impaired work programs; traditional cultural programs	Securing relevant background information on the client, his mental status & social situation & the motivators of substance abuse. Referring a client to a treatment program, based on the assessment	Classifying the problem as a type of behaviour pattern & assessing risks and identifying inter-vention goals	Anticip-atory advice & counsel; family support; assistance with practical affairs; making trans-portation arrange-ments	Intensive intervention, whether: a) out-patient counselling from Traditional Healer or Counsellor; b) short-term residential care (1- 2 wks.) c) Interme-diate term residential (28-35 day programs)* & d) Long-term care : 2+ mos. * e) Family support counselling & self-help f) Ongoing harm reduction	Post-treatment support, including: a) Relapse prevention programs b) Couples therapy c) Family therapy d) job club e) social club f) volun-tary service work	Later stage, formal relapse prevention programs/ stays at residential treatment centres

* Both "c" and "d" of *Tertiary Intervention* include traditional elements & life skills (personal coping) & social engagement and social problem-solving skills.

3.11 COMPONENTS OF A RENEWED AND STRENGTHENED NNADAP

As a national program policy, the renewal of NNADAP must be implemented in a manner that folds recommended changes and enhancements of the program into its existing infrastructure, as well as integrating it with other health, social and community service systems. In its renewed form, the program will integrate all addictions programs, including the National Youth Substance Abuse Program (NYSAP), into a single administrative unit in the First Nations and Inuit Health Branch. It will also depend heavily on our efforts to work in *partnership* with Aboriginal and Non-aboriginal governments, community-based social service and health organizations, and the private sector. The integrated program will consist of the components listed and briefly described below.

3.11.1 - COMMUNITY-BASED PREVENTION PROGRAMMING

The program will fund prevention programs delivered by First Nations and Inuit communities. Financial resources provided will be as follows:

1. to employ trained community workers to provide health education services to children, youth and adults related to substance abuse and addictions problems;
2. to assist with, organize and, when appropriate, coordinate primary prevention programs, such as early childhood development programs, cultural camps, after-school, pro-social recreational programs;
3. to facilitate and, when appropriate, coordinate secondary prevention programs, such as activities for children and youth who have exhibited substance abuse problems;
4. to prepare a community prevention plan consistent with a community prevention planning framework provided by NNAPF Inc.;
5. prevention program funding related to administration and equipment and rental costs identified as needs to support the community prevention plan;
6. completion of an evaluation exercise with annual and 3-year summary research elements.

3.11.2 - COMMUNITY RECOVERY SERVICES

The following problem intervention activities will be supported in the community:

1. problem assessment;
2. diagnostic assessment, including medical examinations, when in-community counselling services are chosen;
3. referrals and transportation services to medical detoxification centres when the need is indicated;
4. supervised, out-patient detoxification services when the need is indicated and medical detoxification is contra-indicated;
5. professional counselling services when non-residential therapy and healing is indicated by the assessment/diagnostic process;

6. pre-care services, when residential treatment outside the community is chosen, including counselling and practical advice for the client and his/her family, advocacy and practical problem-solving assistance, transportation, and information exchanges and planning advice and support with the receiving treatment centre;
7. after-care services, including assistance with re-integration, temporary housing, support with practical needs, relapse-prevention counselling, and support through facilitated self-help groups;
8. data communications in support of an outcome-oriented, client-centred information management system.

3.11.3 - Intensive Intervention

The program will fund the following, non-medical intervention services when a need for intensive remedial healing processes are indicated:

1. when determined to be practically appropriate in a particular health services area, a structured therapy program may provide supervised, non-medical detoxification services;
2. structured, residential therapy programs of various duration, from one week to 3 month lengths, offered to clients whose needs fall within a range of interventions and supports that can be provided by an in-patient centre;
3. structured, residential therapy programs of various duration provided as either (a) a demonstration ("pilot") program to be evaluated as a model to be considered for implementation in other centres or (b) a program tailored to the special needs of specific target groups, such as youth, dysfunctional families, drug addicts, prescription drug users, abused women;
4. a capital program to support residential facilities;
5. structured, day- and evening, out-patient therapy programs, providing healing and personal and social skill development training of vary lengths, as determined by the requirements of the methodology described in the program model upon which the program is based;
6. relapse prevention skill training to out-going program participants;
7. refresher ("booster") programs of 3- to 6 day's duration provided to former clients after a minimum of 6 months sobriety.

3.11.4 - A Renewal Process Guided by a National Aboriginal substance Abuse and Addictions Prevention Organization and Regional Coordinating Bodies

The NNADAP Renewal process will be guided nationally by the National Native Addictions Partnership Foundation Inc. The Partnership Foundation will recommend new program components and enhancements, as well as program elements to be retained. The Foundation will identify renewal implementation priorities and advocate, promote and in some instances directly develop and manage program components.

To promote and maintain communications with the Regions and service delivery sites, the

Partnership will have a Website, have monthly teleconferencing updates, and publish a regular newsletter for NNADAP.

The renewal implementation strategy specific to each First Nations and Inuit Health Region will be facilitated through a partnership with Regional Coordinating bodies, structured according to Regional guidelines.

Regional forums that include NNADAP workers and Oversight Bodies will be promoted in each Region.

Support will be provided for Regional Addictions Policy Forums and the development of Regional Strategic Plans.

Directly in communities, annual prevention plans will be promoted to guide work throughout the year and to serve as a basis for evaluation.

3.11.5 - HUMAN RESOURCE DEVELOPMENT SUPPORT

Through a partnership between Health Canada and NNAPF Inc., a labour market survey will be conducted to determine substance abuse and addictions training needs and the costs of training supplements required to ensure that qualified personnel are in place to meet changing community needs.

Guided by the advice of NNAPF Inc., and referring to a national First Nations and Inuit health services workforce needs study, a *Human Resources Development Strategy* will be prepared that will support curriculum development, training and direct implementation related to the following elements:

- publication, communication and promotion of a Code of Conduct for both treatment program boards and for substance abuse and addictions workers;
- an expanded Scope of Duties for NNADAP Community Workers and Treatment Program workers, as well as a standardized statement of qualifications required for the performance of specific duties;
- a set of guidelines for the evaluation for community programs;
- methodological tools to address the needs of specialized populations, such as youth, prescription drug users, injection drug users, etc.;
- detailed guidelines on expanded treatment modalities, such as pre-treatment, aftercare, cultural camps, couples treatment, and Healing Circles;
- intervention guidelines for work with client groups with special needs, such as individuals with cross-addictions; dual disorders; the age-specific needs of youth; the age- and culturally-specific needs of Elders; solvent abusers; users of "street" or non-medically used prescription drugs; people living with FAS/FAE; and survivors of physical and/or sexual abuse;
- a Registry of Approved Addictions Service Worker Training programs that will be linked to national worker certification and will allow for a learning credit and continuing education program;

- a Staff Development and Supervisory Program provided to community workers on a shared services basis (multiple communities organized through an administrative/service program hub);
- national correspondence training and/or other, electronically-assisted distance learning training provided in skill development areas not accessible in many communities.

Training support will also include the development and implementation of a national NNADAP worker certification process, directly associated with a national program accreditation process.

3.11.6 - Quality Assurance and Continuously Improving Quality

The NNADAP program will sustain the accountability mechanisms already in place, including supervisory processes now in place and those reflected in contribution agreements and transfer agreements. Those measures include policy and procedures manuals and the terms and conditions directing management and reporting systems directing community prevention programs and treatment programs.

In addition to quality assurance measures already in place, program evaluation procedures will be implemented in communities and treatment programs, with significant data provided by the First Nations and Inuit Addictions Information System.and other procedures described in published manuals. This will ensure that envisioned upgrading is not a "one-shot" effort but a continuing process.

The most significant element of the renewed approach to quality assurance in NNADAP is the development of a National Program Accreditation system, overseen by NNAPF Inc. Accreditation of treatment programs will receive developmental support and it will be a mandatory requirement of entering into a Health Transfer Agreement. Financial and developmental incentives will be provided for the accreditation of community programs.

The capturing of program outcome measures in the new First Nations and Inuit Addictions Information System (FNAIS) will also provide the basis for evaluative judgements regarding the quality of services provided.

3.11.7 - Research and Development Support

A research and development program organized nationally through a partnership between NNAPF Inc. and Health Canada will be established as a principal program component. The program will develop project funding criteria, fund projects, and encourage and support projects from treatment centres, communities and Regions that are consistent with the NNADAP Renewal Strategy.

The NNADAP research and development support base will also include the First Nations and Inuit Addictions Information System (FNAIS), which will support case management, program evaluation and quality assurance. The system will integrate information of relevance to the full continuum of care and will include outcome measurements.

3.12 ROLES AND RESPONSIBILITIES OF PARTNERS AND STAKEHOLDERS

This section sets out the suggested and invited roles and responsibilities of the stakeholders and stakeholder organizations intimately involved either in mounting the NNADAP renewal strategy, delivering its existing and enhanced components, or participating in its programming.

The subsequent sub-sections each describe the roles of a specific stakeholder and potential partner.

3.12.1 - CLIENTS

Clients will be invited to provide opinions regarding proposed changes to NNADAP prevention and intervention. As informed and conscious community members, it will also be the role of prevention clients to ensure that the Partnership Foundation, Regional Working Groups and program staff are accountable in that they are consistently developing and delivering an ethically-based, culturally sensitive, and highly professional set of policies and programs.

Clients in treatment will be encouraged to reflect upon and understand the antecedents and consequences of their substance abusing and addictive behaviours. The client's central challenge is to work consciously with or without NNADAP staff or other counsellors to develop the skills to live a sober and healthy lifestyle, responsible to family, friends and community.

Our hope is that the individual community member who is currently *not* a substance abuser, to continue to live a balanced life and to provide support and encouragement for those who are set to begin or are well along the way on a journey of self-discovery and healing.

3.12.2 - COMMUNITY HEALTH SERVICE ADMINISTRATIONS

3.12.2.1 - Boards and Committees

Community Health Boards and Community Health Committees will be asked to review the national and regional NNADAP renewal strategies and to encourage and support the efforts of NNADAP workers to:

- review and organize programming in keeping with prevention and community-based counselling models made available by the Partnership Foundation;
- prepare for and enter into a community program accreditation process.

The Boards and Committees will also be asked to ensure that, when entering into or renewing Transfer Agreements, terms and conditions will be included that support the national and regional NNADAP renewal strategies.

3.12.2.2 - NNADAP Community Workers

NNADAP Community workers will continue to be a focal point of community delivery, with their role gradually being expanded to include professional, out-patient counselling, pre-care and after-care services. The Community Workers will also play the primary role in promoting and adopting national and regional strategies within the communities that employ them.

The Community Workers will also be expected to prepare Annual Community Prevention Plans and to participate in program information management as an information provider and user. They will also be expected to facilitate or undertake the evaluation of the community program, according to an evaluation model prepared by NNAPF.

In relation to the NNADAP Renewal Strategy, the role of the community workers will be to provide advice and opinions to regional working groups and to National Partnership Foundation representatives regarding the financial resource, management, programming, and human resource development needs of prevention and in-community counselling, pre-care (treatment readiness advice and assistance) and aftercare/relapse prevention support.

With respect to the NNADAP Renewal Strategy, specific responsibilities will include:

- serving as a primary source of data collection for the research program of the National Partnership;
- becoming knowledgeable about major new program initiatives arising from the Renewal Strategy and, subject to Health Board and management decisions and the availability of resources, incorporating these initiatives into program operations;
- utilizing newly designed information systems;
- participating in training sessions to implement a mandatory treatment follow-up system;
- learning and participating in training sessions to implement revised community evaluations and community planning and program implementation procedures, including standardized assessment procedures;
- participating in and pro-actively seeking program accreditation through the national accreditation process;
- participating and pro-actively seeking personal certification as a Prevention Program Coordinator and Community Addictions Counsellor
- participating in Area and Regional working partnership initiatives.
- serving as host sites for demonstration programs in community prevention alternatives.
- participating as central functionaries in revised approaches to information-gathering, assessment, non-residential counselling, pre-care, and aftercare approaches;
- providing both critical and constructive opinions and evaluative feedback to regional representatives on the NNAPF Board and to regional organizations responsible for implementing regional strategic plans.

3.12.2.3 - The Community Health Services Staff: The Team as a Whole

It is hoped that the community health team will renew its partnership and enhance the integration of relevant, overlapping work goals with NNADAP services. The NNADAP worker is a part of the "health service team" and other health workers are invited to continue to serve as primary colleagues of the NNADAP Workers. Like other employees of the health service unit, typically, NNADAP Workers will be administratively supervised by Community Health Directors,

The community health workers will also be asked to review the national and regional NNADAP renewal strategies and to play an active role in their implementation. Examples of shared undertakings include:

- community prevention activities that focus on family violence and *Brighter Futures* supports for children and families;
- health education focussed on substance abuse, alcohol and drug addictions, and nutritional addictions;
- participating with NNADAP workers in casework processes focussed on clients with substance abuse and addictions problems;
- assisting with pre-care and aftercare programming by developing team work approaches;
- jointly assisting in the development and management of the First Nations and Inuit Addictions Information System.

3.12.3 - Family Support, Relationship Education and Early Childhood Development Programs

It is intended that NNADAP programming at the community level will be linked in a working relationship to family support and early childhood development programs, such as "day care" and "Headstart." Specific areas of interaction include common, parent-oriented prevention education programming, joint work-up of community prevention plans, and common contributions to case management efforts.

At the local, regional and national levels, partnerships should be established between NNADAP and health education efforts aimed at motivating mothers to avoid substance abuse during pregnancy in order to Fetal Alcohol Syndrome (and Fetal Alcohol Effect). Given the relationship between substance abuse and contact-based infectious disease transmission, similar partnerships should be struck with organizations focussed on relationship education and sexually transmitted diseases, including AIDS.

3.12.4 - Treatment Programs (Including Solvent Abuse Centres)

3.12.4.1 - Management Boards

Treatment Centre Boards will continue to serve as the most immediate policy-making and

general management body overseeing program operations. They will also be asked to review the national and regional NNADAP renewal strategies and to direct and support the efforts of the management and staff of treatment programs to:

- review and organize programming in keeping with prevention and community-based counselling models made available by the Partnership Foundation;
- prepare for and enter into a community program accreditation process.

The Boards will also be asked to ensure that, when entering into Transfer Agreements, terms and conditions will be included that support the national and regional NNADAP renewal strategies.

It is hoped that Management Board members will review and adopt the Code of Conduct prepared and circulated by NNAPF Inc.

3.12.4.2 - Treatment Centre Staff

The treatment centres will be a focal point of implementation for the overall strategy.

Specific operational responsibilities will include:

- continuing to be the direct operational managers and delivery agents for intensive intervention services provided in a residential or group, outpatient format;
- preparing policy and procedures manuals consistent with the National NNADAP Renewal Strategy, including the new Scope of Duties and Codes of Conduct for workers;
- conducting their duties according to formalized policy and procedures manuals;
- serving as a primary source of data collection for the research program of the National Partnership;
- becoming knowledgeable about major new program initiatives arising from the Implementation Strategy and, subject to Board and management decisions and the availability of resources, incorporating these initiatives into program operations;
- utilizing newly designed information systems;
- participating in training sessions to implement a mandatory treatment follow-up system;
- learning and participating in training sessions to implement new treatment models;
- participating in and pro-actively seeking accreditation through the national accreditation process;
- participating in area and regional working partnership initiatives;
- serving as host sites for demonstration programs (e.g., as a “Centre of Excellence) in client- or methodology-specific treatment approaches;
- participating as principal functionaries in revised approaches to information-gathering,

assessment, non-residential counselling, pre-care, and aftercare approaches;

- providing both critical and constructive opinions and evaluative feedback to regional representatives on the NNAPF Board and to Regional organizations that are mandated to develop and implement strategic plans of Regional scope.

3.12.5 - First Nations and Inuit Area and Community Governing Councils

Chiefs and Councillors and Inuit Community leaders will be asked to consciously become acquainted with the national and regional strategies, and to host presentations by representatives of the NNADAP Renewal Framework. Upon agreement with the substance and detail of these plans, it is hoped that community leaders will make every effort to support the upgrading, accreditation, community planning, worker training and new evaluation processes that will be attempted in the single community or group of communities they represent.

Addictions advisory services operating through Area Governing Councils will also be consulted with and asked to play a supportive role in developing addiction services "hubs" in conjunction with community program personnel and treatment centres.

3.12.6 - Regional NNADAP Renewal Coordinating (Working) Groups

The general role of Regional Working Groups will include:

- Participating actively and responsibly in the Partnership Foundation;
- Assisting in the promotion of all national recommendations**;**
- Promoting and facilitating and, in some instances, developing, Regional strategic plans that are consistent with the vision, mission, values, and goals of the National Native Addictions Partnership Foundation's NNADAP upgrading strategy;
- Seeking partnerships and working cooperatively with other regional First Nations and Inuit health policy and service organizations that will assist in the implementation of NNADAP upgrade recommendations;
- Seeking and participating in partnerships and working cooperatively with non-aboriginal and Metis substance abuse and addictions and health policy and service organizations in order to assist in the implementation of the Foundation's implementation strategy;
- In keeping with the recommendations of major regional needs assessment studies and strategic plans and the national Implementation Strategy, promote and facilitate the re-engineering and integration of the First Nations and Inuit treatment system within each Region.

The Regional Committees will also be responsible for the specific responsibilities outlined below.

- Pro-actively supporting the program and personnel upgrading processes associated with the accreditation of programs, training courses and practitioners and encouraging and, when resources allow, assisting communities and treatment centres in their efforts to meet national standards and to achieve accreditation;
- Seeking joint program funding in each of the respective regions;
- Facilitating pilot projects in each region, such as "Centres of Excellence," when special program funding is available;
- Promoting co-operation and participation in each region of all First Nations and treatment centres in the Partnership Foundation's research and development program;
- Establishing a Task Force on the Prevention of Illegal Alcohol and Drug Sales in each Region;
- Establishing Regional information-gathering and coordinated First Nations/Inuit and Provincial-Territorial prevention and intervention approaches to problem gambling;
- Pro-actively promoting accreditation and personnel upgrading in conjunction with the national accreditation process;
- Encouraging NNADAP workers and mental health workers to assist in the development of a treatment network information system and to routinely utilize the system for referrals once the system is up and running.

3.12.7 - NATIONAL NATIVE ADDICTIONS PARTNERSHIP FOUNDATION INC.

The Partnership will primarily be responsible for playing the lead advocacy role at the national level in developing, promoting, steering and monitoring the implementation of the strategic response to the 1998 General Review of NNADAP. The Foundation will also identify subsequent, emerging issues in substance abuse and addictions and formulate and advocate solutions. In all of its undertakings, it will give emphasis to working through partnerships with Regional First Nations and Inuit coordinating bodies and through Health Canada.

In its initial form, namely the National Partnership Committee, the national group was responsible for the initial development work required to "kick off" the organizational arrangements required to establish a disciplined, multi-partite, steering mechanism to guide the implementation of the strategy throughout the country. The national body was responsible for conceptualizing, developing and incorporating the National Native Addictions Partnership Foundation.

The Partnership Foundation is also responsible for working independently and jointly with Health Canada in actively pursuing funding and other resources to assist in the implementation of the Renewal Framework.

The Foundation is responsible for facilitating and synthesizing the outcomes of consultations with Regional Working Groups and other stakeholders.

In addition to its overall steering function, the Foundation will be responsible for managing several projects and for taking the lead role in promoting specific framework recommendations.

Partnership projects now include:

- the First Nations and Inuit Addictions Information System (FNAIS) Project, which will review, revise and integrate the Treatment Activity Reporting System (TARS) and the Solvent Abuse Information System (SAIS). This project should create a far more useful information system that will allow for credible program effectiveness evaluation by including outcome measurement data. It will also provide an accurate referral system for prevention workers to access treatment beds for clients. To date, the Foundation has commissioned a business plan to facilitate access to financial and human resources to undertake a technical study and design proposal.
- The second project is the First Nations and Inuit Addictions Services Accreditation program, which is current focussed primarily on youth solvent abuse intervention centres. The program is being expanded to include NNADAP treatment centres, inviting the centres to participate on a voluntary basis. To date, five treatment centres have achieved accreditation and 13 more are in the process of working through the accreditation process.
- Placing a high priority on communications between the partners, the Foundation has begun to establish a communications strategy that will, at a minimum, include a website, a newsletter, and facilitation of strategy- and issue-oriented forums.

The Foundation will also play the lead role in establishing a research and development program that will include the following projects:

- developing codes of conduct for boards, managers and staff of all NNADAP and solvent abuse programs;
- working with Health Canada to identify specific sources of funding within Health Canada and from external funding sources that can assist with the implementation of the recommendations given priority in the Implementation Framework;
- developing a Task Force on Substance Abuse Patterns of First Nations and Inuit youth. Respond to expressions of interest from various sources to identify, develop and make available resources for specialized counselling, secondary intervention and health-promoting, community recreation programs focussed on alcohol and drug abuse prevention and intervention;
- seeking funding resources to support a Research Directorate and begin the work required to mount the following priority research projects in cooperation with regional partners (and play a lead or joint role in overseeing these projects);
- the Partnership will also promote the establishment of Regional Task Forces on the Prevention of Illegal Alcohol and Drug Sales;
- in conjunction with Health Canada and regional First Nations and Inuit training and research organizations, establish an Internet Support Service for Community Programs;

- participate in a supportive way with other partners facilitating or directly implementing other recommendations;
- Prepare a National Social Marketing Strategy that links prevention goals to the population health model.

3.12.8 - THE NATIONAL YOUTH SOLVENT ABUSE PROGRAM (NYSAP)

The NYSAP management and staff will be asked to be full participants in the national renewal strategy and they will be asked to act as primary implementation agents for solvent abuse programming.

A NYSAP representative will continue to have a permanent seat on the Board of the National Native Addictions Partnership Foundation (NNAPF).

Subsequent to the formal integration of NYSAP within the FNIHB substance abuse/addictions envelope, NYSAP will continue to have program autonomy at the service delivery level and will sustain its own oversight committee at the national level. NYSAP's Board, operational management and staff will be encouraged to become a full partner in all Regional First Nations' substance abuse and addictions policy-making, training and program development activities.

3.12.9 - FIRST NATIONS AND INUIT HEALTH BRANCH (FNIHB), HEALTH CANADA

Health Canada's First Nations and Inuit Health Branch (FNIHB) will be expected to continue as a Crown Agent discharging its fiduciary, Treaty, and other legal and historic obligations to provide health services to First Nations and Inuit people. Specifically, it will be expected to continue to carry out its established managerial and delivery responsibilities for substance abuse and addictions services, including its more limited, residual role responsibilities for transferred community programs and treatment centres.

The role of Health Canada in the NNADAP renewal strategy will be to serve as a supportive partner with the Partnership Foundation. To this end, a protocol agreement will be struck between Health Canada and the NNAPF Inc. to define the terms of that partnership. At the Regional level, Health Canada will be expected to serve as a supportive partner with the Regional Working Groups and Regional Co-ordinating bodies, community programmers and treatment centres.

Health Canada will also work as a partner with Regional First Nation and Inuit NNADAP coordinating bodies in fostering the accreditation process. It will also make every effort to ensure that the principles expressed in the national implementation strategy will be reflected as terms and conditions in Transfer Agreements with First Nations and Inuit communities, Tribal Councils and First Nations.

In consultation with the Foundation and Regional committees, FNIHB will also investigate the advantages and disadvantages of integrating all its substance abuse and addictions programming

and, if advantageous, implementing that integration. Specific responsibilities will include:

- FNIHB will make every effort to support the NNAPF research and development program through direct provision of financial resources, personnel work assignments, and leveraging of funds from other sources;
- providing opinions and recommendations regarding the revised scope of duties for community workers;
- assisting the NNAPF and the Regional First Nations and Inuit coordinating bodies in the development and implementation of an accreditation process;
- in consultation with NNAPF, reviewing and revising the Community Program funding formula;
- by providing funding and administrative support, assist with the establishment of Regional task forces on the following issues:
  - illegal alcohol and drug sales and sales prevention in reserve communities;
  - joint First Nations & Inuit/Provincial-Territorial studies of problem gambling incidence and best practice prevention and intervention methods
  - the introduction of new and revised treatment and prevention models and regional system re-engineering in accordance with regional needs assessments and the national Implementation Strategy

3.12.10 - Provincial and Territorial Substance Abuse and Addictions Organizations

Provincial and Territorial substance abuse and addictions organizations will be asked to become familiar with the NNADAP Renewal Framework and to participate as partners in various aspects of the renewal process. Specific areas of significant overlapping interest include:

- jointly sponsoring or directly conducting research into incidence rates for substance abuse and various substance-based and other addictions, including gambling;
- rationalizing the development of treatment programs in each region with open entry to clients;
- establishing referral protocols to reduce gaps in the continuum of care available within both NNADAP and the provinces and territories.

3.12.11 - Provincial and Territorial Metis Substance Abuse and Addictions Organizations

Metis substance abuse and addictions organizations will also be asked to become familiar with the NNADAP Renewal Framework and to participate as partners in various aspects of the

renewal process. Specific areas of significant overlapping interest include:

- jointly sponsoring or directly conducting research into incidence rates for substance abuse and various substance-based and other addictions, including gambling;
- rationalizing the development of treatment programs in each region with open entry to clients;
- establishing referral protocols to reduce gaps in the continuum of care available within both NNADAP and the provinces and territories.

3.12.12 - MENTAL HEALTH LINKAGES

The renewal strategy should also be linked at several levels to mental health services initiatives.

3.12.12.1 - National and Regional Working Groups on First Nations and Inuit Mental Health Services

It is hoped that the National Working Group on First Nations and Inuit Mental Health Services, comprised of Assembly of First Nations and Health Canada representatives, will pro-actively enter into a mutual strategic planning process with NNAPF.

Joint strategies are possible in a number of areas, including:

- development and joint implementation of community mental health and addictions services models;
- development of integrated, shared service approaches to mental health and addictions services in sub-regional (e.g., Tribal Council) administrative areas;

Similar and overlapping working relationships between NNADAP Regional operations and Regional First Nations and Inuit mental health services coordinating bodies are also proposed.

3.12.12.2 - The Aboriginal Healing Foundation

The Aboriginal Healing Foundation serves as an important funding source for enhancing the capacity of front-line community workers to effectively provide substance abuse prevention and intervention programs. It can also support projects that will assist with traditional healing approaches. Also supported by the Foundation are projects that enhance community and family understanding of the relationship of residential school abuse and substance abuse by recording the stories of local people victimized by first or second generation legacies of abuse.

3.12.12.3 - Area and Community Mental Health Services

At the community level:

- It is hoped that close working relationships between Mental Health Therapists, Elders,

Traditional Healers and NNADAP Workers will ensure that a full continuum of care is possible in each community.

- Mental Health Counsellors can provide client assessments and provide an active role in training NNADAP Workers and other Community Health Workers in assessment procedures.
- Mental Health Counsellors should become proficient in effective addictions and substance abuse intervention methods and when and where necessary, provide professional counselling services related to these problems.
- When proficient, Mental Health Counsellors can provide psychological assessments for NNADAP clients.
- Mental Health Counsellors will combine their work with individual clients by sharing in local case management practices;
- Mental Health Counsellors will be asked to assist in advising and in appropriate instances, providing, prevention and intervention programs for at-risk youth;
- Mental Health Counsellors will also be asked to provide "best practice" advice regarding multi-systemic community interventions for remote communities experiencing widespread high rates of youth suicide or inhalant abuse.

3.12.13 - First Nations and Inuit Educational Institutions

School authorities and officials in schools serving First Nations children will continue to play their current role in providing curriculum "space" for prevention and health education workers to present information on substance abuse effects issues. They can also play a critical support role by participating as a space-provider or delivery agent for after-school, weekend and holiday recreation, athletic, personal skill development programming, as well as targeted, secondary prevention programming.

3.12.14 - Justice and Policing

The fact that substance abuse and addictions problems are so frequently implicated in conflicts with the law and anti-social and violent behaviour patterns

3.12.14.1 - The Department of Justice

The Department of Justice will continue to work with First Nations and Inuit people in developing alternative sentencing approaches. The Department should work closely with NNADAP to ensure that substance abuse and addictions programming is not held hostage by the courts through a process in which the courts treat rehabilitation as an alternative form of sentencing and clients approach treatment as a means of avoiding jail or fines.

3.12.14.2 - Corrections Canada

Corrections Canada should continue to provide substance abuse and addictions treatment to incarcerated First Nations and Inuit people. Culturally sensitive approaches such as pipe ceremonies, Sweat Lodges, and having Elders and Traditional Spiritual Healers available to Aboriginal inmates for consultations should be applauded and expanded.

Corrections Canada and NNAPF Inc. should work on a common strategy for jointly funding half-way houses and other forms of supervised, community residences for offenders with substance abuse backgrounds who are completing periods of incarceration.

3.12.14.3 - Provincial and Territorial Justice and Corrections' Authorities

As well as partnering with Federal justice and corrections authorities on substance abuse reduction strategies, similar partnerships will be sought between NNADAP and Provincial and Territorial Justice and Corrections' Authorities.

3.12.14.4 - Police Services working in First Nations and Inuit Communities

Police services can play a support role by becoming knowledgeable about the population health model of addictions causation, prevention and intervention, and by being supportive of national, regional and local strategies.

Specifically helpful roles for police services include:

- playing active roles in the organization of youth programs;
- participation in role modelling and career day programs for children and youth;
- participating in case management processes with NNADAP workers and other community health team members;
- working at the Regional and service site levels in developing strategies to prevent the illegal sales of drugs and alcohol in First Nations and Inuit communities;
- participation in harm reduction programs focussed on alcoholic and drug-addicted individuals with severe dependency, health and persistent impairment problems.

3.12.15 - Adult Training and Economic Development Authorities

Given the close relationship between socio-economic development and substance abuse and addictions problems, broadly based community prevention strategies should incorporate adult education and training and economic development, job-creation plans.

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Appendix A

RECOMMENDATIONS OF THE GENERAL REVIEW OF NNADAP, 1998

NUMBER	RECOMMENDATIONS
1.	The use of legally obtained and illegally produced and sold alcohol remains a major issue that affects the whole community. It is recommended that there be a renewed focus in commitment which comes both from Health Canada and First Nations to deal with this issue. This should also be coordinated with law-enforcement and crime prevention specialists.
2.	The use of illegal drugs is a rising and pernicious concern at the community level. The establishment of a task force to examine means of dealing with the issue of illegal drugs is recommended. Further, that this task force be composed at minimum of First Nations and Inuit, Health Canada, Justice, RCMP, and Solicitor General. The focus for this task force would be the development of strategies to improve coordination, planning and funding of community needs. Further that the Justice Department, Health Canada with First Nations and Inuit organizations have joint discussions on coordination and funding priorities within the crime prevention funding initiative to deal with the illegal sale of alcohol and drugs.
3.	The issue of prescription drug abuse should be examined. This could be achieved through a review of system delivery and a more thorough examination of this issue through surveys coordinated with the Health Promotion Branch Senior Research Program. The possibility of devoting one or more centres to deal with prescription drug abuse and/or to provide training to communities should seriously be considered.
4.	Gambling is an issue that is on the rise and should be dealt with before it becomes even more pervasive. Health Canada and First Nations and Inuit leaders must jointly negotiate with respective provincial and national beneficiaries of various types of gambling such as lotteries, pull tabs, and casinos. Resources should be negotiated for determining incidence levels, in designing appropriate information campaigns and in providing necessary intervention and treatment services.
5.	Solvent is an important issue. It is recommended that the solvent abuse program be integrated into the overall NNADAP program to enhance success of both programs.
6.	Health Canada should reinstate a structured research program the would provide a means of tracking and anticipating areas of program need. In developing this structured program there should be an implementation committee consisting of persons experienced in research from First Nations and Inuit communities and organizations such as in Addictions Research Foundation (ARF) of Ontario and the Alberta Addictions and Drug Abuse Commission of Alberta. It is also recommended that both Health Canada, AFN and Regional and Provincial First Nations organizations make a commitment to include addictions questions in the next iteration of the First Nations longitudinal health survey currently underway.
7.	To develop revised scope of duties for the community workers, which should take into consideration advanced and basic counselling. There should also be recognition and a training strategy developed to assure that NNADAP workers have skills in areas of grief and loss, family violence, sexual abuse, tobacco, gambling, and other areas. Sample protocols should be developed to assist communities in dealing with 24 hour requirements and means for handling on-call within communities. (This should be related to the recommendations on a national accreditation process.)

NUMBER	RECOMMENDATIONS
8.	There should be work plans and procedures developed to assist workers to focus on areas of need within communities. Health Canada and First Nations should develop strategic and annual priorities that will assist the program in providing necessary focus, leadership, and support to communities. In developing work plans and procedures, the means to be particular emphasis on dealing with prevention, intervention, and treatment strategies for adolescents and in coordinating with other health and social programs within the community.
9.	That there be a National Social Marketing Strategy developed with Medical Services Branch to support program goals in prevention to correspond with the population health model.
10.	There should be an overall program estimate developed for basic coverage for communities to deal with addictions. This costing should be developed from the perspective of types of services and programs that should be made available in each community. Part of the package should identify the context in which advanced counsellors would be recognized and those circumstances whereby part-time workers are necessary. This will facilitate a process by which First Nations leadership can more effectively allocate funds available for the programs and to determine potential shortfalls. Health Canada and First Nations should consider these estimates as a benchmark for all communities in determine opportunities to meet needs. Such a process should be linked to the implementation of an outcome based reporting system.
11.	As part of an overall accreditation process, a group of stakeholders should be involved in developing a code of conduct for NNADAP workers which could be posted in First Nations buildings and in NNADAP offices. This would outline expectations relating to confidentiality, obligations, possible remedies and penalties where there are violations. (See recommendations on training.)
12.	Health Canada in a lead role with First Nations organizations should conduct necessary legal and programmatic research to develop standard protocols for release and sharing of information. There should be a particular focus on networking, information sharing, and protocols with social programs such as child and family services and social assistance programs.
13.	Various organizational models should be documented which will assist in communities to coordinate services and/or integrate NNADAP with other programs and services in particular with health and/or social service agencies.
14.	Health Canada should take a lead role in collaboration with a steering committee of stakeholders to develop facility models, which would enhance client perceptions of confidentiality. This concern is also related to similar requirements associated with program initiatives in mental health, child welfare, and social services. Part of the study should identify costs to make facility, equipment, or office furniture modifications for ensuring confidentiality.
15.	That Health Canada determine opportunities to supplement funding from other sources including provincial and other federal departments for NNADAP Treatment Centres.
16.	It is recommended that treatment centres consider reorienting their summer programs to assist in the delivery of programs carried out in their area cultural camps. It is also recommended that treatment centres who deliver programs in cultural camps do not lose funding
. 17.	It is recommended models be developed to for "couples" treatment. This would be a practical alternative to family treatment, which would eliminate complications arising from having multiple age groups and family units in programs.

NUMBER	RECOMMENDATIONS
18.	It is recommended that Health Canada review its present funding process and formula and factor in isolation, actual costs, effectiveness and efficiency to ensure they are equitable with other services such as provincial addictions agencies. Further that Health Canada and First Nations examine means by which Treatment Centre budgets could be increased to provide orientation, training and treatment in grief, loss, cultural programs and in treating other emerging addiction areas such as gambling, prescription drug abuse, etc. This could be achieved through better coordination and seeking interest with other federal and provincial governments in cost sharing, applying fee-for-service with other programs including child welfare, alternate sentencing and early release programs, etc. Additional monies should be made available to residential treatment centres for the purpose of providing their counselling staff training in mental health areas such as victims of sexual abuse, violence, residential school affects, loss and grief and abandonment issues and general post-trauma processes.
19.	That pre-treatment programs be developed or models for both the community level and treatment centres. Pre-treatment can be defined as an assessment, orientation, and readiness phase to treatment for clients. Length of pre-treatment programs should vary depending on the treatment program itself and range in length from one week to three weeks. That existing pre-treatment programs such as the one developed by Society of Aboriginal Addictions Recovery (SOAR) for Corrections Services Canada be considered as a possible resource.
20.	TARS needs to be revisited with input from all the treatment centres that use this system. Efficiency and cost analysis of either developing a new national system or allowing treatment centres to develop their own data system needs to be explored in order to determine the most effective response to drug and alcohol issues. TARS or its replacement needs to have additional capabilities such as tracking client outcome and measuring quality assurance programs for the treatment centres.
21.	Health Canada, First Nations and Inuit organizations should negotiate accreditation with groups such as Ontario Interventionist Association to utilize certified alcoholism counsellor title or develop a similar accreditation process. The program could also consider granting parallel privileges to individuals with certain educational qualifications as well such as Bachelor of Social Work (BSW), Master of Social Work (MSW), psychology, or other fields which would be considered as equivalent.
22.	That Health Canada and Human Resources Development Canada conduct a labour market survey in Aboriginal health training particularly in areas of alcohol and drug abuse, early childhood, health promotion, mental health. This survey should be aimed at determining resources required due to the changing needs of community.
23.	Health Canada in collaboration with a steering committee of First Nations and Inuit representatives and representative stakeholders within the various NNADAP workers should develop a new training strategy to enable the communities to respond to the directions contained in this review. A second task would be to develop an inventory of courses that may be shared with different jurisdictions. This strategy should include a review of accreditation options and should include development of a strategy to meet the considerations of recognition, targeting of training resources to positions, advance training, and multi-disciplinary training. Health Canada in collaboration with First Nations and Inuit representation should finalize concrete measures through an organized system of capacity building at the community level. That strengthening capacity within the management, planning and evaluation receive priority in the work plan. In finalizing these measures, the concepts presented on Centres of Excellence, Treatment centres as training centres, and promotion of communities as models of best practice should be considered within the overall plan. Coordination with other federal departments such as DIAND and Regional Advisory Board, Human Resources Development (HRD), Corrections Services Canada will be essential to the implementation of common areas of interest.

NUMBER	RECOMMENDATIONS
24.	It is recommended that all addictions programs within Health Canada be integrated into one system for dealing with addictions. This integration should include the development of common strategies for research, information gathering, training, and information dissemination.
25.	That the federal government and First Nations and Inuit organizations encourages models of integrated programming through recognition of such communities as role models and centres for information exchange and training. Further to provide resources to community-based resource centres to ensure that communities do not suffer when they assist other communities. It is further recommended that Health Canada support development of integrated models of health care through funding of an Aboriginal Health Institute and centres of excellence.
26.	It is recommended that Health Canada review financial and program development requirements for treatment in advance of allowing use of treatment centres for other purposes. It is recommended that Health Canada and First Nations consider development of regional and national healing strategies, which would involve working groups consisting of relevant groups such as community NNADAP workers and treatment centres among others. It is further recommended that a study of existing healing lodges be carried out to investigate the potential benefits and liabilities of this approach. Finally, as part of an overall strategy, there is merit in having a pilot project, which would examine in detail, and implications of changing focus for treatment centres.
27.	It is recommended that Health Canada and First Nations and Inuit organizations support communities and treatment programs through funding a National Aboriginal Addictions organization or by funding a strong and distinct addictions element within a National Aboriginal Health Institute. It is further recommended that a directed research program be partially reconstituted as a priority by Health Canada and potentially augmented by funds from the Non-Insured Health Benefits program to deal with alcohol, drugs, solvents as well as emerging addictions issues such as prescription drug abuse and gambling.
28.	It is recommended that Health Canada and First Nations and Inuit representatives implement the centre of excellence concept to promote communities and treatment centres with recognized strengths and expertise as training and support mechanisms for other communities and treatment centres.
29.	Discussions should be held with treatment centres to determine feasibility of having treatment centres as service hubs for community workers in such issues as general orientation, training on referral and assessment, information on addictions and other addictions in coordination needs which have been expressed from both treatment centres and the community level.
30.	Health Canada, through a steering committee of stakeholders should develop and implement a system similar to the Ontario Drug and Alcohol Abuse Rehabilitation and Treatment [DART] system which will assist community workers in determining availability of treatment programs and in matching needs of clients to those systems. It is further recommended that Health Canada develop a basic mandatory aftercare/follow-up system. The Round Lake Treatment centre system should either be adopted or revised to take advantage of quality work done in this area. Similar to the preceding recommendation, this work should be done through the use of a steering committee of key stakeholders. This work would be critical in our implementing an outcome system as described in the preceding paragraph. Ideally, this system would interact with provincial treatment systems as well to make use of other services available; for cocaine addiction, prescription drug misuse, gambling or detoxification.
31.	The Health Information System developed by Ontario Region within Health Canada should be reviewed and revised to serve as an outcome measurement system. This system should be oriented to providing a schedule for followup on clients as well as case management with other providers within the health system such as Community Health Nurses, Mental Health services and other providers using this system.

NUMBER	RECOMMENDATIONS
32.	Health Canada should develop a training package on program evaluation which could be used to train NNADAP staff and treatment centres at the community level to perform effective program evaluation. This training package should address both process evaluation and impact evaluation.
33.	Health Canada in partnership with various stakeholders should develop a list of core indicators to conduct process and impact evaluation of the NNADAP.
34.	There is a need for reliable data collection processes that will provide data on an ongoing basis for case management and for program evaluation. A working group should be established to examine data requirements and potential sources of data for effective case management and for the evaluation of the NNADAP on an ongoing basis. This working group should examine the use of the abuse profile subsystem of the Health Information System as one of the potential sources of data for the NNADAP. It is imperative that any system for collecting data for program evaluation also data to NNADAP staff for case management purposes. The primary focus of such a computerized system should be to support the day-to-day activities of NNADAP staff. If the system does not support the work of NNADAP staff in case management, there will be little support for the system at the community level and the availability of data for program evaluation will be significantly diminished.
35.	Health Canada should clarify or eliminate policies, which have resulted in unwanted barriers to treatment in areas such as transportation to treatment in order to eliminate problem areas in multi-regional issues such as access to specialized programs.
36.	That Internet support the considered for Aboriginal youth focussing on prevention initiatives. Further, that resources to access Internet at a program level the established to assist in national program communications.
37.	That Health Canada in a partnership approach with First Nations and Inuit organizations representatives develop a working group to develop a work plan to oversee response to this review. It is further recommended to establish a six-month deadline for this work plan. Further consideration should be given to establishing regional groups to examine recommendations from this review.

Appendix B

GLOSSARY

Accreditation refers to an objective process by which a licensed, external examining agency determines whether or not a human service or health program meets standards set which describe a minimum of acceptable quality. In substance abuse programming, the process involves a comparison of a program's characteristics with a set of standards set by a legitimate examination body responsible for accrediting substance abuse treatment or prevention programs.

In residential programs, accreditation should cover such aspects of a program as patient rights and responsibilities; the completeness and quality of the continuum of care provided; the assessment of clients; the quality of care; the education of staff; the social atmosphere of the centre; the competence of management; general administration and financial administration the appropriateness of the therapeutic curriculum; the program's cultural sensitivity and capacity to accommodate and serve different personalities, people of different cultural backgrounds, and people with specialized needs. The quality, structural soundness and upkeep of buildings and grounds, and the appropriateness of space and space use should also be examined as part of the

accreditation process. Finally, health and safety standards, access to medical care and psychiatric care, and client and staff security should all be a part of accreditation of residential centres. In prevention programs, consideration should be given to the existence of a community plan, the link between a local needs assessment and goals and objectives of the plan, the support provided for the programming reflected in the plan, the linkage of programming to partnerships with other services in the community, the level of participation in programming, administrative and reporting aspects of the program, and program outcomes, as indicated in evaluation reports and information provided to the First Nations and Inuit Information System.

Accreditation of community counselling programs and outpatient counselling programs would focus primarily on staff qualifications, client rights, confidentiality management, therapeutic approaches, follow-up support, information-management and client satisfaction and outcomes.

Addiction: While the World Health Organization has dismissed this term for being "unscientific" and, instead, recommends the use of the term "drug dependence," when it comes to alcohol or other drug dependence, the two definitions overlap. Many health workers in the substance abuse, mental health and social work fields also believe that the term "addiction" appropriately applies to any habitual behaviour pattern involving substance ingestion that affects central nervous system activity, which creates a psychological and/or physiological dependency that is preoccupying to the point of disadvantage in other aspects of one' life, and is perceived as extremely difficult to overcome.

Certification is a process by which a worker's knowledge and skills are tested and affirmed by an examination body or process responsible for assuring the public that practitioners of a given art, trade or profession meet standards set by already certified practitioners and recognized by the public as legitimate.

Continuum of Care (including assessment, prevention, diagnosis, pre-care, intensive intervention, aftercare): See Appendix C

Elder: An Elder in Aboriginal cultures is an individual of senior years who has gained sufficient respect in his community for his experience, exemplary behaviour and thoughtfulness that his insights and wisdom are considered to be exceptionally valuable. Elders can be especially helpful in providing guidance to individuals and communities of people trying to secure balance in their lives and healing from pain caused by personal troubles associated with substance abuse.

Healing from Addictions: A process of self-discovery in which the motivators and triggers of addictive behaviours are identified, healthy personal and social skills that serve as substitutes for dependencies are acquired, and a lifestyle is pursued in which balance is found in one's spiritual, emotional, physical, and rational aspects of well-being. Ultimately, healing is centred on our search, as human beings, for wholeness—fulfilment, self-understanding, and connection to other people and the Creator—in our fundamental quest in life. However, in today's society, it is difficult to find such wholeness, to feel fulfilled and connected.

Human Resource Development is an organizational strategy aimed at socializing, educating

and training workers for basic employment and for increasing skill requirements and decision-making capacities in a specific organization or employment sector. Like the assembly and development of land or the acquisition of technology, preparation of a work force can be considered a basic factor of production that must be developed by any organization. However, in human service work, it is the organization's most important developmental strategy.

Information Management for Substance Abuse and Addictions Programming. This is an organized system, typically computerized, for engaging administrators and addictions workers in an information gathering process that will assist in planning programs, making referrals, selecting helping strategies, coordinating case management services, and tracking the outcomes of former clients. Such systems can also be used to manage prevention programs. The information must be carefully protected through strict confidentiality management procedures and information sharing protocols (including client information release permission requests). It can be used to inform research and planning at a service delivery site or for regional or national program planning purposes.

Medicine Wheel: Human beings use symbols to express meaning, and meaning is what provides us with purpose and understanding in our lives. The Medicine Wheel is an ancient symbol used by most indigenous cultures in North, Central and South America. The Wheel is divided into sets of four, including the four winds, the four cardinal directions, and four fundamental properties of human health, namely our mental, physical, spiritual and emotional well-being. The Medicine Wheel can be used as an exploratory tool. It acts as a mirror which helps us reflect on the goodness and balance in our lives. It helps us consider if we are living a life that is balanced between our the different aspects of living that are part of our existence.

Problem Gambling: While the means of measuring whether or not one is having problems as a result of gambling behaviour are not wholly consistent, most measures attempt to determine if gambling is reducing funds needed to pay for one's own basic needs and the basic needs of one's family. They also include questions to determine if a person is experiencing escalating indebtedness, tends to borrow from others, and if s/he feels compelled to return to gamble after facing significant losses (*Note*: This is referred to as "chasing"). Another indicator of problem gambling is a compelling attraction to continue gambling, even after gaining a desire to quit because its negative consequences have become apparent and an awareness and worry about these consequences is persistent. Gambling problems vary in intensity and, consequently, people who routinely experience a need to gamble, despite the consequences, are sometimes referred to as "compulsive gamblers" or "pathological gamblers." There is an ongoing debate amongst mental health workers regarding whether or not gambling is properly referred to as an addiction or as a compulsive behaviour pattern.

Professional Substance Abuse and Addictions Counsellor: An individual who is deemed by a recognized practitioner-certification authority to have sufficient theoretical education, skilled training and supervised counselling experience to be accepted amongst colleagues as being qualified to provide general and specialized substance abuse and addictions assessment, counselling and support services.

Professional Supervision is an advisory, monitoring and teaching process by which a more

qualified professional practitioner assists a less qualified practitioner in the growth of his or her knowledge and skills in their common field of practice. Professional supervision is also a form of quality assurance for the client and a means of protecting the reputation of the profession itself.

Residential School Abuse: Residential school abuse refers primarily to the physical, emotional and sexual abuse suffered in residential schools by Aboriginal children at the hands of administrators, teachers and other children. It is sometimes used to embrace a much broader spectrum of abuse that includes the very act of imposed assimilation practices, such as forced English language acquisition, contemptuous references to Aboriginal cultures and punishment for expressing their own traditions.

Residential School Abuse Legacy: 'After-effects' or 'Syndrome": The legacy of residential school abuse may have created a common dysfunctional behaviour pattern typical of what sociologists call "total institutions." A holdover from institutional life, the syndrome is viewed by some Elders and Mental Health Counsellors to be characterized by exceptional dependency during adulthood, deference to authority, low self-esteem, poor motivation to achieve in education and through employment, substance abuse and addictive behaviour patterns, depression, anxiety, and guilt. Socially, it may be associated with immaturity in relationships and inadequate knowledge and motivation for effective parental roles. The syndrome is also characterized as tending to have inter-generational effects: The personal troubles arising out of residential school abuse impacts on dependent children by reproducing the same or similar dysfunctional behaviours in them and which they, in turn, repeat themselves, thus becomeing a multi-generational legacy. Residential school abuse can also impact negatively on spouses and intimate partners. It is believed by many Aboriginal people and the health workers who serve them that another grim legacy of the residential school system is that, all too often, abuse in childhood leads to characteristically unbalanced partnerships.

Social Marketing is a conscious, systematic strategy for enhancing the health or social well-being of a given population by promoting a health-assisting innovation or current practice, or by introducing or increasing the utilization of a particular service or agency. Social marketing involves raising awareness through strategies that may include various forms of personal networking, in-person presentations, letter-writing campaigns, press and media advertising and public service communications.

Substance Abuse: The use of a mood-modifying, psycho-active substance in a fashion that places the physical and/or emotional safety of the user and/or others at risk due to the poor judgement and careless or hostile communications and physical actions accompanying central nervous system impairment. While most substance abusers are not dependent on drugs in a habitual way, their behaviour, on occasion or invariably, is sufficiently destructive that they should seriously consider either quitting heaving drinking or impairing doses of other drugs or learn to control the amount and style of their use within a risk-free limits.

Substance Dependence: This term refers to a condition of psychological and, by increasing degrees, physical, dependence on a psycho-active drug, such as alcohol, opiates, sedatives, amphetamines, hallucinogens, nicotine, or manufactured substitutes for these substances.

Typically such dependence is caused by increasing levels of tolerance for the drug and, often, physical deterioration of physical and mental health.

Traditional Healers: In Aboriginal cultures, a Traditional Healer is considered to be a gifted person who has gained a knowledge of verbal, herbal and ritual remedies and healing practices by learning at the side of a Healer from an older generation. In most North American indigenous cultures, these healing arts are passed down from generation to generation in specific families, although individuals outside of a Healer's immediate biological family can also become a Helper and learn these practices.

Quality Assurance in a health or human service organization, including in substance abuse and addictions programming, refers to all the means by which the clients, patients or consumers of an organization's services are assured that they are being served in a fashion which, at a minimum, meets basic professional standards.

Accountability in a health or human service program refers to the process by which an organization serving a given public provides assurances that is is operating in a fashion that is responsive to the best interests of clients. Those assurances should be provided to the general public, to funding agencies and to clients. Accountability assurances include overseeing bodies, codes of conduct, policy and procedure manuals, supervision and administrative management systems, program evaluations, and professional financial accounting and formal audits.

Appendix C

DESCRIPTIVE ELABORATION OF CONTINUUM OF CARE

A. PROBLEM CONTINUUM

The following is a more detailed description of the types of substance abuser that are identified along the continuum profiled on Page 42 above.

The Abstainer (Acuity Level=0): Individuals at Point "0 "of the continuum abstain from any and all recreational alcohol or illicit drug use. Obviously, a potentially pleasurable product such as a drug always poses some degree of temptation to a non-user; it can be used as a respite from anxiety or buffer against shyness at a social. Further, the vast majority of children and early teens live with environmental constraints which, for the most part, do not make alcohol or drug abuse a realistic option. Yet they are all potential problem users. In short, non-users comprise a vast population that should be the targets of various forms of preventive education, guidance and reinforcement for sober lifestyles. Most of these preventive and educational elements are best handled informally, by parents and peers and the norms of community life. But when large numbers of parents and entire communities have lost their capacity to provide these informal deterrents, formalized programs should be introduced.

The Moderate Drinker or Light Drug User: At Point 1 of our substance abuse continuum, the individual will rarely (or occasionally only) use alcohol or other recreational chemicals, buts/he is able to do so without the typical problems associated with the more serious levels of alcohol or drug use.

Frequent, Low-risk Drinker or Drug User: At point 2, individuals are included who abuse a substance frequently but moderate their drinking and do not enact "drunken" behaviours. The dangers of frequent drinking are real, however: It *can* lead to addiction and is certain to have some negative impact on one's physical health.

The Infrequent but High Risk Substance Abuser: Individuals in this category on the continuum are likely to be seen as a "problem drinker" or "drug user" because their accompanying behaviour earmarks them. Whatever their potential for chemical dependency, their behaviour during or after a relatively rare drinking episode causes their family and their peers to consider them as having an alcohol or drug problem. The behaviour goes through obvious transformation from normalcy to a depressive/self-destructive or manic, hostile-aggressive, eccentric or bizarre behaviour style. This is the "bad drunk," the person who may or may not have an escalating problem but whose tendency to lose control is indicative of a chemically-triggered psychotic reaction—a reaction that calls for a moderation-management or abstinence program and/or therapeutic attention to an underlying psycho-social problem. Often people with significant, independently occurring, psychological problems that are sometimes only latent or not moderately expressed outside of substance abuse episodes fall into this

category.

Chronic Heavy Use with Moderate Problems: For the drinkers and drug abusers who can be situated at Point 4 on our continuum, alcohol or chemical use has become habitual. While the individual may have some concern and employers, friends and relatives may be worried about the person becoming increasingly dependent, s/he may still be able to quit independently or learn to drink in moderation on his/her own if directly confronted or encouraged by family members, friends, employers or a counsellor. At this phase, the individual will demonstrate some classic withdrawal symptoms when unable to continue to use alcohol or drugs. He or she will also experience various combinations of ongoing social, legal, financial, occupational and personal problems while at the same time exhibiting a diminishing capacity to effectively address these problems. Problems become increasingly worse unless the individual breaks the pattern on his/her own or with assistance from others.

Clear-cut Chemical Dependence: At the 5th point on the continuum, the person demonstrates the classic substance dependency or addiction syndrome. Multiple social, legal, financial, occupational and personal problems become increasingly worse. The person will also present various medical conditions, some of which maybe life-threatening.

B. CONTINUUM OF CARE

A full continuum of care should be available to all First Nations and Inuit peoples in Canada. As graphically described on page 40 in the text above, the National Native Addictions Partnership will promote a full continuum of care to combat substance abuse and addictions. Each of the various categories across the continuum of problems described above call for particular types of service responses. These types of problems are described below.

Clients with intensive rehabilitation needs must be served but so must those with high-risk drinking or drug use styles who only abuse on occasion.

Low risk clients in the communities can benefit from programs that educate them about the risks of substance abuse; they can also benefit from recreation programs that provide them with more attractive lifestyle options than activities involving substance abuse, thus positively reinforcing (i.e., rewarding) their non-abusive lifestyles.

Compared to expended treatment dollars, prevention funds have the potential to be expended in more strategically effective, cost-efficient ways. It is also the case that the tragic circumstances of those afflicted with substance dependency and high-risk binge drinking patterns cannot simply be forgotten; their needs do not go away simply because effective prevention programs are given greater emphasis.

It is now conventional in the community/public health and social services field to distinguish several types of organized, preventive responses to perceived risks to the health or social well-being of the public as a whole or to a specific segment of the population. In that literature, the

term "prevention" is used to encompass any type of activity deliberately aimed at health promotion, whether it refers to prevention before the onset of a problem or prevention of continuance of the problem or its harmful effects, once the problem has emerged and is actively implicated in the lives of an individual, family or community.

The following types of prevention activities and interventions should be a part of a continuum of services in a community:

❑ Primary Prevention

The first type, *primary prevention*, refers to strategies directed at the general (or "normal," non-afflicted) population. Its purpose is to preclude the occurrence of problems before they arise.

Primary prevention can refer to education, economic development or other health-promoting strategies that lie outside of substance abuse and addictions intervention. However, *within* the alcohol and drug abuse field, primary prevention can involve either *health education* activities, such as stop-smoking campaigns aimed at educating the public about health risks and healthy lifestyle practices, or it can involve deliberate environmental manipulations such as alcohol control policies or taxation at the point of purchase. The term can also be used appropriately to refer to policies which fall completely outside the mandate of addictions programs. It this category we can include general economic development activities and policies, education, organized recreation, and religious practices, all of which fall outside the formal mandate of substance abuse programs.

If an individual may be developing or has a substance abuse or addictions problem, several other services kick into place along a continuum of care, beginning with assessment and diagnosis.

❑ Assessment

Assessment is the act of determining the nature and causes of a client's problem. During the preliminary period of contact between a counsellor and a client, counsellors gather data according to a pre-established, formally scheduled procedure, in order to increase their understanding of the client and his or her problem. The assessment should begin with an initial intake interview and then move on to a psycho-social an substance abuse history. It should end with an assessment of the antecedents and consequences of the client's substance abuse behaviour and an examination of how the client acquired these behaviours and when and in what circumstances the client abuses substances.

❑ Diagnosis

Once the assessment is completed, the counsellor is in a position to make a diagnostic impression. Various diagnostic approaches are possible, including the diagnostic scales represented in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

❑ Secondary Prevention (Including Early Intervention)

Preventive interventions into problems before they become "full-blown" psychological, social or physical health problems are commonly referred to as "secondary intervention" in the addictions literature. Strategies that are described as secondary prevention generally address groups of children or youth whose deviant or unhealthy behaviours are placing them at some immediate risk, as well as placing them at risk of *habituation,* i.e., acquiring a long-term, habitual, pattern of behavioural problems.

Another type of secondary prevention strategy is more often referred to as *Early Intervention*. These programs tend to be focussed on adults in the early stages of acquiring a problem. The most familiar of these programs in the addictions field are impaired driver's treatment programs and Employee and Family Assistance Programs (EFAPs), both dependent upon coercive referrals from courts or employers. Those referred to such programs are expected to participate in some form of therapy for a substance abuse problem on a conditional basis (e.g., If they don't they will lose their job or spend additional time in jail). Early intervention can also simply mean brief counselling provided to self-referred individuals concerned about a drinking problem that seems to be getting out of hand.

❑ Pre-care

Pre-care refers to the assistance provided by a counsellor or community health service team to a client who is preparing to enter into an intensive treatment program. Pre-care includes preliminary counselling sessions, advice on what to expect in treatment, anxiety-reduction training, advice and information-sharing with the family or partners of the client going into treatment. It can also involve the provision of assistance in dealing with practical affairs, such as family management, household maintenance, dealing with creditors, or legal matters arising out of criminal or civil charges or convictions. Finally, pre-care can involve arranging for transportation to and from a residential treatment centre or out-patient day or evening program.

❑ Tertiary Intervention (Intensive Intervention or 'Treatment')

The aim of *tertiary prevention* is to reduce the prevalence of problems that are already established. Interventions are provided that essentially train individuals how to identify the problems that lead to substance abuse. They also teach participants how to better manage the psychological processes and/or the social milieu that have acted as motivators. It is common to call these programs *treatment* programs, perhaps because of the pervasive influence of the medical and psychiatric field on other occupations focussed on helping people with a variety of behavioural problems, including addictions.

A sub-strategy of tertiary intervention is often referred to as *harm minimization* or *harm reduction*. It is targeted on people for whom the prognosis for overcoming substance dependency is very poor, whether in the short- or long-run. Typically, these individuals, such as chronic skid row drinkers or drug addicts, experience very limited success in

treatment/rehabilitation programs. In some instances, programs to minimize the harm they often experience can provide a more realistic option. Examples include residential shelters, disease screening programs, needle exchange programs for drug addicts, and outreach programs, such as street patrols that place inebriates in protective shelters rather than leaving them vulnerable to the dangers associated with impaired thinking and behaviour.

❑ Quaternary Intervention (Aftercare/Relapse prevention)

It is also possible to speak of *quaternary* prevention, which involves efforts to reinforce and sustain the gains made at the tertiary stage by individuals who have completed an intensive period of therapy. It can involve providing family or couple support counselling and providing advice about or assisting with entry into a half-way house residence. It can also involve arranging for a client to be involved in a job club, recreational activity, occupational training or adult education opportunity, or providing help in finding a job. This is also often called aftercare and, in substance abuse remedial work, one of the key methodologies is *relapse prevention*. Relapse prevention is a method involving the identification of behavioural motivators to substance abuse and the skills required to self-monitor and avoid or neutralize such motivators. While training in relapse prevention techniques is provided in many treatment centres

Also as a part of quaternary intervention, residential treatment programs often provide "booster" or refresher programs for former clients at risk of relapse