



Addictive Behaviours Among Aboriginal People in Canada

The Aboriginal Healing Foundation Research Series

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Prepared for
the Aboriginal Healing Foundation

By
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2007

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The client who shared her story is a testament to the healing and hope that is possible even in the most dire and difficult circumstances. Her commitment to a lifelong journey of recovery illustrates the determination and resilience of those struggling to heal from addictive behaviours. It also affirms the crucial role of those many dedicated workers on the front line whose unflagging, non-judgmental support for people in pain enriches us all.

Heartfelt thanks to the eighteen key informants for contributing their time and expertise. These key informants bring a wealth of experience in research and front-line services among diverse Aboriginal populations; their knowledge and insights have been invaluable in shaping this report. Even so, it cannot begin to reflect all of the best ideas or the rich complexity of Inuit, Métis, and First Nation cultural approaches to health and healing; nor does it assume to have all the answers for preventing and treating addictive behaviours. Those using this report are encouraged to learn more about Aboriginal culture, history, and healing by actively seeking out additional resources and learning opportunities within their communities. Addictions recovery is a lifelong commitment to a journey of transformation and healing taken one step at a time.

Appreciation as well goes to the Aboriginal Healing Foundation research team for their patience and professionalism throughout the evolution of this report; it would not have been possible without their support.

The *Aboriginal Healing Movement* is sustained by an unshakable belief in the wisdom and beauty of traditional cultural teachings. Keepers of these teachings are the many respected Elders from Inuit, Métis, and First Nation communities across Canada. Special gratitude is owed to the Elders of the Ottawa community whose extraordinary generosity, practical good sense, and wise interpretations of traditional teachings are an ongoing inspiration and guiding light. Special thanks go to Grandmother and residential school Survivor Irene Lindsay, Jim Albert, Heather Sole, Paul Skanks, Angaangaq, and Ina Zakal.

This report is dedicated to those Survivors whose courage and determination to heal is an inspiration to all others struggling to restore balance.

Introduction

“Our voices are our medicine and our stories are our medicine and we’re all a bundle of stories.”

Mi’kmaq Grandmother Heather Sole

A Client’s Story of Healing

“My father was a chronic alcoholic. His parents had seven children and five died of alcoholism, including my father. My mom drank also and I started drinking at age eight. I was in and out of group homes and foster care and by the age of fifteen I was ordered to attend AA. I started on IV drugs at sixteen.

Alcohol, drug addictions and sexual abuse were rampant everywhere when I was a kid and I don’t know anybody who escaped it. We were still living in tar paper shacks on the reserve and it was incredible, the poverty and isolation.

I was only 15 to 18 months old when the sexual abuse started from my father and his brother. My father was charged for molesting two other girls but they still left me alone with him. Then the abuse continued from my stepfather and in foster homes. It didn’t stop until I was twelve but by the age of ten, I’d turned my first trick in Winnipeg.

People have to know how this happened so it can be reversed and we can stop the pattern. They have to understand that this is an epidemic—this cycle of abuse of children and then they repeat that abuse to themselves through drugs and alcohol. Now I’m seeing it’s not just me but other people too and there’s tons of us who have lived this.”

Increasingly, evidence shows the most effective addictions prevention and intervention programming for Aboriginal people is grounded in the wisdom of traditional Inuit, Métis, and First Nation teachings about a holistic approach to a healthy life. Aboriginal belief systems have much to teach about a broader approach to recovery because they emphasize:

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

In the context of addictive behaviours, an Aboriginal approach begins with the premise that each of these three areas must be addressed in order to sustain improvements over the long term.

“Good Medicine” is what strengthens the mind, body, heart, and spirit. Stories of healing strengthen and inspire those who hear them; these stories are the “Good Medicine” of the healing movement.

This report explores five aspects of an Aboriginal approach to addictions. This unique approach enframes addictive behaviours within a wider context of Aboriginal history and culture. The report is divided into six chapters:

- Chapter 1 looks back at historical injustices and their impacts on the collective health of Aboriginal people in Canada.
- Chapter 2 describes types of addictive behaviours and the prevalence and impacts.
- Chapter 3 illustrates types of healing models and how the wisdom of traditional cultural teachings and practices is applied in addictions prevention and recovery.
- Chapter 4 shares some stories of hope that demonstrate the uniqueness of an Aboriginal cultural approach.
- Chapter 5 summarizes the most promising practices in an Aboriginal approach to addictions prevention and intervention revealed by key informants, in success stories, and in the literature review.
- Chapter 6 outlines some next steps in the unfolding of the healing journey.

To ground this report in lived experience, each chapter begins with excerpts from an Aboriginal client's story of recovery. Interwoven throughout are quotes from key informants and resource materials. An annotated bibliography of addictions-related resources is appended, as well as fact sheets that provide additional information on addictive substances and types of addictions.

Significant progress has been made over the past three decades within Aboriginal communities to address one of their most urgent, widespread, and long-standing social and health issues—that of addictive behaviours. There are now many stories from individuals, families, and communities that have progressed on their healing journeys. This report shares some of these stories and highlights some promising practices that have shaped their success.

The Aboriginal Healing Foundation (AHF) describes a best practice as “a promising practice or activity that appears to work well and can easily be adapted to a variety of contexts” (Kishk Anaquot Health Research, 2003:66). By sharing these Aboriginal success stories and the most promising practices they have in common, the vision of this report is to:

- enhance the cultural awareness of service providers working with Aboriginal clients and communities;
- encourage a collaborative approach in developing a full continuum of community-driven, culture-based interventions; and
- increase awareness of the enduring beauty and wisdom of Aboriginal cultural beliefs and practices in promoting and sustaining health.

The long-term success rate for addictions recovery, regardless of the population group, has not been encouraging. Because of its alternative, holistic health-promoting world view, an Aboriginal approach shows real promise, not only for Aboriginal programs, but for prevention and recovery programs anywhere.

Methodology

This report was developed through the following process:

1. discussions with eighteen key informants (see Appendix B) from the field of addictions with experience in an Aboriginal context;
2. review of key recent documents including:
 - ♦ Aboriginal Healing Foundation interim evaluation reports of program activity (Kishk Anaquot Health Research, 2002; 2003),
 - ♦ *Mapping the Healing Journey* (Lane et al., 2002),
 - ♦ NNADAP general review and renewal framework discussion paper (National Native Addictions Partnership Foundation Inc. [NNAPF], 2000), and
 - ♦ *Escaping the Legacy: Understanding Addictive Behaviours in Aboriginal Communities in Canada* (Barlow, 2004); and
3. review of the literature.

Looking Back to Move Forward

A Client's Story Continued

"My mother was raised in residential school and I was raised in foster homes and group homes. There is a quote they use when they're talking about residential schools; it's that, 'You have to kill the Indian to save the child.'

That's the whole of what the problem is right there; that's what the biases and prejudices did to us. When you take the children away you take the spirit and the hope from that family and when you do not value and love those children you create people who don't know what love or value is.

It's a long road back from that. It's taking generations to undo what has been done. I had lots of people who tried to show me a different way but I was still so messed up. I did this 'all or nothing' thing, going back and forth from abstinence to relapse for years."

Why Aboriginal History Matters

No other population group in Canada's history has endured such a deliberate, comprehensive, and prolonged assault on their human rights as that of Aboriginal people. Yet, despite growing recognition of past wrongs, many Canadians remain unaware of the full scope of these injustices or their impacts.

Approximately 4 per cent of the Canadian population or more than 1 million people are of Aboriginal ancestry. Of these, approximately 62 per cent are First Nation, 30 per cent are Métis, and 5 per cent are Inuit (Statistics Canada, 2003). Of the approximate 105,000–107,000 residential school Survivors still living, 80 per cent are status Indians, 9 per cent are Métis, 6 per cent are non-status, and 5 per cent are Inuit (Department of Indian Affairs and Northern Development, 1998). These Survivors continue to inspire and shape the Aboriginal healing movement. Their fierce determination to restore health to their communities and the living examples of their own healing infuse recovery programs with hope.

Knowledge of Aboriginal history and experience is especially important for those working in health, justice, and social service sectors. Mohawk Elder Paul Skanks poses these questions to service providers working with Aboriginal clients and communities:

- How can you serve a people you don't understand?
- How can you have empathy for people without an understanding of the issues that brought that person to you for help in the first place, and that impact on them or their family?

Knowledge of the collective experience of Aboriginal people, especially related to the legacy of residential school abuse and its intergenerational impacts, has become a cornerstone of the Aboriginal healing movement. The Aboriginal Healing Foundation (AHF) has identified several learning outcomes of

Legacy education that reflect its importance in healing programs. According to an evaluation study undertaken by the AHF, participants who attended healing programs and received Legacy education show the following outcomes (Kishk Anaquot Health Research, 2002:245):

Table 1) Specific Learning Outcomes

Learn history	<ul style="list-style-type: none"> ✦ demonstrate ability to identify colonial mentality (stereotyping, bias) in action; ✦ know schools where family or community members attended; how students were enlisted to attend, general conditions and academic standards; ✦ know the experiences of family or community members; ✦ able to identify problems in family and community associated with the Legacy.
Understand the impact of the Legacy	<ul style="list-style-type: none"> ✦ new impression of parents and grandparents leading to forgiveness; ✦ identify personal behaviour that is shaped by family and peers; ✦ emerging self image; evaluation of coping strategies; use Legacy knowledge as a basis for self discovery; ✦ make informed choices that will contribute to physical, mental, emotional, and spiritual well-being; ✦ set appropriate goals for their healing journey, make realistic plans, and keep track of and evaluate their progress.
Apply understanding to address the Legacy	<ul style="list-style-type: none"> ✦ offer creative and critical suggestions for action designed to end the Legacy; ✦ perform an activity that demonstrates awareness of their responsibilities as healing Survivors (e.g. share with others, teach, participate in anti-racism programs); ✦ demonstrate concern and care for other Survivors; ✦ use a variety of forms, media, and languages to communicate knowledge and understanding of Legacy.

Learning about Aboriginal historical experiences is also crucially important for service providers to work effectively with Aboriginal clients. All key informants for this report agree that education and professional development related to the Legacy will improve services.

Colonization and Its Impacts

To understand how Indigenous cultures that had flourished for thousands of years began breaking down, giving rise to epidemic levels of addictive behaviours, it helps to look back at history through an Aboriginal lens. Reviewed from an Aboriginal perspective, the history of European contact is a chilling account of unrelenting destruction on a massive scale. Prior to European arrival, estimates show a thriving Indigenous population of over seven million people in what is now North America. Ninety per cent of

this population was decimated through diseases such as smallpox and influenza, war, displacement, and theft of lands and resources causing poverty and starvation.

The origins of alcohol abuse can be found in early Canadian history with the introduction of liquor by European fur traders in the early seventeenth century. Prior to this, drunkenness and violence were virtually unknown to Aboriginal people who had a “very low incidence of violence” in their own communities (Dickason, 2002:261). As well as introducing alcohol, trading practices had a dramatic impact on traditional diet; healthy, natural foods readily available through hunting, gathering, and agriculture were gradually replaced with convenience foods.

Tobacco, which had been cultivated and used respectfully for thousands of years as a sacred medicine for ceremonial purposes, became a commercially grown addictive substance.

Federal policies such as the *Act for the gradual enfranchisement of Indians* (1869), the *Indian Act* (1876) and the creation of residential schools (1892) were deliberate attempts by the Government of Canada to wipe out all traces of Aboriginal cultures including languages, beliefs, customs, and spiritual traditions. The actions carried out under these policies continue to profoundly affect all Inuit, Métis, and First Nation people.

The Indian Act

The *Indian Act* of 1876 detailed the Canadian government’s system for controlling and assimilating Aboriginal people. Through this legislation, First Nation people were denied basic human rights and were made wards of the state.

Many Canadians are unaware that when the South African government was designing its own system of apartheid in the mid-1940s, they studied and borrowed from the “Indian” reserve system in Canada. Some features of the *Indian Act* had included:

- ✦ Native people were prevented from leaving or travelling off the reservations without written permission signed by a government agent.
- ✦ The status rights of Native women who married non-Native men were removed, and their children denied rights under the *Indian Act*; while non-Native women who married Native men, as well as their children, were granted status rights.
- ✦ Traditional spiritual ceremonies were criminalized; anyone practicing them was liable to imprisonment as was anyone who encouraged such practices.
- ✦ Traditional leaders and forms of governance were replaced with leaders and governance chosen by the Canadian government.
- ✦ It was illegal for Natives to kill any of their own livestock or sell any fish they had caught off the reserve.

- Rules from inheritance rights to the smallest details about which crops could or could not be planted, to whom they could be sold, and for what price, were imposed and enforced by government agents.
- Legislation was passed in 1888 to prevent Native people from taking out loans for farm machinery; the reason given by Hayter Reed, then deputy minister of Indian Affairs, was that forcing the Indian to work the soil using only hand implements would help him evolve from hunter to peasant, and only then to modern man.
- In response to Native people organizing to raise money for lawsuits against these injustices from 1900 to 1927, the Canadian government made it illegal to raise money or contribute funds to Indians for political purposes, including land claims.

The Act explicitly prohibited various activities such as alcohol consumption and voting, taken for granted by ordinary Canadians. It also outlawed participation in ceremonies that were central to many Indians, the Sun Dance of the Plains and the potlatch of the Northwest Coast. This is analogous to passing a Catholic Act to regulate the lives of Canadian Catholics that prohibits them from attending mass, or passing a Baptist Act banning baptism (Morrison and Wilson, 1995:608).

Métis Struggle for Recognition

The term *Métis* means “mixed,” referring to the mixed blood offspring of Algonquin, Ojibwe, and Cree women and French and Scottish fur traders. A distinct Métis identity began to emerge in the early eighteenth century as the fur trade became well established. Referred to as “half-breed,” this new nationality was defined by its unique blend of First Nation and European cultural and spiritual traditions, while also being completely distinct from both.

The long struggle for a Métis land base, and recognition of their distinct identity, continues to this day. It is a history marked by broken promises and armed battles for their rights, as well as the now infamous hanging of Métis leader Louis Riel in 1885 after being found guilty of high treason by the Canadian government.

Reflections From a Key Informant

“The pain of exclusion for Métis is that we are not fully recognized as a people unto ourselves because our history has been denied and hidden by the government. People don’t know who Métis are; like the Basques in Spain—they have their own culture, language and history. Métis are a new race, a new nation that combines Cree or Ojibwe women with British men. Even most Métis don’t know why we are considered indigenous under the constitution—it’s because we’re indigenous to Canada. Métis don’t exist anywhere else. And we know about medicines but not about ceremony because for our native ancestors, ceremony was run by men and medicines were the role of women.”

Susan Dahlseide

Forced Relocation of Innu and Inuit

Inuit live in remote areas of the Canadian Arctic, including Nunavut and Nunavik; Innu inhabit the eastern subarctic regions of northern Labrador and Quebec. Inuit and Innu were not included under the provision of the *Indian Act* because regular contact was not established until the nineteenth century.

Although the *Indian Act* only applied to First Nations, the nomadic way of life of the Inuit was also abruptly and dramatically altered by Canadian government policy. Under a policy of forced relocation, both Inuit and Innu were removed from their ancestral homelands and traditional hunting territories to far-off, centralized settlements created by the government. The first official “Eskimo relocation project” took place between 1934 and 1947 when Baffin Island Inuit were removed to Devon Island. This was a “colonization project” implemented jointly by the Hudson’s Bay Company and Canada’s Department of the Interior. Although the official reason given at the time for relocation was to remove families from areas where they were experiencing hardship, the unofficial reason was to reduce administrative and trading costs. This first relocation project ushered in a lengthy process of removal and resettlement in the Arctic. These actions were rationalized by the stated belief that Inuit “would be better off” (Royal Commission on Aboriginal Peoples, 1996:456).

The forced relocation of Labrador Innu began in 1967 when the Canadian government decided to establish industrial and military bases in Innu territory. The formerly nomadic Innu were removed from their ancestral lands to an island in Davis Inlet.¹

Separated from the lands to which they had been culturally and spiritually tied for 6,000 years, social disorders such as violence, suicide, and addictive behaviours began to multiply in Inuit and Innu communities.

Disconnection from ancestral lands caused a deeply rooted collective grief that is still felt today. When Premier Danny Williams of Newfoundland and Labrador apologized to the Inuit in January 2005 for the disastrous consequences of forced relocation, his voice was almost drowned out by the sound of people weeping (Canadian Broadcasting Corporation, 2005).

The Killing of the Dogs

Sled dogs, called “Qimmiit” by the Inuit, were a central feature of Arctic life for over 11 centuries. Each dog was able to pull 45–50 kilograms to distances of up to 70 miles per day. They could also sniff out seal breathing holes, provide a first line of defense against polar bears, and track muskox for Inuit hunters.

Today, the Inuit sled dog or “huskie” has all but vanished, reduced from over 20,000 in 1950 to 279 registered dogs today. Virtually unknown to the general public is the mass killing of sled dogs that took place from the mid-1950s to late 1960s in Canada’s Arctic territories known today as Nunavut and Nunavik (northern Quebec). This time period coincided with the height of forced relocations. According to recent reports,

¹ At the request of the Innu, a second relocation has moved them from Davis Inlet to the new community of Natuashish in 2002.

as many as 20,000 dogs were slaughtered in what officials describe as a necessary action to protect the communities from disease and dog attacks. Interviews with over 100 Nunavik residents who witnessed the killings reveal Inuit were not properly consulted and did not consent to the extermination, nor were the social impacts even considered. One Inuk witness, Susie Aloupa, spoke of her account:

I believe we had eight of our dogs killed. We were informed by the teachers and missionaries that all of the dogs had to be killed. That was not comprehensible as we had no stores, we had no snowmobiles and our dogs had to be killed! How were we to go on? I had numerous small children to take care of and their father had no choice but to approve of the killing. We heard that the police of whom we were 'iligasutuq' (intimidated by) were to do the killing. We were informed that there was a small child attacked and killed in Kangirsuk and that was the reason for having to kill the dogs although no one was ever attacked by dogs in our community (as cited in Makivik Corporation, 2005: section D, para. 10).

A recently produced film, *Echo of the Last Howl*, uses documentary footage and re-enactments to depict the heartbreaking effects of the slaughter and what the loss of the sled dogs has meant to the people of Nunavik. The loss of the dogs and of hunting as a way of life created growing economic dependency and contributed to physical inactivity. The trauma of witnessing the brutal killing of their animals and being helpless to prevent it is an emotional pain still carried by many Inuit. The Makivik Corporation, which administers the Quebec Inuit land claim, has collected dozens of stories from eye witnesses and produced a film about the massacre. It has also submitted a report of its findings to the Canadian government, demanding a full inquiry, an apology, and compensation.

Residential School Abuse

The Aboriginal Healing Foundation's *Program Handbook* defines "residential school" as the "Residential School System in Canada, attended by Aboriginal students. It may include industrial schools, boarding schools, homes for students, hostels, billets, residential schools, residential schools with a majority of day students, or a combination of any of the above" (Aboriginal Healing Foundation, 2001:5).

When the residential school system was created in the late 1800s, the prevailing belief was that "Indians" were "savage" and in need of "civilizing." In the opinion of church and government officials, the best way to accomplish this was to bring Aboriginal children completely under the control and influence of church-run boarding schools. The purpose of residential schooling was to separate children from the "evil surroundings" (Fournier and Crey, 1977:55) of their families and communities, and indoctrinate them into the ways of Canadian society. The educational curriculum was primarily aimed at preparing them to join the "lower fringes of that society" (Dickason, 2002:315).

From the opening of the first residential school at Brantford, Ontario in 1831 to the last closure in 1998, approximately 130 schools were in operation and hundreds of thousands of Aboriginal children were enrolled (Aboriginal Healing Foundation, 2006). During this 167-year period, five generations of some Aboriginal families had spent their entire childhood institutionalized in these schools. Although the stated purpose of the schools was to provide an education to Aboriginal children, they were subjected to continual, relentless denigration in order to assimilate them into mainstream culture.

In one of the first published accounts of residential school abuse in Canada, Fournier and Crey point out that the notion “Kill the Indian in him and save the man” (1997:55) was a watchword of Richard Henry Pratt, who established the first residential school for the United States government in 1878. This model was recommended to the Canadian government in 1879 by the minister of Indian Affairs. The notion of killing what was “Indian” became a popular slogan for assimilation. In the context of residential schools, it meant “killing” the children’s Aboriginal languages, cultural beliefs, and identity by teaching them that they were sinful, dirty, and wrong. As well, many children were physically and sexually abused, often by multiple perpetrators, over their entire decade-long residency in these schools:

As more became known about the extent of sexual abuse within the school system, some have suggested that the residential school system was nothing short of ‘institutional pedophilia’ (Tait, 2003:68).

The following are some examples of abuse described by residential school Survivors:

Psychological and Emotional Abuse:

- Continual shaming by name-calling, such as “heathen” and “savage.”
- Humiliation and degradation, such as being forced to crawl at the feet of those in authority, scrubbing floors or toilets with a toothbrush, being forced to wear diapers for bedwetting, and to wear soiled clothing as punishment.
- Taught to believe that women are inferior to men, and Aboriginal people are inferior to white people (Chansonneuve, 2005).

Physical and Sexual Abuse:

- Sexual assault, including forced oral-genital, masturbatory, or sexual intercourse between men and women and the girls and boys in their care.
- Sexual touching and fondling of children by those in authority.
- Arranging or inducing abortions in female children impregnated by men in authority.
- Beating children to the point of unconsciousness, drawing blood, breaking or fracturing bones, or inflicting serious injuries causing deafness or other permanent disabilities or chronic pain.
- Severe torture when children spoke their own language or tried to escape, including needles stuck in the tongue, lye soap in the mouth, or beatings.
- Beating naked or partially naked students in front of other students and authority figures.
- Starving or isolating children who were sick; forcing them to eat their own vomit.
- Withholding medical treatment from children who were suffering the effects of abuse or illness, sometimes to the point of causing death (Chrisjohn and Young, 1997).

In 1907, both the *Montreal Star* and *Saturday Night* reported on a medical inspection of the schools that found aboriginal children were dying in astonishing numbers. The magazine called the 24 per cent national death rate of aboriginal children in the schools (42 per cent counting the children who died at home, where many were sent when they became critically ill), “a situation disgraceful to the country” (Fournier and Crey, 1997:49).

As more and more Aboriginal children spent their childhood in these environments, their families and communities became inundated with people suffering from unhealed trauma, grief, and rage. Increasingly, Survivors turned to addictive behaviours and other negative ways of coping to numb their grief and pain. Some expressed this grief as lateral violence directed toward family and community members, creating intergenerational cycles of unhealthy relationships mirroring those in residential schools.

The long-term social and psychological impacts of policies such as the *Indian Act*, forced relocation, and residential schooling are seen today in disproportionately high rates of suicide, addictions, and violence in the Aboriginal population. These symptoms of social distress have received worldwide media attention over the past two decades, but their origins have not. It is only recently with the silence of residential school abuse broken that the experiences of Aboriginal people in Canada are reaching broader public awareness.

The impacts of residential school abuse continue to reverberate in Aboriginal families and communities as they struggle to recover from the magnitude of their losses. These losses include:

- for over a century, many Aboriginal children aged 4–18 had virtually no experience of family and community life;
- families were deprived of ordinary bonds of love, care, and pride and the right to parent their own children;
- traditional knowledge about parenting skills and child development were destroyed;
- loss of language and the ability to communicate with Elders;
- theft of homelands and ancestral territories diminished hunting, fishing, and agricultural skills;
- economic self-sufficiency and an ancient, deeply spiritual connection to the land was undermined;
- denigration of spiritual traditions led to loss of cultural identity and pride;
- loss of feeling loved, valued, and cared for led to an inability to trust in self or others; and
- loss of self-determination undermined the capacity for hope.

There are four churches that have issued apologies: the United Church of Canada in 1986; the Oblate Order in 1991; the Anglican Church in 1993; and the Presbyterian Church in 1994 (Bavelas, 2004). Although the government of Canada has never apologized for the human rights violations of residential school policy, a *Statement of Reconciliation* was issued in 1998 that contains the following reference to physical and sexual abuse:

The Government of Canada acknowledges the role it played in the development and administration of these schools.

Particularly to those individuals who experienced the tragedy of sexual and physical abuse at residential schools, and who have carried this burden believing that in some way they must be responsible, we wish to emphasize that what you experienced was not your fault and should never have happened.

To those of you who suffered this tragedy at residential schools, we are deeply sorry (Government of Canada, 1998:2).

Because many addictions workers are unaware of this tragic history, they are also unaware of the unresolved trauma underlying addictive behaviours; nor are the origins of other social problems facing the Aboriginal population fully understood, such as suicide and violence. Even with the best of intentions, this lack of cultural competency carries with it the risk of Aboriginal clients being revictimized instead of being helped. It is crucial that non-Aboriginal service providers increase their awareness of the barriers faced by those Aboriginal people seeking help for addictions.

Intergenerational Impacts of Residential School Abuse

To get a full picture of the mental, physical, emotional and spiritual impacts of residential school abuse from an Aboriginal perspective, it is helpful to understand some of the core Indigenous beliefs about health and well-being. A central belief in an Indigenous world view is that all things are interconnected: the past, present, and future; people and all of creation; individuals and their families, communities, and nations; and within each person the body, mind, heart, and spirit.

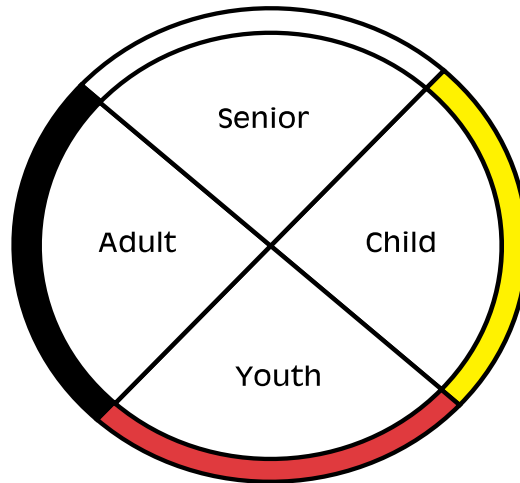
Within Inuit, and perhaps all land-based indigenous cultures, all aspects of life are seen as connected to each other in a web of infinite relationships. No part of life is separate from another part. All animal species, all vegetation and mineral life are related to each other, and to the earth. Nothing and no one can be understood outside of their place within this larger web of relationships. It is not possible to understand one person, or one event by itself, without putting that person or event in its full historical, biological and spiritual context (Levan, 2003:3).

One of the enduring symbols of this belief system is the *circle*. For many Aboriginal cultures today, the circle continues to represent balance and connection within a context of ongoing change. Because change in nature occurs in cycles, transformation is understood to be a natural process that is part of all things in creation. This traditional belief was known among many Indigenous cultures as Natural Law or teachings of the Medicine Wheel, Sacred Hoop, or Circle of Life. In this belief system, the sense of oneself as a sacred being with a spiritual connection to all other things in creation is a core aspect of health and well-being.

Because all beings and things in creation are seen as interconnected in a greater, sacred “whole,” it follows that disruption or disconnection of any part to the whole can cause great damage. When this sense of the sacred is lost or disrupted, people may destroy others, the environment, or themselves. Every culture develops its own understanding of what is needed for healthy development at each stage in the life cycle. Many Inuit, Métis, and First Nation cultures hold special ceremonies to mark an individual’s progression through these stages, celebrating the changing seasons of life from birth and childhood through youth and adulthood, old age, and death. The following figure is one interpretation of a Medicine Wheel² teaching that describes four milestones in the cycle of life, each with its own developmental task. This model is useful in showing how residential school abuse impacted mental, emotional, physical, and spiritual development throughout the life cycle.

² Model developed for the Ontario Aboriginal Healing and Wellness Strategy, Draft Interpretative Framework (Aboriginal Healing and Wellness Strategy, 2005).

Figure 1) Cycle of Life



Child Development: The first milestone of life is childhood. Each new child is welcomed as a sacred gift whose first developmental task is to learn safety, security, and belonging. By watching and play-acting what adults do, children learn that everyone and everything in creation has its own unique value, place, and purpose. From this place of safety and belonging, children learn to trust and develop confidence in others and themselves.

Traditional families valued each individual. They were strong and supportive and each member developed a sense of being accepted by, and likewise accepting, the others around him or her—nuclear family members, extended family and the entire group (Minor, 1992:53).

From as early as four years old, generations of Aboriginal children were abruptly removed from their place of belonging in family and community life. Upon their arrival at residential schools:

- their heads were shaved,
- they were assigned unfamiliar names and/or a number, and
- they were forced to wear unfamiliar clothing, eat unfamiliar foods, speak an unfamiliar language, and practice an unfamiliar religion.

The despair of young children separated from home and parents for the first time was ignored. Any return to their former way of life was forbidden, often by way of severe physical punishment; many were physically abused for violating rules, such as “no contact” with siblings or not allowed to speak their own language. Those who tried to run away were hunted down, returned to the schools, and brutally punished in front of their peers.

Young Aboriginal children quickly learned that their caretakers were untrustworthy, and the institutions they were forced to live in were sterile and potentially dangerous. They learned they no longer belonged with their families or communities, but could never belong to the white world either. For many it was an unsafe, uncaring place.

Youth Development: Young people learn the interconnection between trust and truth as they continue to grow through positive interactions with others. Youth is marked by the struggle to come to terms with the concept of a higher ideal and a deeper personal longing for meaning and purpose in life.

At residential schools, Aboriginal youth began their day very early with mass or religious teachings, followed by work in the fields, barns, or school buildings. Although much of this work was far beyond the age or physical capacity of the children, they were punished or humiliated if their performance was not satisfactory.

Inuit, Métis, and First Nation children were taught that their ancestors were “savages” who were doomed to “burn in hell,” and that cultural traditions spanning thousands of years were irrelevant at best, and destructive at worst. They were taught to practice a shame- and fear-based spirituality that reinforced disconnection from their culture and identity. As a result, generations of children were denied an experience of themselves as sacred beings, worthy of love and respect. In the words of Elder/Survivor Alex Skead:

In residential school, we were told that if you follow what your mother and father are doing in Native culture, you will go to hell with them, because they are going to hell, and that hurts a child. Then we were told that if you follow the church, you will have eternal life. That is the way we were taught, we could not even use our own language, we were slapped around, kicked around for doing so (as cited in Kulchyski, McCaskill, and Newhouse, 1999:193).

Children and youth were also taught that their normal sexual development was sinful and shameful. At puberty, girls were forced to bind their breasts, and there was a strictly enforced rule forbidding any contact with the opposite sex. Many endured the additional trauma of sexual abuse over the course of their entire childhood, often by multiple perpetrators. The longing of youth for meaning and purpose in life was undermined by these experiences. Because they were unable to change their situation in any healthy way, their formative years became characterized by helplessness, dependence, and unexpressed pain.

Adult Development: Adults are responsible for using their knowledge and skills to build healthy lives for themselves, their families, communities, and nations. It is now their turn to love, provide, and care for children and elders as they were once loved, provided, and cared for; creating for others the safety and security they experienced.

At the age between 16 and 18, young Aboriginal people left the institutional life of residential schools to either return to their home communities or begin life in the cities. For most, the skills they had learned in residential school in the fields, kitchens, and sewing rooms and the quality of classroom education were inadequate for economic self-sufficiency. As a result, in addition to being psychologically traumatized, many young people left these schools undereducated and unprepared for meaningful employment. Most crucially, parenting, relationship, and social skills were neither modelled nor taught in the sterile institutional environment of residential schools. Survivors had difficulty creating relationships with others because they had been deprived of the experience and feeling of being loved, cared, and provided for.

Senior Development: In the final stage of life, the wisdom of experience is shared for the benefit of others through thoughtful guidance and transfer of knowledge. Cultural teachings and knowledge are a vital part of a living tradition, ensuring the well-being of each generation that follows.

With the loss of language, Aboriginal children, youth, and adults could not benefit from the oral teachings of the Elders and grandparents or receive guidance that may have helped them to heal from the abuse they had suffered. As well, the spiritual beliefs and practices that help heal and sustain people through hardship were still illegal under the *Indian Act*. As the century passed, up to five generations of families spent their childhood in this way, and there were fewer Elders who carried the traditional teachings:

Beyond the impact on individuals of abrupt separation from their families, multiple losses, deprivation, and brutality, the residential school system denied Aboriginal communities the basic human right to transmit their traditions and maintain their cultural identity (Kirmayer, Brass, and Tait, 2000:608).

Residential School Policy and Human Rights

Residential schools could be viewed through a wider lens as part of a broader political understanding of historical events. Aboriginal children being forced to attend residential school could be viewed as an act of “aggressive assimilation” or “cultural genocide.” The Convention on the Prevention and Punishment of the Crime of Genocide includes in its definition of “genocide:”

[A]cts committed with the intent to destroy, in whole or in part, a national, ethnic, racial or religious group ... Forcibly transferring children of the group to another group (United Nations, 1948: Article 2).

Taking Aboriginal children away from their families and giving them to members of another group was not restricted to just one generation. For as many as five generations, Aboriginal children in Canada were taken away from their families and communities to be taught shame of their heritage, language, customs, and spiritual traditions by people of another race. Although not all were physically or sexually abused in these schools, the act of forcibly removing and shaming children is a cruel and unusual form of emotional abuse, as well as a violation of basic human rights:

It is a fundamental human right for parents to nurture, to protect, and to love their children. It is a fundamental and basic human right that parents raise their own children. It is a fundamental right that parents determine their own children’s culture and heritage, and what their own children learn.

These fundamental rights were seized, and are still being seized, from Aboriginal people in this country. Aboriginal children were seized from their homes and forcibly placed in sterile, military-like, hostile institutions called residential schools.

These places of horror were invariably run by people who, themselves, never had children, and whose only goal was to “civilize.” This process took place during the child’s most essential stages of development. There [sic] resultant breakdown in our communities emerged from helpless parents left with nothing to live for and children raised in racist hostility and dispassion (as cited in Miller and Chuchryk, 1996:x).

The roots of addictive behaviours are found in the impacts of this mass psychological trauma and these human rights violations. Unexpressed and unhealed, these impacts have manifested in social disorders. Cultures that had never before seen youth suicide, addictive behaviours, substance abuse, or physical and sexual abuse began a spiral into tragedy.

An examination of current commentary on the Canadian residential school system highlights how destructive and damaging the system has been for Aboriginal people, past, present and future. Much of the contemporary discord in Aboriginal communities, such as increased prevalence rates of substance abuse, family dysfunction and suicide, have been linked to intergenerational impacts brought about by residential schooling (Tait, 2003:60).

Addictive Behaviours and Residential School Abuse

A Client's Story Continued

"I was trying to treat my symptoms of anxiety and PTSD [post-traumatic stress disorder]. I was suicidal; I just wanted to die everyday. I couldn't eat or sleep and I had body memories every day and was dissociating all over the place.

I felt like I was damaged goods and I was never going to go anywhere. I was despondent and hopeless and they just let me be that way and they let me wail and whine. They never said I was a bad person and they always understood, they said, 'Why wouldn't you feel like this?' That validation finally made me okay."

Early childhood experiences lay the foundation for healthy development throughout the lifespan and through the generations. Children who are nurtured and cared for become, in turn, parents who are able to understand and meet their children's needs for physical, emotional, and mental health.

Healthy self-expression is one of the building blocks of positive character traits such as self-respect, self-care, and personal responsibility. These in turn generate feelings of respect, care, and responsibility for others. A core Aboriginal belief is that positive parenting is a process of role modelling on how to identify and express thoughts and emotions in healthy ways. Contemporary theories of mental health are also useful in understanding the psychological and social impacts of residential school abuse. *Attachment disorder* and *complex post-traumatic stress disorder* help explain how the trauma of residential school abuse has passed from generation to generation in Aboriginal families.

Attachment theory emphasizes the crucial importance of early caregiver-child bonding in mental, physical, and emotional health. According to this theory, mental health in adulthood is dependent upon a secure base in childhood where children are "nourished physically and emotionally, comforted if distressed, reassured if frightened" (as cited in Saakvitne et al., 2000:18). Although attachment is essential for healthy development throughout life, the **mental health** of children is especially shaped by how well their anxieties about abandonment and separation are addressed. Children who are comforted through these fears learn that their caregivers are dependable, caring, predictable, and trustworthy. As a result, these children are better able to form emotionally healthy and secure attachments.

Attachment also plays a central role in healthy **physical** development by regulating physiological arousal (Saakvitne et al., 2000). Infants and young children express separation anxiety as agitation and acute distress, which heightens their state of physiological arousal. When a caregiver responds to a child's distress by providing comfort and reassurance, the child is calmed both physically and emotionally. In this way, the child gradually learns "to internalize the external soothing and calming from caregivers, and is increasingly able to self-regulate or self-soothe" (2000:19). According to Saakvitne:

"The long period of parental care we [humans] require profoundly shapes our minds and brains, and it provides the foundation for all subsequent development. Ideally, parenting is the

essential buffer against trauma” ... Survivors of childhood trauma have the dilemma of having experienced both the overwhelming arousal of abuse, and the absence of adequate soothing and comforting. Thus, survivors are both often in a state of hyperarousal and particularly unskilled at self-soothing” (2000:18-19).

Children who are punished for expressing separation anxiety, deprived of healthy caregiver bonding, or abused in their early years may develop attachment disorder. In adulthood, this can be characterized by the following:

- coping with distress by self-punishment or attempts to stop any feelings at all;
- inability to self-soothe in healthy ways;
- inability to develop relationships based on mutual trust; and
- avoidance of help-seeking behaviours (Saakvitne et al., 2000).

Dr. Brenda Saxe, an addictions specialist who is one of the key informants, describes addictive behaviours as a way of coping with emotional pain, “a way of self-soothing that is not appropriate.” Residential schooling brutally severed generations of Aboriginal children’s attachments to family and community, placing them in sterile institutions among strangers. Children who expressed their fears and anxieties about this separation were at worst punished, and at best ignored. Some Survivors of residential schools describe carrying, as young children, mental images of their estranged parents and grandparents. These mental images helped the children self-soothe and ward off feelings of intense isolation that would otherwise have been too overwhelming.

The psychological and social effects of forcibly removing Aboriginal children from their families have passed from generation to generation. Survivors and their descendants report difficulties forming trusting attachments with others, including their spouses, children, and grandchildren. The inability to form trusting, supportive attachments, compounded by the inability to self-soothe in healthy ways, has contributed enormously to the level of addictive behaviours in the Aboriginal population.

Reflections From a Key Informant

“Because trauma is a breach of trust, an amazing breach of trust and because what we have done to the Aboriginal community is so traumatizing, we have to respect the fact that it is difficult and sometimes impossible for them to trust someone who fully does not understand their experience. That’s the point we have to start at.”

Dr. Brenda Saxe

Post-traumatic stress disorder (PTSD) refers to the psychological impacts of an overwhelming experience of fear, horror, or helplessness. Symptoms of PTSD include:

- re-experiencing the event through nightmares or flashbacks;
- avoiding anything associated with the trauma through numbing or feelings of detachment from the external world; and

- hypervigilance or increased arousal causing sleep disturbances, exaggerated startle response, or outbursts of anger.

In order to cope with trauma, the mind and body find ways of managing that enable the person not only to survive but also to continue on in an almost “normal” way. These coping mechanisms come into play both during and after a traumatic event to help keep feelings of fear, horror, or helplessness at bay that would otherwise be overwhelming. Two coping mechanisms relevant to addictive behaviours are *dissociation* and *re-enactment*.

Sometimes referred to as a trance state, *dissociation* is a natural way of coping with intense emotions that are too overwhelming to manage. Dissociation allows people to put themselves outside of the pain of an experience by disconnecting their feelings from their thoughts. Dissociation permits them to detach from a traumatic event by not allowing it into consciousness or memory. Children who are traumatized early in life learn to escape emotionally from situations where physical escape is not possible. According to Judith Herman (1992), survivors of **prolonged** childhood abuse develop the capacity for dissociation “to the extreme” sometimes to the extent of borderline or multiple personality disorders.

Dissociative states range along a continuum from mild symptoms, such as daydreaming or time loss, to intense symptoms, such as multiple personality or dissociative identity disorder. Survivors of childhood trauma may also use drugs, alcohol, or other addictive behaviours as dissociation strategies to block or disconnect from any strong feelings, whether positive or negative.

Re-enactment is another way of coping with psychological trauma. Some survivors become compelled to unknowingly re-enact aspects of their traumatic experience in a disguised form. This allows them to regain feelings of power and control that had been taken away by the abuse. Because the initial trauma was marked by feelings of overwhelming helplessness, the ability to control re-enactment can evoke exhilarating feelings of power and triumph. Regardless of how it is done, re-enactment carries all the emotional intensity of the initial event. Re-enactment can take many forms, including compulsive behaviours, such as playing chicken, slashing, burning or cutting, unsafe or rough sex, sex with multiple partners, starvation or compulsive eating, or abusive relationships that repeat the harm, *whether from or against* others.

Self-abusive behaviours can take a variety of forms - a readiness to take unsafe physical risks (e.g. reckless driving, unsafe sexual practices, etc.), alcohol or drug addictions or active self-mutilation are some of the more common ones (as cited in Barlow, 2004:11).

Complex post-traumatic stress disorder refers to the psychological impacts of traumatic events: “*prolonged, repeated trauma can occur only where the victim is in a state of captivity, under the control of the perpetrator*” (Herman, 1992:377). According to Herman, repetitive trauma appears to intensify the symptoms of PTSD, especially the practice of dissociation. Cynthia Wesley-Esquimaux and Magdalena Smolewski propose an even broader, historical context for understanding psychological impacts of prolonged and repeated trauma unique to the Aboriginal population. They suggest “chronic, complex or endemic PTSD first manifested itself in Aboriginal communities over 500 years ago” (2004:52). They point to the massive collective suffering that has disrupted Aboriginal families and communities since contact, beginning with the staggering loss of life from diseases introduced by Europeans, and continuing with the loss of ancestral lands and acts of cultural genocide:

For Aboriginal people, loss of their cultural identity was not an abrupt event, but continued in one form or another through centuries of intense pain and suffering, and they were never able to reach the recovery stage. In a sense, they are still grieving their losses with only limited outside social resources to help them in the process (2004:53).

Wesley-Esquimaux and Smolewski (2004) apply the model of *historic trauma transmission* (HTT) developed by Maria Braveheart to the intergenerational impacts of ongoing and repeated trauma from residential school abuse. "Historic trauma" refers to a series of traumatic events occurring over time with no opportunity for recovery and rebalance between these events. Rather than one area of impact, there are multiple, cumulative areas of impact that emerge as social disorders, each with its own cluster of symptoms. Social disorders are "repetitive, maladaptive social patterns that occur in a group of people and are associated with a significantly increased risk of suffering (for example, post-traumatic stress disorder, disassociative disorders, etc.)" (2004:65). According to the HTT model, the impacts of historic trauma are transmitted to each successive generation through four channels:

1. biological (through symptoms of PTSD that are passed along genetically);
2. cultural (through storytelling, culturally sanctioned behaviours);
3. social (through inadequate parenting, lateral violence, acting out of abuse); and
4. psychological (through memory processes) (Wesley-Esquimaux and Smolewski, 2004).

The HTT model is useful for more fully understanding the wide-ranging impacts of mass historical trauma on the Aboriginal population. Linking a history of uninterrupted traumatic experiences directly with widespread dissociative disorders places addictive behaviours within a broader social and political context.

Psychiatrists, psychologists, anthropologists and social workers agree that experiences of violence and trauma from massive and horrific death, coupled with the loss of everything safe and familiar, have profound influences on psychological functioning; sometimes, to such an extent that people are unable to think or behave flexibly anymore (Wesley-Esquimaux and Smolewski, 2004:79).

The Cycle of Trauma and Addictions

Research consistently reveals a strong link between PTSD and alcoholism. Studies of Vietnam veterans show more than half of those diagnosed with PTSD subsequently developed signs of alcohol addiction. Similarly, studies of women who had been raped during childhood identified alcohol abuse as a coping strategy to reduce PTSD symptoms. A study of inpatients receiving treatment for substance abuse found that 40 per cent also met the criteria for PTSD (Volpicelli et al., 1999).

A review of case files for 127 Aboriginal Survivors of residential schools who had undergone clinical assessments in British Columbia also revealed an increase in substance abuse. Of the 82 per cent who reported that their substance abuse behaviours began after attending residential schools, 78.8 per cent had abused alcohol (Corrado and Cohen, 2003). An earlier survey in 1990 of Native treatment centres across Canada revealed that 80 to 95 per cent of their clients had been victims of child abuse. Employees of these programs report that they now see "alcohol and drug addiction[s] 'merely as symptoms' with sexual abuse as the underlying cause" (Fournier and Crey, 1997:116).

Many Survivors of residential school abuse became caught in alcohol and drug addictions or compulsive behaviours, such as eating, sex, or gambling, to numb painful memories or regain feelings of power and control. Dr. Brenda Saxe, a key informant, notes:

What differentiates someone who is highly sexed from someone who is really addicted to sex, is that the sex actually makes them feel worse in the long run, although there may be very short-term positive feelings. But there's a cycle that goes with it which is, activate, have their conquest, then they actually go into a severe depression where they feel awful, they can't calm themselves down, and because they can't calm themselves down they feel more anxious, upset, unhappy; and therefore they go out looking for another conquest. ... this pattern becomes repetitive, a *re-enactment* over and over again, with usually the same patterns and it's not something they can control. It's not something where someone can say, 'I choose not to have sex with that individual today.' They can't do that—it's like: 'I've got to have my fix. If I get my fix I'll feel better. I better get my fix.' And then it makes them feel worse."

Dr. Dennis Kimberly, another key informant, estimates that in his Labrador clinic addictions caseload, the proportion of clients who have experienced either physical or sexual violence is *close to 100 per cent*. He notes "there is a *transgenerational repeating* of these patterns and one of those is physical and sexual trauma—you end up with an interactive effect and it's a problem that is unspeakable as is the sexual abuse."

Reflections From a Key Informant

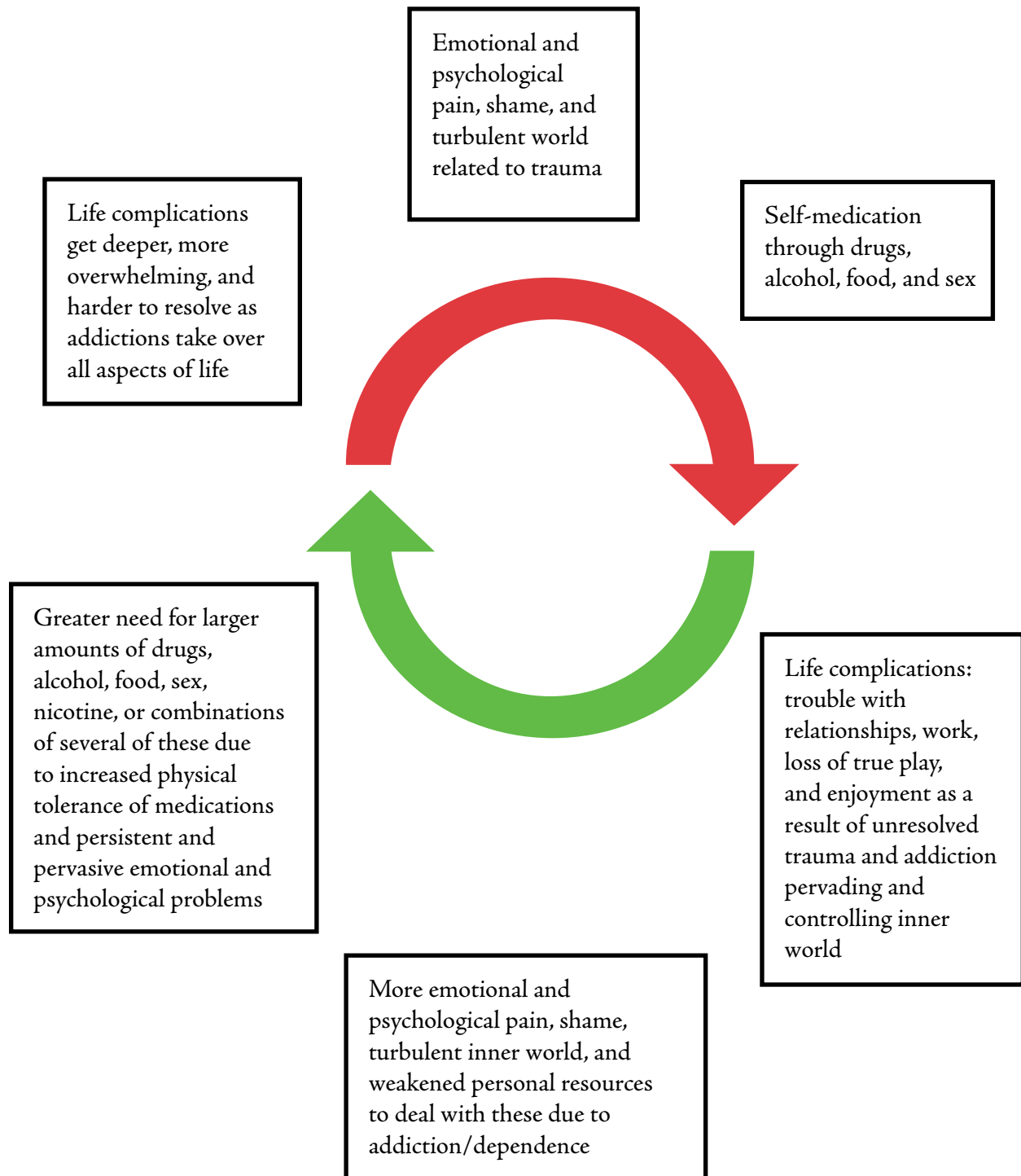
"Identity, abuse, abandonment and isolation are the four main issues underlying addictions."

Susan Dahlseide

Social indifference allowed the tragedy of residential school abuse to continue unabated for over a century, impacting generations of Aboriginal children in Canada. Cloaked in silence, its unacknowledged and untreated psychological effects have passed from generation to generation in an ongoing cycle of abuse, trauma, and addictive behaviours.

Intergenerational or multi-generational trauma happens when the effects of trauma are not resolved in one generation. When trauma is ignored and there is no support for dealing with it, the trauma will be passed from one generation to the next ... Children who learn that physical and sexual abuse is "normal," and who have never dealt with the feelings that come from this, may inflict physical and sexual abuse on their own children ... This is the legacy of physical and sexual abuse in residential schools (Aboriginal Healing Foundation, 1999:A5).

Figure 2) Cycle of Trauma and Addictions³



³ Jane Middleton-Moz, Trauma and Addictions Conference, Journey to Wellness Workshop, Ottawa, ON, September 2004.

Prevalence and Impacts of Alcohol Abuse and Substance Abuse in the Aboriginal Population

According to a report from Health Canada (2003), alcohol (73%) and drug abuse (59%) were considered problems in First Nation communities. Also, 1 in 5 Aboriginal youth reported having used solvents; of these, 1 in 3 were under the age of 15, and over half started using solvents before age 11.

A study by the National Native Addictions Partnership Foundation Inc. (NNAPF) (2000) found that the primary addiction or substance abuse problem for clients in NNADAP treatment centres is alcohol (58.4%). Other drugs, such as narcotics (12.2 %) and hallucinogens (8.6%), were identified by more than 20 per cent of NNADAP clients. A report from Health Canada (1998) also mentioned that the use of alcohol (87.75%) and illegal drugs (77%) were deemed the most frequent or constant problems by service providers and community leaders.

Pauktuutit Inuit Women's Association (2002) reports that Inuit identify alcohol and drug abuse, family violence and abuse, and suicidal behaviour as their most prevalent mental health problems.

The cause of death due to alcohol use is 43.7 per 100,000 in the Aboriginal population, almost twice the rate of the general population (23.6 per 100,000); and death due to illicit drugs is approximately three times than the rate of the general population (National Native Addictions Partnership Foundation Inc. [NNAPF], 2000). Health Canada (2003) reports that injury and poisoning is the leading cause of death for children through adulthood (accounting for 40% of deaths among males). Suicide and self-injury accounted for 38 per cent of deaths among youth and 23 per cent among adults aged 20 to 44.

Other studies reveal the rate of injury and poisoning for First Nations is four times that of the general population, and suggest that these high rates of hospitalization and deaths due to injury, poisoning, and suicide "are all closely related with impairment from alcohol and other psycho-active drugs" (NNAPF, 2000:5). Three top issues identified by Royal Canadian Mounted Police (RCMP) detachment commanders for all 566 Aboriginal communities they service directly related to drugs and/or alcohol are:

- assaults;
- alcohol offences; and
- property damage (Shirley Cuillierrier, key informant).

The rate of incarceration for Aboriginal youth in 2000 was 64.5 per 10,000 population, compared to 8.2 per 10,000 population for non-Aboriginal youth; of these, 1 in 6 were suspected or confirmed with fetal alcohol spectrum disorder, and 8 in 10 had a substance abuse problem (Latimer and Foss, 2004).

The impacts of addictive behaviours on children are far-reaching and unspeakably tragic. In January 1999, the report, *No Safe Haven: Children of Substance Abusing Parents*, states:

- children of parents who have a drug and alcohol addiction are almost three times more likely to be physically or sexually assaulted, and more than four times more likely to be neglected than children of parents who are not substance abusers; and

- children of substance-abusing parents suffer low self-esteem, depression, self-mutilation, suicide, panic attacks, truancy, and sexual promiscuity, and will replicate later in life the drug and alcohol abuse problems they witnessed in their parents (National Centre on Addiction and Substance Abuse, 1999).

In reviewing the report, *Family Violence in Canada: A Statistical Profile*, statistics showed that:

- 6 per cent of people whose partner is a frequent, heavy drinker will experience spousal violence;
- Aboriginal women are three times more likely to be victims of spousal violence than non-Aboriginal women;
- almost one-half of Aboriginal victims of spousal violence (54%) experienced more serious forms of violence at the hands of their partners than non-Aboriginal victims, such as being beaten, choked, threatened with or had a hand gun or knife used against them, or sexually assaulted;
- almost one-half of Aboriginal people who were assaulted by a spouse reported that a child had witnessed the violence, and the majority of these were female victims;
- overall, rates of spousal homicide among Aboriginal women are more than eight times higher than for non-Aboriginal women; and
- among Aboriginal men, the rates of spousal homicide are 18 times greater than for non-Aboriginal men (Canadian Centre for Justice Statistics, 2005; 2001).

Aboriginal youth are at two to six times greater risk for every alcohol-related problem than their non-Aboriginal counterparts. They are more likely to use all types of illicit drugs than non-Aboriginal youth, and they will begin using substances (tobacco, solvents, alcohol, and cannabis) at a much younger age than non-Aboriginal youth (Currie, 2001). Major factors in the sexual practices of Aboriginal youth are the use of alcohol and drugs, and there is a high rate of teen pregnancy among this group (Anderson, 2002).

The prevalence of prescription drug abuse accounts for 48 per cent of Aboriginal people using addiction treatment services; of these, 74 per cent use benzodiazepines and over 60 per cent are poly-prescription drug users. During a one-year period in 2000, there were 1 in 3 status Aboriginal women over the age of 40 in western Canada who were prescribed benzodiazepines. The number receiving benzodiazepines through Non-Insured Health Benefits increased by 25 per cent in just over four years. The impacts from the use of this type of drug include: auto accidents, fatalities due to overdose and suicide, and policing impacts due to violence, aggressive behaviour, and theft; increased falls and fractures; and frequent and intensive use of the health care system due to mental and physical health problems caused by the use of this type of drug (Currie, 2003).

According to *A Statistical Profile on the Health of First Nations in Canada*, the rate of smoking among First Nation individuals is 62 per cent, almost three times the national rate of about 23 per cent. Inuit have the highest rate of smoking at 72 per cent. The rate for both First Nation and Inuit people who began smoking before the age of 16 is 60 per cent (Health Canada, 2003).

A 1987 study found that Inuit, Dene, and Métis children aged 5–9 years old have high rates of smokeless tobacco use (12% of boys and 4% of girls use snuff, and 7% of boys and 2% of girls use chewing tobacco). Another study in 1990 found that 30 per cent of Aboriginal children in Saskatchewan between 7 and 21 years use a smokeless tobacco product. A 1997 British Columbia study found that Aboriginal people are twice as likely to be exposed to tobacco smoke at home (15% vs. 6%) and at work (11% vs. 6%)

than other British Columbians. The highest incidence of exposure is at homes of relatives and friends (67%) and at restaurants, bars, and clubs (80%). Also, Aboriginal children are more likely than non-Aboriginal children to be exposed to environmental tobacco smoke (ETS) at home (27% compared with 15%). Evidence suggests that ETS contributes significantly to respiratory disease in Aboriginal children (Canadian Paediatric Society, 1999).

Commercial tobacco use is a leading cause of preventable death in Canada. Although smoking has generally decreased over the past two decades, tobacco-related death and illness rates remain very high, especially among Aboriginal people. First Nation populations on reserves have a 40 per cent higher rate of stroke and a 60 per cent higher rate of heart disease than the general population of Canada. One of the major causes of death—lung cancer—is prevalent among Inuit women who have the highest rate in the world.

Prevalence and Impacts of Gambling

According to a National Native Addictions Partnership Foundation report, virtually all studies of First Nation and Inuit respondents show rates of problem gambling far higher than the general population and suggest that “gambling is often seen as a ‘replacement addiction’ for abstaining, former alcoholics” (NNAPF, 2000:9).

The Nechi Institute for Training, Research and Health Promotion (2005) conducted a study in 1995 on gambling among Aboriginal youth in the Alberta school system from grades 5 through 12. They found that the children and youth who had a gambling problem were more than likely to have one or both parents who also gambled. The study reports that:

- over 89 per cent have gambled for money in the past year;
- the average age at onset of gambling activities is 11, with 25 per cent beginning before age 10;
- gambling activities with the highest prevalence rates are bingo (57%), cards (49%), scratch tabs (48%), betting on sports teams (42%), and betting on personal skills games (35%);
- gamblers are more likely to also smoke tobacco, use marijuana, and drink alcohol than non-gamblers;
- gamblers are more likely than non-gamblers to have experienced physical abuse and to have their property damaged or stolen;
- gamblers had family members who committed suicide (15%); and
- gamblers had experienced violence (71%).

Relationship and Sexual Addictions

The National Council on Sexual Addiction and Compulsivity (NCSAC) defines sexual addiction as “a persistent and escalating pattern or patterns of sexual behaviors acted out despite increasingly negative consequences to self or others” (n.d.: para. 1). Sexual addiction affects both men and women, heterosexual and homosexual, and it appears to be common among those people who also suffer from other addictive disorders such as drug abuse (Herkov, Gold, and Edwards, 2001). Many addictions specialists and front-line workers involved with Aboriginal communities believe that the disproportionately high rates of relationship and family conflict arise from the same type of dependencies that characterize addictive behaviour patterns (NNAPF, 2000).

Statistical information is not available on the prevalence of sexual addictions in the Aboriginal population; however, Aboriginal sexual offenders comprised 17 per cent of the offender population in provincial institutions between 1989 and 1990 (the second largest group) (Hylton, 2002). There have been high incidences of sexual assault found in many Aboriginal communities (National Crime Prevention Council, n.d.).

Summary

Addictive behaviours and substance abuse have taken a terrible toll on the Aboriginal population, contributing to far greater incidences of accidents, disease and illness, violence, and death than in the general population. Alcohol and drug abuse are still the most prevalent and urgent types of addictive behaviours in Aboriginal communities today (Lane et al., 2002; NNAPE, 2000). Effective long-term solutions have been hampered by the lack of cohesive public policy, lack of cultural awareness in mainstream health and social services, and lack of infrastructure in Aboriginal communities. The following chapter shows that this situation is steadily improving. Understanding the long-term impacts of residential school abuse is another step on the path toward more effective addictions prevention and intervention. With this understanding, strategies that fit with the underlying causes can be developed.

As with other self-harming behaviors, addictions serve the function of managing feelings, isolation, and self-hate (representing poor self capacities), and thus represent an attempt to solve a problem (Saakvitne et al., 2000:97).

Using the Wisdom of Culture to Promote Healing

A Client's Story Continued

"Everything that has ever happened to me has led me to here. I've always been in touch with nature and animals but knew nothing about my culture. Then I got hooked up with a mental health worker who does extended hours outreach and she's also Native. She was a 'sister of the soul' and she referred me to Aboriginal services.

When I did finally go to a pow wow and an Aboriginal centre it was like knowing the truth; they were talking about stuff that made sense to me.

As someone who was never comfortable in my own skin I felt at home there. I brought my mom to the cultural reclamation programs and residential school healing programs. This was the first time my mom ever talked about her residential school experience; the first time she ever cried about it. Then we got her hooked up with a residential school healing program in Vancouver.

The next time I brought my daughter who was pregnant at the time, then my son - and we all did a blanket ceremony that brought real closeness to our relationship. I believe the spirit of my father is watching all this and is healing too. I grieve for his pain because I know now that his abuse of me is because he was abused - I know this for a fact from my own issues and healing."

Milestones in the Recovery and Healing Movement

"Healing" within a Canadian Aboriginal context refers to a cluster of ideas, activities, events, initiatives and relationships, happening at every level from the individual to the inter-tribal. This cluster has drawn widely on models and experiences from around the world, and is also developing its own unique models, methods, language and analyses, many of which are just beginning to enter mainstream dialogue. We can describe this cluster as the Aboriginal "Healing Movement" (Lane et al., 2002:23).

A major shift has occurred in social attitudes about Aboriginal people and cultures in Canada. One of the major drivers for this shift in thinking is the grassroots-driven Aboriginal movement toward healing and cultural reclamation. This movement has helped change the social perception of Aboriginal cultures as sources of problems to Aboriginal cultures as sources of strength. The following highlights milestones that have shaped a new understanding of healing from addictive behaviours in an Aboriginal context:

1. the worldwide spread of the grassroots Alcoholics Anonymous movement and 12-step approach to abstinence;
2. the growing political power of national Aboriginal organizations in Canada, alongside a widespread grassroots revitalization of traditional spirituality;

3. federal initiatives, such as the National Native Alcohol and Drug Abuse Program, the Royal Commission on Aboriginal Peoples, and the Aboriginal Healing Foundation; and
4. the emergence of health promotion and harm reduction models as alternatives to the disease model of addictions.

1. Alcoholics Anonymous (AA) Model

From its inception in 1935, AA quickly grew into a worldwide self-help movement that empowered individuals to acknowledge and to take control of their addictive behaviours. In Canada, the growth of the AA movement corresponded with the rise of national Inuit, Métis, and First Nation political organizations. Their role in cultural and spiritual revitalization was instrumental in adapting the AA model for Aboriginal communities. The AA model contributed enormously to the first stages of an Aboriginal approach to addictions for these reasons:

- ✦ no fees or membership requirements other than the desire to stop drinking alcohol or abusing substances means the model is *accessible*;
- ✦ the commitment to abstinence is promoted one day at a time, and sustained through *strong peer support and a practical 12-step plan*;
- ✦ families and friends are included through Alateen and Al-Anon, an approach that *resonates with Aboriginal family and relationship values*; and
- ✦ the 12-step model is *readily adaptable* to diverse Aboriginal cultural beliefs and practices, as well as to a range of addictive behaviours.

2. National Aboriginal Organizations

The growth of national Aboriginal organizations was integral in shaping a uniquely Aboriginal approach to addictions through: promoting and lobbying for the social, cultural, economic, and political well-being of Inuit, Métis, and First Nation people; establishing bodies to control research and apply for funding; recasting history in a new light, naming human rights violations, and creating opportunities for redress; and revitalizing cultural practices and traditions and restoring the role of Elders. These efforts have been led by the National Indian Brotherhood (renamed The Assembly of First Nations in 1982) in 1968, Inuit Tapirisat of Canada (renamed Inuit Tapiriit Kanatami in 2001) in 1971, Native Women's Association of Canada in 1974, Métis National Council in 1983, Pauktuutit (Inuit Women's Association) in 1984, and Métis National Council of Women in 1992.

Although not a national Aboriginal organization, Two-Spirited People of the First Nations⁴ was established in 1995 to advocate for the needs of Aboriginal gays and lesbians. The collective efforts of these and many other groups to revitalize traditional spirituality have restored to common practice such ceremonies as the sweat lodge, pipe, fast, potlatch, shaking tent, and sun dance. This, in turn, laid the groundwork for culture-based healing and recovery efforts now underway in Inuit, Métis, and First Nation communities throughout Canada.

⁴ Two-Spirit is the term used by some Aboriginal people to describe lesbian, gay, transgendered, and bisexual individuals.

3. Federal Initiatives

The **National Native Alcohol and Drug Abuse Program (NNADAP)** initially started as a pilot project in 1975, and was funded permanently in 1982. The program was created in response to the “urgent and visible nature of alcohol and drug abuse among First Nations and Inuit people” (NNAPF, 2000:11). NNADAP develops and implements addiction treatment services for Aboriginal people, assists in training, programming, and placement of special needs clients, and promotes quality assurance. The primary federal funding source for addictions prevention and intervention services in Inuit and First Nation communities has grown to include a total of 695 treatment beds in 49 treatment centres, including outpatient services providing non-medical, post-detoxification treatment, and more than 500 community-based prevention programs with staffing in excess of 700 workers, most of whom are employed directly by the Inuit and First Nation communities (NNAPF, 2000).

Two significant milestones within NNADAP itself are the *General Review* in 1998 and the subsequent *Renewal Framework* in 2000.

The *NNADAP General Review* identified a number of key problems within NNADAP services including: lack of integration of community programming; lack of staffing stability including isolation of staff; lack of consistent training; lack of specialized services for children, youth, and families; lack of consistent standards; lack of aftercare; and lack of adequate funding, among others (NNAPF, 2000). Recommendations for improvements cover seven broad areas: networking, research and development, best practices, training, communications, resources/capital, and continuum of care (see Appendix A). The report also suggests shifting from the disease model to a health promotion model that “reflects a return to spiritual and philosophical themes that are central to Aboriginal traditions in North America” (NNAPF, 2000:28).

The population health model ... 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 specialties, 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 (NNAPF, 2000:29).

As well, the NNADAP report offers a clearer definition of both substance abuse and addictive behaviours:

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 ... 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 (NNAPF, 2000:25).

Identifying opportunities for partnerships among all levels of government aimed at reducing jurisdictional barriers to a coordinated system of services is a key feature of the NNADAP *Renewal Framework* (NNAPF, 2000). The National Native Addictions Partnership Foundation⁵ was created to implement the plan for the new framework. A statement of values created to guide NNADAP renewal and the work of the Partnership Foundation includes respect, accommodation for cultural diversity, honesty, compassion, trust, family strength, humility, and commitment to a holistic approach.

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 (2000:28).

Another important federal initiative during this period was the First Nations and Inuit Community Youth Solvent Abuse Survey undertaken by Health Canada in 1993. This led to the creation of the National Youth Solvent Abuse Program, and the opening of several solvent abuse treatment centres for Aboriginal youth across the country.

In 1991, the **Royal Commission on Aboriginal Peoples** (RCAP) was created to find ways of improving relations between the government and Aboriginal people. In 1996, RCAP released its final report, calling for a new Aboriginal healing strategy that is based on a holistic approach to encompass family and community healing systems as well as individual healing. RCAP recommended that this new healing strategy be supported by a human resource strategy, social housing, and cultural renewal. The RCAP report linked the disproportionately high level of addiction and substance abuse in the Aboriginal population with the impacts of residential school abuse.

Gathering Strength - Canada's Aboriginal Action Plan (Indian Affairs and Northern Development, 1998) recognized the need to reconcile past injustices through a renewed partnership with Aboriginal people. Acknowledging the federal government's role in the development and administration of residential schools, it conceded that resolving the pain of the past is one of the greatest challenges to improved relations between Aboriginal people and the government of Canada. A cornerstone of this plan was a \$350 million dollar fund allocated to support community-based healing for those impacted by residential school abuse, including their descendants. The Aboriginal Healing Foundation was established as an Aboriginal-run (independent of governments), not-for-profit corporation to manage and dispense this healing fund.

Since its inception in March 1998, the **Aboriginal Healing Foundation** (AHF) has undertaken research and funded numerous Inuit, Métis, and First Nation healing programs throughout Canada. Its approach is to empower Aboriginal people as key agents of change by building on their strengths and capabilities to heal. The AHF approach has made a tremendous difference in raising levels of awareness

⁵ Precursors were the Society of Aboriginal Addictions Recovery (SOAAR) and the National Native Association of Treatment Directors.

and understanding of the legacy of physical and sexual abuse in the residential school system, including its intergenerational impacts.

4. Health Promotion and Harm Reduction Models

Health promotion as an alternative to the “disease model” of health began in the 1980s when Health Canada identified four main factors contributing to the health of Canadians:

1. Biology
2. Lifestyle
3. Health care organization
4. Environment (including physical and social)

In this context, health promotion was defined as having three key aspects:

1. a process of enabling people to increase control over and to improve their health;
2. health is seen as a resource for everyday life and not the objective of living; and
3. the fundamental conditions and resources needed for health are peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice, and equality.

The health promotion model aligns with Aboriginal beliefs about holistic health, self-actualization, and control over the means to improve health.

In 2005, the Public Health Agency of Canada (2005) launched a national consultation process to define public health goals for Canada, building on what has been learned about determinants of health over the past several decades. Addressing inequalities in social conditions that impact health is part of these goals. Twelve key determinants that influence health and well-being were discussed:

1. Income and social status
2. Social support networks
3. Education and literacy
4. Employment/working conditions
5. Social environments
6. Physical environments
7. Personal health practices and coping skills
8. Healthy child development
9. Biology and genetic endowment
10. Health services
11. Gender
12. Culture

These determinants are now seen as indicators by which conditions of life in Aboriginal communities across Canada can be measured. Social and economic conditions have had a profound impact on the health of Aboriginal people in Canada. Recommendations of the RCAP report of 1996 underscore the urgency of addressing the deplorable living conditions, such as substandard housing and unsafe water, in many

Aboriginal communities. The impacts of addictions and substance abuse in the Aboriginal population are compounded by disproportionately poorer health. While there is now widespread awareness that social and economic conditions contribute to addictions and substance abuse, the focus of prevention and intervention relies too narrowly on individual solutions versus social and economic solutions.

The harm reduction model grew out of health promotion as a “next best” approach to prevention. While the goal of the AA 12-step approach is complete abstinence, the harm reduction model aims at reducing the health and social impacts of addictions by reducing the associated harm. A major impetus for harm reduction is the urgency of the HIV/AIDS epidemic. Stopping the spread of HIV/AIDS among high-risk groups quickly took precedence over abstinence from illegal substance abuse. A few examples of harm reduction measures relating to illegal substance abuse are:

- ✦ needle exchange and safe injection programs;
- ✦ methadone programs; and
- ✦ street outreach services that provide information and referrals to prevent the spread of HIV.

Because of its proven effectiveness in reducing HIV risk, the harm reduction model is being applied to other addictive behaviours as well as abuse of legal substances, such as commercial tobacco and alcohol. Some examples of harm reduction in this context include counselling, tapering off programs, and “buddy” systems where women look out for each other’s safety. The harm reduction model aligns with an Aboriginal approach to addictions in the following ways:

- ✦ recognizes the inherent value and worthiness of all human beings;
- ✦ does not judge behaviour, but encourages safety and self-respect in decision-making; and
- ✦ emphasizes building on successes, learning from mistakes, and proceeding at an individual’s own pace.

Although standard prevention and intervention programs have relied heavily on the AA abstinence model, there is a growing shift toward a more expansive approach that includes health promotion and harm reduction. This shift is especially important in programming for clients whose physical and mental health is badly compromised due to substance abuse. The advantage of this approach, according to the *NNADAP Renewal Framework* report, is that “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” (NNAPE, 2000:30). The abstinence orientation of many decision-makers and treatment staff has been identified as a major barrier in moving towards a harm reduction model for alcohol (Health Canada, n.d.).

Reflecting an international shift toward health promotion and harm reduction, the World Health Organization (WHO) proposes viewing alcohol problems along a continuum; thus, a full range of prevention and intervention alternatives can be aligned with underlying causes. “The goals of therapy are the reduction of alcohol-related morbidity and mortality, and the reduction of other social and economic problems related to chronic and excessive alcohol consumption” (as cited in Marlatt and Witkiewitz, 2002:869).

Because drugs today are highly potent, leading to rapid addiction even for first-time users, prevention and intervention strategies must be focused, comprehensive, and include all key stakeholders. An example is the recent response to the growing urgency of *crystal meth* abuse among Aboriginal youth. In 2005, the

Federation of Saskatchewan Indian Nations and the Assembly of First Nations coordinated a national meeting of government health representatives and other key stakeholders to discuss strategies for action on the impact of crystal meth in First Nation communities.

Many important gains have been made over the past quarter century to address the widespread problem of addictions. New ways of thinking about addictive behaviours in an Aboriginal context are emerging. The capacity of Inuit, Métis, and First Nation communities to act on their own health and social issues is steadily increasing.

The AA self-help movement has grown alongside a widespread Aboriginal-driven movement for cultural revitalization. These two movements strengthen the efforts of Aboriginal communities toward individual, family, and community healing. In turn, the move toward community healing is responsible for shattering the long silence and penetrating the social denial around residential school abuse. As well, continual progress has been made in addictions research and development in Canada, as well as in other countries. One such development is the shift away from a conceptual model that focuses on disease toward a model that focuses on health promotion. Increasingly, research shows the effectiveness of a harm reduction approach within a culture-based framework, not only for addictions programming, but in broader health promotion efforts.

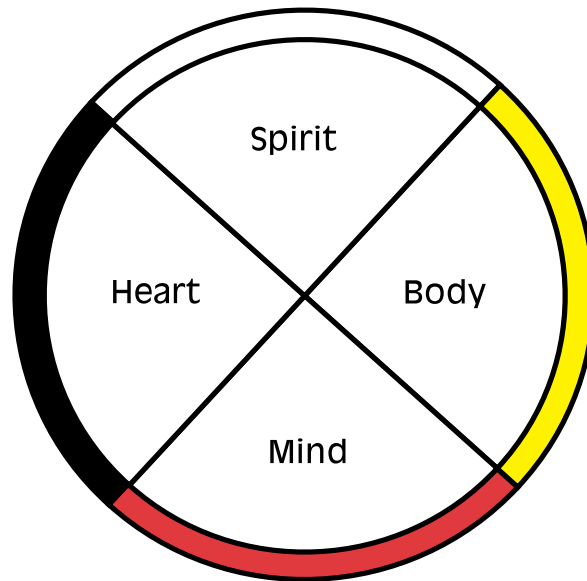
Community-Based Healing Models

There are now many examples of effective community-based addictions prevention and intervention programs. One of the groundbreaking Aboriginal community healing models is that of Alkali Lake, British Columbia described in Chapter 4. This community healing model inspired other communities, such as Hollow Water in Manitoba, to become leaders in their own right of a holistic and integrated response.

Treatment centres such as Round Lake in British Columbia and Poundmaker's Lodge in Alberta are examples of addictions program models that have broken new ground in a *culture as healing* approach to addictions recovery. The culture as healing model is grounded in an understanding of the impacts of residential school abuse and colonization. Culture as healing counters these impacts through four strategies of cultural revitalization:

1. Restoring a sense of belonging through pride in identity, family, community, and ancestry;
2. Restoring the wisdom of traditional teachings, practices, and medicines that promote balanced health for the mind, body, heart, and spirit throughout the lifespan;
3. Providing opportunities to practice new ways of thinking, behaving, and living with others who are also committed to balanced health; and
4. Restoring the roles of women and Elders and strengthening the capacity of individuals, families, and communities to resolve their own problems.

Figure 3) Holistic Medicine Wheel



The Wisdom of Cultural Teachings

In the words of Elder Berma Bushie:

The spirit piece is at the very core. It has to be in place to bring people back to balance. The whole field of psychology and psychiatry has developed its own language to determine who has a disorder, and how to get people well. We don't have the same concepts or definitions. Ours is holistic. We don't label people. We understand that the decisions we make today will affect our people for several generations, and we use a traditional holistic approach to human living problems. We want our people in our community because it's our heart and soul. Without the spiritual, balance will not be achieved, nor healing attained (as cited in Buller, 2001:6).

Traditional spiritual beliefs and practices are the very heartbeat of the Aboriginal healing movement. Spirituality is understood to have an integral role in mental, physical, and emotional health. Although there is no "pan-Indian" spirituality, many of the basic premises are shared. One such premise is that each person comes into the world possessed of unique and sacred "gifts" or talents. Along with these sacred gifts is the personal responsibility to develop them to their fullest potential in ways that benefit oneself, others, and the environment. The principle of self-actualization reflects a deep belief in the innate worthiness and potential of each and every person.

The role of spirituality in healing is to help individuals re-awaken their sense of themselves and others as sacred beings worthy of respect, to honour the sacred in themselves, and restore their sense of connection. Inner transformation is essential to sustain the movement away from addictive behaviours, where the behaviour controls the individual, to healthy behaviours where the individual is in control of decisions and actions necessary for a balanced and fulfilling life.

The following describes the role of cultural teachings and practices that promote healing from the Legacy of residential school abuse and addictions recovery.

An Aboriginal Approach to Healing and Recovery

The goal of any healing process is a recovery of awareness, a reawakening to the senses, a re-owning of one's life experience and a recovery of people's enhanced abilities to trust this experience. In a successful healing process, this will be coupled with the recovery of a social ability to create a new cultural paradigm, to bring order out of what has been chaos (Wesley-Esquimaux and Smolewski, 2004:78).

Because it is based on a belief in the interconnectedness of all things, an Aboriginal holistic approach to healing and recovery encompasses a wide array of activities. For example, a core belief shared among Inuit, Métis, and First Nation people is that a sacred connection exists among people, the earth, and everything on it. In practice, this means activities such as "on-the-land" or "bush" healing camps where participants can experience the healing power of the natural world as therapeutic interventions.

For Inuit, traditional hunting practices are not just means of subsistence but are also spiritual practices to maintain personal and community health. Indeed, Inuit concepts of self include physical links with animals, maintained by eating country food (Mailloux, 2002:20).

In an Aboriginal context, spiritual teachings and activities are therapeutic when they are practiced in alignment with treatment goals. Sweat lodges, cedar baths, smudging, Qulliq lighting, or other spiritual ceremonies align with treatment goals such as reducing anxiety and building trust. Seasonal ceremonies, communal meals, potlatches, medicine walks, pow wows, feasts and give-aways, Métis *réveillons* (community celebrations with feasting, dancing, and fiddling), and Inuit community celebrations are all activities that promote healing through positive relationships.

Reclaiming spiritual teachings and practices is not only an important counterpoint to the shame-based identity fostered in Aboriginal children by residential schooling, it is also a way of building healthy relationships and reducing social isolation. These are key aspects of sustaining recovery over the long term.

The renewal of spirituality in general and indigenous cultural forms of spirituality in particular, is very central to the healing journey for most Aboriginal communities. When communities have been forcibly separated from their own spiritual roots for a long enough time, a lack of vision and coherence at the core of community life tends to make it difficult for the people to 'see' any pattern of life for themselves other than the one in which they are currently enmeshed. On the other hand, it has been clearly demonstrated that rekindling spiritual and cultural awareness and practices can greatly strengthen the coherence and vitality of a community healing process (Lane et al., 2002:57).

Another core belief shared by Inuit, Métis, and First Nation cultures is the value and importance of experiential learning. In an Aboriginal belief system, knowledge is considered a reflection not of what people *say* but of how people *live*. Prevention and intervention programs that provide opportunities for

participants to *experience and live* self-respect, sharing, and cooperation are inherently promoting health. Examples of culturally relevant experiential learning include storytelling, art therapy, talking circles, or performance art where participants have the opportunity to express powerful feelings indirectly through stories. Sharing their own stories, and having those stories validated by others who have lived through similar experience, is a powerful form of affirmation and healing. Treatment models based on creative self-expression have proven to be more effective with Aboriginal clients than talk therapy and instructional learning (Kishk Anaquot Health Research, 2003).

Learning about Aboriginal history is another important aspect of culture-based healing. As individuals come to understand the social and political origins of their pain, they are able to move away from self-blame, self-hatred, and lateral violence toward self-acceptance, self-care, and community building.

All key informants and resource people for this report agreed it is essential that non-Aboriginal addictions specialists, program planners, and front-line workers increase their knowledge of a culture-based approach to recovery. It is now widely understood that cultural competency is an essential aspect of accessible services. Culturally competent service providers are better able to understand and meet the needs of Aboriginal clients.

The following examples of some cultural teachings that illustrate an Aboriginal value system are provided to show the healing power of Aboriginal cultural beliefs as well as their practical application to addictions programming.

The Anishnawbe Seven Sacred Teachings

Many First Nation cultural traditions tell of seven gifts or teachings that were given to their people. Following these teachings or natural laws would ensure the survival of all living things. Although there are variations among First Nations in the way these traditional teachings are told, the basic principles are the same. According to Elder Jim Albert, these teachings are a gift that guides day-to-day behaviour toward oneself, others, and all of creation:

1. **Love** is wanting the best for oneself, others, and all of creation;
2. **Respect** is honouring all in creation, past, present, and future;
3. **Humility** is knowing one's place in the circle of life as not above nor below any others;
4. **Wisdom** is using one's gifts in a way that benefits oneself, family, community, nation, and all of creation;
5. **Courage** is confronting problems with integrity to resolve them in a good way;
6. **Honesty** is speaking well of oneself and others; and
7. **Truth** is knowing all of these things and living by them.

According to Aboriginal key informants, one of the foundational questions of addictions recovery is: How do I begin to treat myself with respect when I've never experienced being treated with respect?

Reflections From a Key Informant

“The beauty of these teachings is their relational aspect; they allow people to connect with who they really are, and then from that place of authenticity, they can connect in a good way with others. None of these teachings is sufficient in itself; if you don’t have Humility in a good way, then that will impact on your ability to Respect yourself and others.”

Elder Jim Albert

These *Seven Sacred Teachings* have guided healing and recovery programs in many Aboriginal communities, most notably at the Hollow Water Community Holistic Circle Healing program in Manitoba. These are also a useful and practical guide for addictions program planners and evaluators in reviewing program activities and outcomes as well as the health of the organization and staff team.

Building healthy organizations that model love, forgiveness, unity and mutual support amongst staff is of the utmost importance, because only such a healthy circle of people could hope to bring that kind of wellness to others (Lane et al., 2002:51).

The following table shows how the *Seven Sacred Teachings* can be used as a framework for developing, implementing, and evaluating addictions prevention and intervention programs.

Table 2) Applying the Anishnawbe Seven Sacred Teachings to Addictions Prevention and Intervention Programming⁶

Seven Teachings	Practical Application
Love: Commit to a lifelong vision	Love enters the work of recovery when the vision is lifelong and holistic, integrating physical, emotional, mental, and spiritual aspects of health, and creating places of belonging and hope that strengthen individuals, families, and communities.
Respect: Face up to the problem and own the solution	By acknowledging all aspects of the problem in an honourable way, how it came about (the past), and what it looks like (the present), not by shaming and blaming, but by creating a vision for change, respect for self and others enters the process.
Humility: Build a circle of care	Humility enters the recovery process when everyone is welcomed into the circle as equally respected members in a continuum of care: clients, Elders, community leaders, families, addictions specialists, and stakeholders from other sectors.
Wisdom: Create a strategic plan	By cherishing traditional knowledge and valuing the experience of everyone in the circle, a full range of holistic healing options is developed that match the unique healing needs of each individual, family, and community.
Courage: Carry out the plan	Integrity enters the process when individuals, families, and communities have the courage to carry out their plans in the face of barriers such as denial, lateral violence, and unanticipated barriers, and when community leaders mobilize resources in support of family and community health.
Honesty: Evaluate, monitor, and readjust the plan	Honesty in recovery and prevention requires ongoing, rigorous monitoring and evaluation, the capacity to readjust plans based on a forthright assessment of what works, what does not work, as well as emerging obstacles and unforeseen impacts.
Truth: Live, share, and pass along what is learned	Knowing all of these things and living by them means role modelling healthy behaviours, sharing resources, lessons learned and best practices, and empowering every Inuit, Métis, and First Nation community to self-manage their own recovery from addictive behaviours.

⁶ This table is based on the teachings of Elder Jim Albert, other key informants, and the literature review.

The Six Principles of Inuit Traditional Knowledge (Inuit Qaujimajatuqangit)

Inuit social life has long been guided by core foundational principles known as “natural law.” These principles helped ensure Inuit survival over millennia despite one of the most demanding environments on earth. The *Principles of Inuit Traditional Knowledge* were developed by the Inuit Qaujimajatuqangit working group of the Department of Sustainable Development, Territory of Nunavut (Arnakak, 2000). These six principles, shown below, adapt equally well as a framework for effective addictions prevention and intervention planning.

Table 3) Inuit Qaujimajatuqangit

Principles	Description
The Concept of Serving (Pijitsirniq)	The concept of community service is a central Inuit value and a measure of each person’s level of maturity and wisdom. Everyone (youth, Elders, leaders, service providers, addictions specialists, and educators) has a role and responsibility in supporting the communities’ move away from addictive behaviours to achieve health.
The Concept of Environmental Stewardship (Avatimik Kamattiarniq)	The health of people is inseparable from the health of their environment. Providing opportunities for people to experience the healing power of the connection to nature can help maintain this balance. Monitoring program environments to ensure they promote mental, emotional, physical, and spiritual health and safety for individuals, families, and communities can also help maintain balance.
Consensus Decision-Making (Aajiiqatigiingniq)	Consensus decision-making relies equally on effective communication skills (listening as well as speaking) and the ability to create a shared vision. For Inuit, the healing process is successful when it is reciprocal—when client and counsellor each recognize and value the perspectives and contributions of the other. Thinking, speaking, and acting collaboratively ensures workable solutions to challenges, and openly acknowledging what is and is not working ensures the healing process stays on course.
The Concept of Skills and Knowledge Acquisition (Pilimmaksarniq)	Acquiring and using new skills and knowledge are crucial to individual, family, and community survival in a demanding environment and during challenging times. These new skills and knowledge include building personal and professional capacity in cultural ways of knowing and doing (cultural competency) and continually expanding the knowledge base by sharing cultural teachings, lessons learned, and promising practices.
The Concept of Being Resourceful and Adaptable to Solve Problems (Qanuqtuurunnarniq)	This principle underscores the importance of using skills, knowledge, and resources in creative ways to overcome new obstacles as they arise. Some examples of being resourceful and adaptable include utilizing non-Inuit specialists who have achieved cultural competency to play important roles beyond therapy with clients, building capacity through training and clinical supervision for Inuit staff, creating flexible new partnerships to pool human and financial resources, and refusing to be diverted from the vision by choosing to focus on solutions in the face of unforeseen problems.
Collaborative Relationships or Working Together for a Common Purpose (Piliriqatigiingniq)	This principle underscores the importance of the group over the individual by fostering a strong sense of teamwork to achieve a shared vision, and allowing decisions to benefit all within the group, whether in family or community contexts.

Applying the *Six Principles of Inuit Traditional Knowledge* and the *Anishnawbe Seven Sacred Teachings* to addictions policy and program development ensures all aspects of services arise from a solid foundation.

Breaking the Cycle of Trauma and Addictions: Why Culture Matters

According to Elder Jim Albert, traditional Aboriginal teachings are especially important to addictions and trauma recovery as they are the very opposite of what Aboriginal children were taught at residential schools:

There they were not permitted to take personal responsibility. They were taught they were savage and incapable of responsibility in order to justify having the values and beliefs of others who were supposedly more worthy, imposed on them. These teachings aren't intellectual; they're experiential. How do we teach and live them in a way that is meaningful? How can we provide an experience that will illustrate each teaching? People who are suffering need to learn these teachings experientially. That's how we learn. What does this mean for programs?

Traditional teachings counter the residential school legacy by replacing the shame-based beliefs that children were taught about Aboriginal cultures with beliefs that are life-sustaining. Whether from Inuit, Métis, or First Nation traditions, traditional teachings have in common the capacity to promote and restore:

- ✦ self-respect, self-care, and self-responsibility; and
- ✦ respect and responsibility for the family, the community, the nation, and the environment.

The capacity of traditional Aboriginal values to transform social problems first gained attention and recognition within the criminal justice system.

If we have learned anything from the errors of our past it ought to be that Aboriginal peoples should have control over their own destiny and over their own problems. Indeed, we should have the good sense to learn from Aboriginal ways. Certainly their way of dealing with offenders of all types could teach us as much as we are ever likely to teach them (Marshall and Fernandez, 1997:88).

The following are examples of methods used by Aboriginal programs to reverse the intergenerational impacts of residential school abuse described in Chapter 2. Taken together, these illustrate the wisdom and value of cultural teachings in practice.

Addictions Prevention and Treatment Approaches: In order to reverse the impacts of residential school abuse, Aboriginal approaches to prevention and recovery focus on healthy attachments and healthy coping strategies in the context of restoring cultural identity and pride. Healing and recovery strategies that address *attachment* and *dissociative disorders* and *re-enactment* include the following:

Attachment Disorder is the inability to form healthy attachments or relationships as a result of an absence of a secure attachment to a primary caregiver early in life. Forming *safe* attachments to others

is an essential first step in recovery. Trust is built on relationships that are safe, caring, consistent, and respectful. From a place of safety and respect, clients begin to *experience* self-respect, self-care, and self-responsibility. The emotional isolation and shut down underlying addictions can be transformed when people come to believe their needs for physical and emotional safety will be met. Attachment disorder is addressed through a range of therapeutic interventions aimed at restoring relational capacity. This includes:

- having safe, ethical, healthy worker-client relationships;
- creating program environments that offer a family-like atmosphere;
- building peer support networks through talking and sharing circles, or arts and craft-making groups;
- strengthening parenting skills through parenting circles and family fun activities;
- promoting social relationships through cultural celebrations and feasts; and
- strengthening spiritual relationships through Elders, ceremonies, and connections with nature.

Many cultural practices are also tools for restoring healthy, respectful relationships:

- smudging is a way of visibly committing to being in a positive, healthy, mental, and emotional state;
- lighting the Qulliq is a way of remembering and honouring the ancestors in healing;
- talking sticks are a tool for practicing the art of speaking and listening well;
- storytelling is a non-directive, non-confrontational way of linking actions to consequences; and
- holding community feasts and potlatches to foster a sense of fellowship and belonging.

Dissociation is when individuals separate themselves from reality. The goal of therapy is to help dissociative clients identify and validate blocked feelings so they can begin to express them in safe, healthy ways. Identifying personal patterns of dissociation is the first step in moving away from unhealthy coping behaviours; however, not all dissociation is unhealthy. Planned or controlled dissociation is an important survival skill for retaining feelings of control in fearful situations. Another therapeutic goal is to learn the difference between uncontrolled dissociation that constricts both positive and negative feelings and controlled dissociation as a survival skill.

Effective treatment helps participants realize they are capable of learning how to protect themselves from physical and emotional harm. Support groups or talking circles are examples of therapeutic interventions that address dissociation in the following ways:

- building an environment in which safe, trusting, emotional connections with others can be slowly developed;
- providing practice in giving and receiving feedback without feeling devastated;
- permitting opportunities to experience consequences in a safe environment;
- practicing to set and maintain personal boundaries as a normal part of group process; and
- providing opportunities to express a full range of feelings and thoughts respectfully.

Grounding techniques are strategies that help people to mentally focus on staying present in the face of strong emotions, whether positive or negative. These techniques use sensory stimuli to reverse dissociation and help clients stay in the moment as stressful emotions begin to build. Some examples of grounding techniques include:

- carrying smooth stones or holding a special carving;
- carrying medicine bundles with sage, cedar, or sweetgrass to smell;
- carrying chewing gum or mints to taste;
- focusing on a sound in the environment that is reassuring, or carrying a recording of special music; and
- wearing a special piece of clothing or jewelry as a visual reminder of the commitment to stay present.

Learning and practicing new coping strategies help reduce anxiety and increase self-confidence in the client's ability to meet their own mental, physical, emotional, and spiritual needs.

Re-enactment is repeating the actions of an earlier traumatic event or incident. Therapeutic interventions that address re-enactment provide opportunities for Survivors to regain feelings of personal power and agency in healthy ways. The goal of these interventions is to help participants:

- identify thoughts, feelings, and behaviours that are aspects of re-enactment;
- create opportunities to re-enact the story, or aspects of it, in healthy ways through performance art, songs, poetry, and/or storytelling; and
- give back to the program or community in meaningful ways.

The appreciation and applause of an audience in response to theatre performances are a powerful and healthy way of meeting re-enactment needs through feelings of exhilaration and triumph. Performance art is not only a deeply meaningful way of healing for Survivors/performers, but also for members of the audience who see their own stories of pain and resilience represented and validated. Performance art also empowers Survivors to give back to their communities through community education.

Legacy Education as Healing: A core element of addictions recovery programming in an Aboriginal context is education about the legacy of residential school abuse. For example, Survivors are invited to share their first-hand accounts of life in the schools, and an array of resources such as videos, posters, and fact sheets are used as educational tools.⁷

Approaches to Concurrent Disorders and Historical Trauma: Therapeutic support for individuals with concurrent disorders of mental illness and addiction requires an especially well-coordinated and integrated plan of care. The following core components are recommended:

1. Assessment procedures that identify complex medical needs and issues including needs for medication and dosage and their side effects.
2. A treatment plan that provides options to address the range of identified needs including physical withdrawal symptoms, relapse prevention, ongoing mental health supports, and trauma recovery.
3. A coordinated plan to provide adjunct supports for everyday living such as parenting/child protection, child care, criminal justice support/advocacy, housing (emergency, transitional, and permanent), and social or disability assistance (Health Canada, 2002).

According to Aboriginal key informants for this report, art therapy and crafts such as beading, sewing, or carving are less stressful for clients with concurrent disorders as they place emphasis on traditional

⁷ See the Annotated Bibliography in Appendix C for information on some of these resources.

coping methods such as creativity and concentration. The issues and needs of clients with concurrent disorders can seem overwhelming and complex. This is compounded by a lack of information about trust in “the system” that characterizes such disorders; therefore, it is crucial to identify a lead agency or worker for each client. Accountability for coordinating and monitoring progress of the treatment plan, resolving issues as they arise, and advocating for the ongoing long-term needs of the client within the system must be clear.

Examples of culture-based therapeutic activities include: expressive arts such as drawing, dancing, singing, drumming, quilting, carving, regalia-making, and sand/play therapy; cultural practices such as cedar baths, being on the land, nature walks, and vision quests; and stress management techniques such as deep-breathing and stretching exercises, journaling, games, and laughter.

Aftercare or Continuing Care: Aftercare or continued care following addictions treatment is crucial. Its primary focus is to:

- increase understanding of relapse as a normal and predictable aspect of healing;
- affirm the importance of experiential learning and skill development in managing triggers;
- create a holistic plan for prevention of relapse through a range of healthy coping strategies; and
- include an alternate plan of action to minimize harm if the strategies fail and relapse occurs.

Culturally-based relapse prevention tools and techniques include a range of mental, emotional, physical, and spiritual strategies to help self-manage triggers. Some examples that have been used effectively in recovery for Aboriginal clients include individual exercises such as breathing and centering exercises, journaling, contacting a “buddy,” physical exercise, and smudging; and group exercises such as carving, beading, sewing, dancing or drumming groups, and talking circles to shares stories of success and lessons learned.

Relapse prevention should be approached as an ongoing opportunity for experiential learning. Personal responsibility for sustaining the commitment to recovery is reinforced through a solution-focused approach to relapse versus a problem-focused approach.

Reflections From a Key Informant

“Relapse prevention focuses on not being overwhelmed, so every step on the journey has to have a plan and supports for when that feeling hits. It might be good stresses like a new relationship, going to a class or starting a job. Any new social or skills situation can trigger a sense of being overwhelmed.”

Shiningwater Diabo

A solution-focused approach uses relapse as an opportunity to identify new ways to improve the recovery plan. Reframing relapse as an opportunity for learning and growth is consistent with Aboriginal cultural teachings of humility, honesty, and courage. As well as arts and crafts, aftercare or continuing care

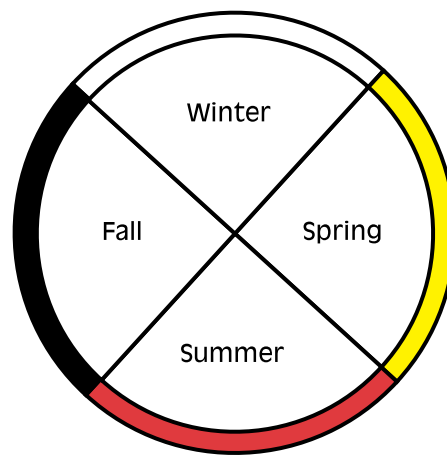
programming includes sweat lodge ceremonies, feasts, dances, and pow wows, as well as community volunteering, sports, and recreation. Opportunities to learn traditional life-sustaining skills such as hunting, fishing, carving, and sewing are ways of preventing relapse through positive experiences. Because these activities are carried out in groups, they are also effective in countering the social isolation that is part of the cycle of addictive behaviours. Support and advocacy to improve the conditions of life and enhance life skills is another important aspect of relapse prevention. A stable, safe living environment following treatment is another crucial aspect of recovery. Support and advocacy for decent, affordable housing, social assistance, employment, and education are all necessary for effective long-term relapse prevention.

Community Healing Model

A research study undertaken to “map out” a framework for individual and community healing has found striking parallels (Lane et al., 2002). Based on a study of six First Nation communities, researchers proposed a four-stage healing model that sheds important new light on the process of individual and community recovery. This conceptual model has its roots in traditional teachings about growth and change. In an Aboriginal world view, change is seen as an ongoing process that follows the same cyclical pattern as the changing of the seasons. Just as the spring planting time transitions into a season of growth and then of harvest, followed by a period of dormancy, so does the stages of healing progress from one “season” to the next. Each of these stages or seasons is driven by its own set of conditions that can either help or hinder the change process. No one season is any more important than the next; each brings with it special gifts and challenges. Similarly, no stage on the healing journey is more or less valued than any other; each has its own rewards. As individuals and communities progress through these stages or seasons of healing, there is a deepening of experiential knowledge and wisdom.

This model is a useful tool in helping individuals and communities fulfill their best potential. By identifying and building on the “drivers” of each stage and problem-solving the challenges, individuals and communities are empowered to better plan and manage their own recovery. The four “seasons” of the community healing journey and their characteristics are as follows:

Figure 4) The Four Seasons of Healing



Stage 1: Winter – The Journey Begins: Stage one of community healing begins when a low point is reached, and key people begin asking questions and challenging the *status quo*. A small core group initiates the first steps toward positive change. Building on Stage 1 drivers will support those who have taken on roles as agents of change and foster an “enabling environment” for healing through a solution-focused, collaborative approach. Addressing Stage 1 challenges will include being prepared to defuse denial and opposition by fostering community awareness and using traditional teachings that promote healthy, respectful relationships and a holistic long-term vision.

Stage 2: Spring – Gathering Momentum: By this stage, new community relationships and networks are being formed and recognized, generating more enthusiasm and hope for change. As more people join in the healing process, there is dawning recognition of the need to address unresolved issues underlying addictive behaviours. As a result, the limitations of community resources start to become evident. Building on Stage 2 drivers will take advantage of the momentum to identify and increase awareness of underlying issues, and welcome all those who share the vision to participate in the process of change. Addressing Stage 2 challenges will build the healing capacity of the community through a range of programs and staff training.

Stage 3: Summer – Hitting the Wall: Although clear progress is evident by this stage, new crises emerge such as different patterns of addictive behaviours, problems with youth, staff burnout, or resistance to sustaining changes over the long term. Healing may become institutionalized or sidetracked by competing agendas. Progress can seem to either backslide or hit a plateau, causing disillusionment. Building on Stage 3 drivers will build on strengths through monitoring activities and assessing emergent needs. Addressing Stage 3 challenges will: prevent staff burnout through self-care and team-care plans; prevent “institutionalization” through a flexible array of holistic healing activities for individuals, families, and the community; and develop plans and protocols for interagency and cross-sectoral information sharing and collaboration.

Stage 4: Fall – From Healing to Transformation: This stage brings a shift in thinking about healing as “fix it” to healing as community building. The focus of healing expands, moving beyond individuals and their relationships to the transformation of systems. New partnerships are created for employment, training, and economic development as part of the vision of a healthy, life-sustaining community. All sectors begin to actively engage in fulfilling this vision. Although the community “healing” journey may have been initiated by health workers or concerned community members, it gradually engages stakeholders from all sectors in a broader vision for community health and vitality.

Leadership for healing normally comes from one of three sectors: grassroots community members, professional agencies and departments, or political leadership. Eventually, as communities heal, all three sectors become engaged (Lane et al., 2002:47).

Building on Stage 4 drivers will continue to build on and strengthen the communities’ cultural/spiritual base and enhance capacity by training and integrating healing program graduates as volunteers and staff. Addressing Stage 4 challenges will build on and diversify partnerships that involve all sectors in healthy social and economic development and share most promising practices and lessons learned to move toward a common vision for a best practices model.

Mapping the Process of Change

The seasonal model proposed by Lane and colleagues (2002) reveals common aspects of the change process that all communities can expect to experience on their healing journey. Key messages of the seasonal model include change as a naturally occurring process, change occurring in a stage-by-stage developmental process where individuals and communities progress at their own pace, and change as a dynamic process although periods of relative stagnation or relapse are a normal part of that process.

Reflections From a Key Informant

“We need to see the ‘standing still time’ is also progress because it’s a time of listening to the spirit; not all progress is about movement we can see.”

Shiningwater Diabo

Equipped with this understanding, communities are better positioned to plan for a full range of activities that align with their own unique needs and realities as each stage of the healing process evolves. The chart on the following page summarizes the four stages of individual and community healing according to the model proposed by Lane and colleagues in *Mapping the Healing Journey*.

Table 4) Mapping the Healing Journey: A Conceptual Model of Holistic Healing

Individual Healing Journey	Community Healing Journey
<p>1. The Journey Begins</p> <ul style="list-style-type: none"> ✦ a low point or crisis is reached, ✦ the story is told, ✦ a “whole” lifestyle review begins, and ✦ underlying trauma or unresolved issues begin to reveal themselves. 	<p>1. Winter – The Journey Begins</p> <ul style="list-style-type: none"> ✦ a low point or crisis is reached, ✦ people begin asking questions and challenging the <i>status quo</i>, and ✦ a small group takes the first steps toward change.
<p>2. Partial Recovery</p> <ul style="list-style-type: none"> ✦ addictive behaviour stops, but the driving forces are still present, and ✦ a “culture of recovery” replaces the culture of addictions. 	<p>2. Spring – Gathering Momentum</p> <ul style="list-style-type: none"> ✦ new community networks are formed, ✦ more people join the healing process, and ✦ driving forces are still in place, but the scope of the problem is beginning to be understood.
<p>3. The Long Trail</p> <ul style="list-style-type: none"> ✦ a new identity and life pattern begins to take shape, and ✦ periods of growth alternate with plateaus or relapse. 	<p>3. Summer – Hitting the Wall</p> <ul style="list-style-type: none"> ✦ progress is evident, but new crises emerge, ✦ healing becomes institutionalized, and ✦ staff begin to burn out or become disillusioned.
<p>4. Transformation and Renewal</p> <ul style="list-style-type: none"> ✦ a higher vision of life is inspired by new relationships and service to the community, and ✦ an identity grounded in culture and community gathers strength. 	<p>4. Fall – From Healing to Transformation</p> <ul style="list-style-type: none"> ✦ a shift in thinking of healing as “fix it” to healing as “building,” ✦ healing focus moves beyond individual and family healing to community building, and ✦ all sectors begin to engage in a vision for growth and change.

Reflections from a Key Informant

“Healing happens one step at a time and we need to honour every step. People need to know that once you start your healing journey you will never be that low again because no matter what happens you can always come back home to that commitment you made to yourself.”

Shiningwater Diabo

Five Stories of Hope

A Client's Story Continued

"If I wouldn't have come back to the teachings I wouldn't have come as far as I have. Now I embrace who I am.

You have to deal with the other issues in order to heal because you can leave the addictions behind but still have the mental illness. I was sober for 8 years and then had a nervous breakdown, so I had to deal with the issues. I had a secondary trauma when I was assaulted by my husband. He'd been sober for ten years and we were talking about our lives. We both got triggered really bad."

This chapter highlights examples of community-based, Aboriginal-driven prevention and intervention programs that have achieved notable success. Some programs are very recent and, while showing early promise, have not been tested over the long term. Others are long-running models that have withstood the test of time. The five success stories described in this chapter illustrate Aboriginal approaches to some of the most serious addictions presently facing the Aboriginal population: alcohol, drugs, and commercial tobacco. In choosing these stories, consideration was taken to describe prevention and intervention strategies that reflect a range of Aboriginal groups, communities, and programs including:

- youth;
- rural and urban communities; and
- models that address early intervention, addictions treatment, and community healing.

Some examples, such as Alkali Lake in British Columbia, are well-established and well-known nationally as well as internationally. Others such as the urban Inuit addictions treatment program in Ottawa, Ontario, the youth early substance abuse intervention program at the Indian Brook and Eskasoni First Nations in Nova Scotia, and the smoking cessation program in Ottawa, Ontario are based on innovations that are very recent and just beginning to have an impact. These examples are only a few of the many stories of courage and hope from Inuit, Métis, and First Nation communities in all parts of Canada. They do not attempt to tell the whole story of an Aboriginal approach to addictions, but taken together, they underscore its unique effectiveness.

Sharing these success stories is meant to inspire other communities and service providers by telling a different story than the one usually told in the mass media. Telling and retelling stories of success also help to sustain the momentum of the Aboriginal healing movement, building on the tremendous sense of hope it has generated. Although the five stories presented here reflect diverse communities and perspectives, all are holistic and grounded in the wisdom of cultural teachings. These are:

1. Alkali Lake Community Healing Model, British Columbia;
2. Eskasoni Community Healing Movement, Cape Breton, Nova Scotia;

3. “Nemi’simk, Seeing Oneself” Youth Early Intervention Program Model, Indian Brook First Nation and Eskasoni First Nation, Nova Scotia;
4. Sacred Smoke, Health Promotion/Smoking Cessation Model, Ottawa, Ontario; and
5. Mamisarvik National Inuit Treatment Centre, Ottawa, Ontario.

The stories begin with those that are longest running and well-established, and end with programs that are more recent innovations.

Alkali Lake Community Healing Model

Alkali Lake (Esketemc) is a Shuswap First Nation with over 35 years experience in addictions prevention and intervention programming. Their long experience in effective prevention and intervention demonstrates the crucial importance of getting at underlying issues such as child abuse in order to stop intergenerational patterns of addictive behaviours.

Prior to 1940, this community of 400 in north-central British Columbia did not have an addictions problem. The introduction of alcohol by fur traders and the traumatic impacts of residential school abuse created a crisis. By the 1960s, the community was in “total immersion into the culture of alcoholism” (Four Worlds International Institute, 1998:4).

[W]ith the alcoholism came poverty, hunger, sickness, suicides, and layer after layer of loss as loved ones died in accidents, from violence or from largely unnecessary disease brought about by constant abuse and neglect of the body [emphasis removed] (Four Worlds International Institute, 1998:4).

The community developed a comprehensive community healing model to address addictive behaviours as well as the underlying causes. They began in 1972 after a seven year-old child refused to go home with her alcoholic parents. Both parents then committed themselves to quit drinking with the help of an AA counsellor and an oblate brother from a nearby community. Shortly after, the community elected the child’s father as chief on a platform to address its alcohol problems, and worked together to create a plan. The actions the community took included stopping all liquor sales on the reserve, arresting bootleggers and putting them out of business; setting up a voucher system for seriously addicted drinkers to prevent them from using welfare money for alcohol instead of food, giving those who committed alcohol-related crimes the choice of treatment or jail, and replacing negative role models with positive ones. The Catholic priest from the community who was addicted to alcohol was ordered to leave the reserve.

The community’s approach to healing began by bringing in traditional teachers from other Aboriginal communities to help rediscover identity and restore spirituality. The community also reintroduced the sweat lodge and sacred pipe as healing tools, and made healing a part of community life through ongoing circles, AA meetings, and support groups.

The community created new employment development projects to provide employment opportunities for those who went into treatment, as well as to provide assistance with child care and housecleaning/repairs.

Evidence of Their Success:

- After 2 years, 35 people had entered treatment;
- after 3 years, 40 per cent of the community was sober;
- after 7 years, 98 per cent completely abstained from alcohol; and
- after 13 years, the community had achieved full employment (Four Worlds International Institute, 1998).

As the widespread alcohol addiction was gradually brought under control, the underlying issue of sexual abuse surfaced. The community then elected a new chief who took a strong leadership role in addressing sexual abuse and countering the anger and denial of some male community members. The community brought in trusted Aboriginal specialists from the Nechi Training Institute and Four Worlds Development Project (both from Alberta) to help. These specialists conducted a series of community workshops that revealed 80 per cent of men and women and up to 90 per cent of children and youth had been sexually abused. The community developed a multi-levelled approach integrating criminal justice system interventions with an intensive healing process. A range of stakeholders from justice and health including police services, courts, prisons, forensic psychologist, therapeutic counsellor or psychologist specializing in sexual abuse, and community-based counsellors were involved. Their approach to healing provided support groups for survivors and abusers, and provided a reconciliation process that involved abusers, victims, and family members of each.

Every aspect of family and community life began to again acquire the ceremonial markers that help to guide people on their journey through life reminding them of their sacred responsibilities and boundaries. Moral values and spiritual teachings again become central in the education of children in community governance and in family life (Four Worlds International Institute, 1998:13).

Eskasoni Community Healing Movement

Eskasoni's story is about meeting the challenges of addictions in a community with a **very large population spread out over an extensive geographical area**. Members of this community have generated a remarkable array of innovative prevention and intervention program partnerships within and outside of the First Nation. Unlike the Alkali Lake community, they have done so without the benefit of committed, elected leadership and a cohesive plan of action. With a population of 3,500 and located in Cape Breton, Nova Scotia, Eskasoni is the largest Mi'kmaq First Nation community in Canada. It is the largest reserve east of Montreal. The first language of the community is Mi'kmaq, and over half the population is under the age of 19 years. The community has a long-established treatment centre with addictions workers funded by NNADAP. Eskasoni community members have identified a number of urgent, interconnected social issues underlying addictive behaviours:

We have a complicated web of issues we are struggling with—alcohol and drugs, gambling, sexual abuse, family violence and the full spectrum of residential-school-survivor issues related to parenting, emotional withdrawal and slow, burning rage (Lane et al., 2002:36).

Pockets of key community members, service providers, and educators have taken a proactive role in developing an array of prevention and intervention projects. Programs to support families have been created. One example is a family-centered healing program designed to be delivered in the home, sometimes up to three times per week. The whole family is considered to be in the program—aunties, siblings, and Elders are all involved in supporting new behaviours. Program staff may also assume family management roles for a few hours to provide guidance while modelling new behaviours and approaches to parenting. Each parent may have a different counsellor than the one for their children. Case conferencing ensures a coordinated view of the whole process. Practical assistance is provided to people struggling with poverty to help them cope (e.g. drive to the store, stop over for a talk, be a friend and a support to help a family heal).

The following are examples of a range of addiction prevention strategies for children and youth involving numerous partners and stakeholders:

- *Moose Camp* was Canada's first program of its type bridging Elders, youth, and RCMP together for positively-centered activities. Fifteen youth spent a week at Moose Camp with police officers, Department of Natural Resources officers, and Elders. In the context of a moose hunt, the youth learned cultural skills such as how to harvest traditional foods for the good of the community. Program activities were designed to strengthen youth's cultural identity and to increase awareness of how the actions of individuals affect the whole community. This program was nominated for an RCMP award in 2004 (Jeff Christie, key informant).
- *The Sunflower Project* helps youth better understand their personal life experiences by planting, growing, and harvesting sunflowers and through traditional teachings about healthy development through the life cycle. This project was developed in partnership with Cape Breton University.
- *PATHS/Empathy Program* targets school children aged 5–11 who engage in anti-social behaviour such as bullying, violence, and lack of interest in school. Communication skills are increased through cultural teachings, family stories, and other activities that fit an Aboriginal learning style. This program was developed through the Eskasoni School Board (Jeff Christie, key informant).

The community of Eskasoni is large and spread out; therefore, more time and effort is required to create and maintain communication linkages toward a cohesive, coordinated prevention/intervention plan for addictive behaviours. A strategy to address this challenge was to create an interagency committee in 2002 as a service provider forum to promote communication, coordination, and planning. It is a multi-sectoral committee with representatives from education, justice, health, and social services that meets monthly.

Eskasoni is the first Aboriginal community in the Maritimes carrying out multidisciplinary case management through the new interagency committee. Service providers and schools are increasingly becoming proactive in seeking out new programming opportunities on behalf of children and youth.

“Nemi’simk, Seeing Oneself” Youth Early Intervention Program Model

(David Wojak and Dr. Nancy Comeau, key informants)

Early Intervention Program for At-Risk Youth, “Nemi’simk, Seeing Oneself,” Indian Brook First Nation and Eskasoni First Nation, Nova Scotia was chosen as a recent example of **constructive, multi-sectoral collaboration among educators, researchers, police, youth, Elders, and community members**. The program was set up to address an issue identified by leaders as a top priority for First Nations in the Maritimes—youth substance abuse. The program was designed specifically to address the root causes of substance abuse and addictions among Aboriginal youth. It is based on a holistic model of “personality-matched, motive-specific brief interventions” to help teens identify and move away from maladaptive coping strategies that contribute to substance abuse. The program name, *Nemi’simk, Seeing Oneself*, was chosen to convey an inner journey where personal gifts of the spirit and the power of self-healing are realized. Indian Brook First Nation is located on the coast of the Nova Scotia mainland and has a population of just over 900. Key informants expressed concern over the communities’ alarmingly high rate of youth suicide.

Chiefs of First Nation communities in Nova Scotia agreed that addressing substance abuse among youth is a priority. The RCMP invited an academic who had developed an early intervention model for youth to meet with community representatives. Trusting relationships gradually developed among community members, schools, police, and researchers. In 2004, these two First Nation communities collaborated with researchers to adapt and pilot test an Aboriginal-specific early intervention substance abuse program for youth. Planning partners included researchers from Dalhousie University (who had developed the base model), the Canadian Institute of Health Research, Institute for Aboriginal People’s Health (CIHR-IAPH), the Aboriginal and Diversity Policing Services of the RCMP, guidance counsellors and representatives from Indian Brook and Eskasoni Mi’kmaq First Nation communities, and high schools.

Elders and youth developed the cultural components for program materials prior to pilot testing these in their communities. They also created stories and illustrations for a series of intervention workbooks to guide self-healing. Interventions are based on a set of workbooks, each one aimed at a specific personality type associated with substance abuse. The stories and situations depicted in each workbook are all based on real life stories of Mi’kmaq youth; all of the artwork is by Mi’kmaq youth and all content reflects traditional Mi’kmaq teachings, symbols, and colours that have significance to community members. Six high school guidance counsellors and eight RCMP trained as “interveners” for the program guided youth through and after completion of the pilot project.

A school-wide screening process identified youth who were abusing substances and invited them to participate in the study. Each participant took part in rigorous testing before and after the four-month program. A pretest assessed each participant’s own underlying needs and motives for abusing substances. Participants then worked through a series of intervention exercises in a workbook that matched these underlying factors. Participants had the option of working through the exercises individually with a trained, personal intervener or in an intervener-led group with other youth. Post-testing at the end of the program assessed the impact of the interventions on reducing substance abuse behaviours.

Although long-term results are not yet available, evaluation of the 4-month pilot project showed a significant reduction in substance abuse among youth participants. The RCMP noted, anecdotally, increased levels of trust among youth participants and high school guidance counsellor interveners, as well

as among community members and RCMP officers. The RCMP Commissioner's National Aboriginal Advisory Committee, Health Canada, and the National Crime Prevention division of the Department of Justice have expressed interest in this early intervention model.

The program enabled the interveners to get right inside the heads of 14 to 18 year old kids abusing substances in a very personal, in-depth way. When you get that close, the kids really open up. As a result of programs like this, communities are really understanding that people care, and it's changing the face of the RCMP. Communities are beginning to understand that the system really cares and is committed to being involved in ways that are more than just a reaction to crime and arresting people (David Wojak, key informant).

Sacred Smoke, Health Promotion/Smoking Cessation Program

(Connie-Gail Crowder, key informant)

Sacred Smoke is the first smoking cessation program in Canada developed by and for Aboriginal people.⁸ It was developed by the Wabano Centre for Aboriginal Health in Ottawa, an Aboriginal Health Access Centre (AHAC) funded by the Ontario Aboriginal Healing and Wellness Strategy. The Centre serves the urban Inuit, Métis, and First Nation population and has a clinical caseload of well over 3,000.

Concerned about the high rate of smoking, not only among clients, but also among the staff of the health access centre, two different smoking cessation projects were tried in collaboration with non-Aboriginal partners. When both of these efforts failed to see results due to the lack of cultural relevance, the Wabano Centre created an in-house pilot project to develop and test the effectiveness of a culture-based smoking cessation model. In 2004, the Wabano Centre developed and pilot tested Canada's first Aboriginal-specific smoking cessation program model, *Sacred Smoke*. With the success of the pilot project, the Wabano Centre then assisted three other AHACs to pilot the model in their communities during the year 2005: the Shkagamik-Kwe Health Centre, Sudbury; Southwest Ontario Aboriginal Health Access Centre, London; and Wassay-Gezhig Na-Nahn-Dah-We-Igamig, Kenora. It is a unique 8-module health promotion program that interweaves traditional teachings about tobacco as a sacred medicine with information about the serious health risks caused by addiction to commercial tobacco. It also promotes peer support to help sustain commitment to reduce and/or quit smoking and to instill cultural pride and self-worth as a shield against further addictive behaviours.

This program enables participants to create their own quit plan, foster peer support in the process of reducing or quitting, and learn about the teachings of traditional tobacco as a sacred medicine. Aboriginal teachings about traditional tobacco—its ceremonial use and positive impacts—are used to show how it differs from commercial tobacco—its misuse and health risks. In conjunction with weekly program modules, Elders conduct pipe ceremonies and sweat lodges that enable participants to experientially learn traditional ways of respecting tobacco. The program also provides holistic stress management techniques to help self-manage withdrawal symptoms and smoking cessation tools such as personal “quit plans” and information fact sheets.

⁸ The National Native Addictions Partnership Foundation Inc. (2005) has also developed a culture-based smoking cessation manual, *Keeping the Sacred in Tobacco*, which also includes a training session.

Peer support is one of the strengths of the program; supportive, caring relationships are formed among people who share a commitment to quitting and who support each other in that effort. Some pilot sites had additional support through smoking by-laws, smoking bans at workplaces and community events such as pow wows, and Aboriginal community leaders who publicly quit smoking in order to be positive role models for youth.

The four pilot projects generated significant interest in their communities—all are continuing the *Sacred Smoke* program. Early results showed that 50 per cent of participants had significantly reduced the amount smoked or had quit; another 46 per cent had firm plans to quit. When one of the pilot sites failed to draw participants to a weekly group as planned, they took the program into the local high school. Co-workers at one health centre also quit smoking due to the influence of the program and the cultural teachings. To date, 10 Aboriginal people have been trained and certified as facilitators/quit coaches. A binder of written materials with instructions for group facilitators/quit coaches has been produced as an ongoing resource for other service providers who want to implement this program.

Mamisarvik National Inuit Treatment Centre

Mamisarvik Healing Centre, a National Residential Co-ed Addictions Treatment Program for Inuit in Ottawa, Ontario is the first national treatment service of its kind in Canada to provide an Inuit-specific dual diagnosis program in trauma and addictions. The centre is funded by the Aboriginal Healing Foundation and was developed by Tungasuvvingat Inuit, referred to as “TI” by community members. TI is a community-based social, cultural, and counselling organization serving the needs of over 1,000 of Ottawa’s urban Inuit population.

TI staff identified alcohol as the number one addictions problem facing the urban Inuit community. Of these, 98 per cent have trauma issues related to intergenerational abuse and neglect (Barbara Seigny, Pam Stellick, and Ginette Chouinard, key informants). TI developed a proposal for a dual diagnosis treatment program with an optional residential component. The treatment program includes three components: individual pre-treatment; 8-week intensive treatment (individual and group); and ongoing aftercare for clients who are residents of Ottawa⁹ (individual and/or group options). The 8-week intensive program is holistic in its approach, touching on every aspect of addictions and trauma through the following components:

- a 3-hour assessment using screening tools for both trauma and addictions;
- group therapy is provided from 9 A.M. to 4 P.M. weekdays;
- individual therapy is provided at least once per week on a formal basis, and informally as needed;
- the addictions treatment component includes education about the impacts and effects of alcohol and drugs and skills to self-manage cravings and triggers;
- therapeutic interventions include a range of modalities including working with clay, voice and movement therapy, and crafts;
- relational skill development includes interpersonal relationship and parenting skills, assertiveness, and social skills;

⁹ Although a partnership has recently been developed to provide coordinated follow-up for Inuit returning to the North, a satellite program was not yet in operation at the time of writing.

- physical development includes Tai Kwon Do and visits to the gymnasium at the local YM/YWCA;
- nature therapy includes canoeing and a 3-day woods-camping trip during each cycle; and
- a culture and history component includes an Inuk Elder from the North, brought in for one week for every 8-week program cycle, who uses visual aids and storytelling to explore impacts of historical experiences unique to Inuit.

Aftercare programming is provided twice weekly for participants of the Mamisarvik treatment program as well as for Inuit who have participated in other treatment programs. Aftercare program activities include bridging to other TI or community services for employment, education, and/or counselling (individual, couple, and family) and case management, as well as ongoing participation in Inuit community cultural events.

The service is bilingual and the majority of the staff is comprised of Inuit who speak Inuktitut. The history of the North from pre-contact to the present is the context for healing exercises in which participants share personal stories of how their families and communities were impacted by experiences such as residential schooling, forced relocation, and the mass killing of sled dogs. There are few barriers to admission; clients do not have to be sober for a fixed time to enter the program, as long as “they are not drunk or high when they walk in the door.” Unlike some treatment programs, service is not terminated if a client relapses (although they are not allowed to live in the residence). Relapse is viewed as an opportunity to broaden learning about how to identify and manage triggers more effectively and recommit more strongly to recovery. The program is flexible and client-driven; day treatment groups can be integrated with residential treatment groups or run separately, and a harm reduction approach is integrated as needed.

The program serves approximately 150 clients annually through its pre-treatment, treatment, and aftercare programming of which 40 clients complete the 8-week intensive treatment program. According to staff, the biggest challenge facing Mamisarvik is human resource development. The majority of staff must be Inuit who speak Inuktitut, and there are few who have the level of specialized training and/or experience in addictions and trauma that is required. To support capacity building, funding is provided by TI to cover costs of certificate training for Inuit staff in trauma and addictions from the local college or other local training programs.

Promising Practices in Addictions Prevention and Intervention

A Client's Story Continued

"I spent 3 years in psychiatric facilities because I was diagnosed with dissociative disorders. It has been a long hard road and harm reduction is what worked for me, because it was dealing with the whole circle of me: the mental, physical and spiritual. They work with where you are, not where someone else wants you to be.

Before when I would relapse people couldn't get away from me fast enough; and we're already shame-based people so it made it worse. I learned about harm reduction 4 years ago through my mental health worker. I learned about what I needed in harm reduction like what it means to sleep properly, eat properly and if you're going to drink, have something to eat and make sure you sleep on your side.

Harm reduction also means surrounding yourself with good, positive people vs. negative people; and reducing sugar at night because it makes you feel hung over in the morning. And it's looking at the spiritual because my spirit was so damaged."

Chapters 1 and 2 of this report described the collective, multiple losses and mass suffering of Aboriginal people in Canada. Residential school abuse and other strategies of colonization have contributed to mass psychological trauma that has been passed from generation to generation. Chapter 3 explored an Aboriginal approach to healing from trauma and addictions that is grounded in the wisdom of traditional cultural beliefs. Chapter 4 described five community-driven healing models that are successful in addictions prevention and/or intervention using a cultural approach. The success stories are from very diverse Aboriginal communities, yet these reveal many promising practices common to all. This chapter summarizes some of those promising practices in addictions prevention and intervention. These have been drawn from the key informant interviews, a review of the literature, the five success stories, as well as from the client story that prefaces each chapter.

There is now ample evidence that the most promising approaches to addictions recovery in an Aboriginal context reflect a shared understanding of the origins of the addictions epidemic, a multidisciplinary approach to addressing the multiple interrelated factors underlying addictive behaviours, and healing strategies that align with the impacts of residential school abuse.

Reflections From a Key Informant

“In treatment they begin to learn they have a choice and they have a voice. Teaching about the history helps them to connect things from the past to the present so they can see where in history this belief system started that ‘white’ people were better. Relating issues of trauma and recovery to that history and to regaining power and control helps them find a balance for themselves in all this through assertiveness, patience and courage.

Countering what happened at residential schools means learning to feel safe verbalizing what is wrong, learning to work together, being action-oriented in an assertive way and healing by learning to give back to the community. Healing is also hunting and sewing; everybody feels that peace and sense of being ‘at home’ when they do things on the land and water, out in the openness.”

Barbara Sevigny

Summarizing the information gathered for this report, ten key characteristics that define a uniquely Aboriginal approach to addictions prevention and intervention become apparent.

Ten Characteristics of an Aboriginal Approach to Addictions

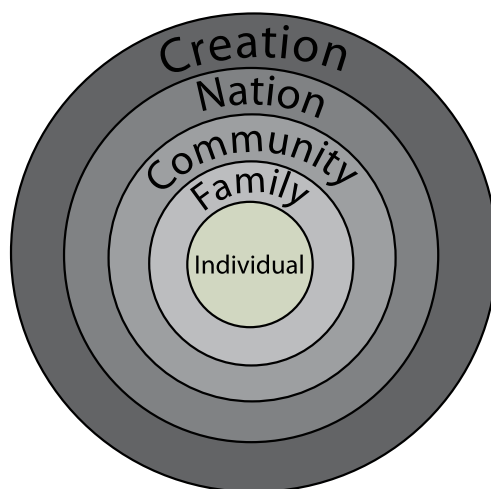
1. An Aboriginal approach identifies and addresses the underlying causes of addictive behaviours unique to the historical experiences of Aboriginal people in Canada.
2. The wisdom of Aboriginal cultures and spirituality is at the very heart of healing and recovery.
3. The relationship among suffering,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

The word “healing” is familiar to non-Aboriginal people, of course, but the idea that Aboriginal people have in mind when they use it is likely not. Healing, in Aboriginal terms, refers to personal and societal recovery from the lasting effects of oppression and systemic racism experienced over generations. Many Aboriginal people are suffering not simply from specific diseases and social problems, but also from a depression of spirit resulting from 200 or more years of damage to their cultures, languages, identities and self-respect (Hylton, 2002:Appendix C:5).

The foundational principle for effective addictions prevention and intervention that is interwoven through all five stories of hope and most promising practices is to **revitalize, live by, and pass on the wisdom of cultural teachings**.

An Aboriginal worldview is based on the concept of holism; therefore, it follows that an Aboriginal approach to prevention and intervention is multidisciplinary. Addressing mental, emotional, physical, and spiritual aspects of individual health in the context of strengthening families and communities allows “healing” to expand and to include a much wider array of therapeutic activities and goals. Figure 5 represents the concept that healing begins with the individual, extends to the family, then out to the community—resulting in a healthier nation.

Figure 5) Community Model for Healing



Ed Buller, Director of Aboriginal Corrections Policy Unit, proposes that Aboriginal community healing programs such as the Hollow Water model are revolutionary for the following reasons:

- they successfully maintain a deeply rooted sense of the individual in the context of a self-family-community dynamic;
- participants move at their own pace in learning how to become accountable in the context of their relationships to self, family, and community;
- participants are not labelled or blamed, but treated as worthy of respect even though they may have temporarily become unbalanced;
- programs are able to integrate professional and personal development of their staff with a blend of diverse healing strategies;

- self-recovery and personal growth are core aspects of staff development aimed at preventing burnout; and
- provincial and federal agencies are required to adjust their role to fit the cultural framework of the communities' healing process.

Young people are the largest and fastest growing sector of the Aboriginal population, creating an unprecedented opportunity for change. The most effective prevention and early intervention programs aimed at children and youth are those that **engage them physically, mentally, emotionally, and spiritually**. "Prevention must be connected to understanding ... why people drink and the abuses suffered in our communities" (Dion Stout, Kipling, and Stout, 2001:24).

Reflections From a Key Informant

"A 'best practice' is listening to the kids who are at high risk, balancing the trauma angle with the strengths and agency of youth to build on their own strengths and relationship bonds; the tremendous capacity in their connections and in their community and the belief and hope they have in their future; their capacity for self-expression through art and music and their connections to the land."

Dr. Nancy Comeau

Promising practices in prevention include a range of activities aimed at reducing social isolation, strengthening parenting skills, fostering healthy identity, and teaching children to express emotions in healthy ways.

Promising Practices

1. Program environments are places of belonging for children and youth to engage in socially healthy, fun ways with their families and Elders, as well as their peers.
2. Programming provides opportunities for fun, experiential, skill-based learning such as growing plants, making crafts, or hunting.
3. Youth services include diversion programs to reduce the number of youth in conflict with the law.
4. Education support is provided for children and youth through Head Start and stay-in-school programs as addictions prevention strategies.
5. Intergenerational activities bridge youth to Elders in planning and developing program materials and resources.
6. Parents are supported in gaining the skills needed to meet the needs and challenges of the adolescent stage in the life cycle.
7. All adults are aware that their role in programs is to model healthy, respectful adult relationships and problem-solving, especially among groups that have historically been in conflict.
8. Program activities tap into the creativity of youth and their need for meaning and purpose by allowing them to contribute in visible ways to their community.
9. Program activities provide opportunities for youth to meet their needs for self-esteem, challenge, and self-mastery in healthy ways.

Reflections From a Key Informant

“With youth even an incidence of substance abuse can be fatal because the context of youth can easily escalate into behaviour that is out of control. They can panic and overuse or someone who is high energy and chasing the fun can spin out of control with serious consequences. It is important to help youth identify and understand the interplay between thoughts, feelings and actions so they’re able to break them down into separate aspects. This can challenge their thinking and lead them to act differently; to slow down and step back.”

Dr. Nancy Comeau

The most promising practices in healing and recovery programs have been grouped to build on categories used in Aboriginal Healing Foundation evaluation reports:

1. Outreach and Engagement
2. Treatment Approaches
3. Significance of Culture
4. Team Qualities and Care
5. Opportunities for Learning
6. Engaging the Community
7. Collaboration and Partnerships

Outreach and Engagement

- Mobile outreach programs that break through isolation and build trust by maintaining a visible, consistent presence on the streets, in the shelters, or in the communities they are meant to serve.
- Outreach programs that engage with clients by providing basic necessities of life such as food, warm clothing, and simple kindness.

Treatment Approaches

The most effective programs are those that address addictive behaviours in the context of healing from trauma and addressing the Legacy:

- Therapeutic priorities include restoring belonging, hope, and self-determination.
- Intake and assessment match intervention strategies with a full range of client needs.
- Program activities help clients tap into the healing power of positive relationships among staff, peers, and Elders.
- Treatment is flexible, integrating a variety of traditional Aboriginal and contemporary therapeutic interventions (e.g. talk and movement therapy, art therapy, being on the land, and talking circles).
- Programs are holistic in addressing physical needs for nutrition and exercise, mental needs for new learning, emotional needs for self-esteem, and spiritual needs for a sense of meaning and purpose.
- Treatment plans are client-driven, include a harm reduction approach, and reflect where the person is on the healing journey.

Reflections From a Key Informant

“In terms of recovery, the most promising practice I’ve seen in the Aboriginal community is to ‘normalize’ the behaviour. I don’t mean to say that it is okay for you to do that; I mean it is totally understandable that you would choose this behaviour to calm yourself down because you don’t have other behaviours to choose - and actually let them ‘be’ with that. What I say to these clients is that I’m not going to take this away from you until we have something to replace it with that helps you manage, and that’s healthy.”

Dr. Brenda Saxe

Aboriginal women are burdened by multiple impacts of poor health, poverty, discrimination, violence, substance abuse, responsibility for children, and over-surveillance (Dion Stout, Kipling, and Stout, 2001). Yet, despite these extra burdens, Aboriginal women have taken a strong leadership role in the Aboriginal healing movement from levels of grassroots community to national organizations.

Promising practices based on a gender analysis are those that address factors specific to Aboriginal women's experiences of addictions, recovery needs, and barriers to service. "[P]overty and victimization by one's partner were shown to be closely associated with women's abuse of substances while pregnant" (Dion Stout, Kipling, and Stout, 2001:24). Prevention and intervention that are gender-sensitive and gender-specific ensure that program activities respond to both women's and men's needs, concerns, and capacities; examples include:

- ✦ *safety* from further violence and abuse for women and girls is a priority;
- ✦ address the stigma and discrimination experienced by substance-abusing women and girls;
- ✦ provide gender-segregated counselling, especially for trauma recovery;
- ✦ align programming with the health needs of pregnant women;
- ✦ ensure male and female program staff members role model gender equality and respect; and
- ✦ integrate education about women's and men's traditional knowledge.

Reflections From a Key Informant

"Women need places to explore the impacts of colonialism in terms of its patriarchal influence over women and how that's been integrated into Indigenous attitudes and behaviours within Inuit, Métis and First Nation tribal systems so women can articulate for themselves what this has meant in terms of their own experience."

Bernice Downey

Program activities in the continuum of care have shown that activities based on a gender analysis ensures pregnant women and women with dependent children are not revictimized when seeking help for addictive behaviours. This means actively making "these services welcoming, accessible, relevant and safe for women with substance abuse problems" (Poole and Dell, 2005:10).

Aboriginal women are less likely to seek treatment for substance abuse for fear their children will be apprehended and placed in adoptive homes or formal arrangements of some kind (Benoit et al., 2001:36).

Information from key informants and the evaluation literature shows a lower participation rate in healing programs for Aboriginal men. Some promising practices for drawing men to healing and recovery programs include engaging men in outdoor, recreational activities to promote trust-building and a sense of belonging and integrating informal therapy with the development of peer support in the context of hands-on group activities.

Promising practices based on a gender analysis also address the experiences, needs, and barriers to services faced by two-spirited people. These are addressed by:

- ✦ ensuring services reflect a “two-spirited friendly” environment by prominently displaying posters and resources depicting two-spirited people and their issues;
- ✦ providing the option of separate, confidential two-spirited counselling programs on both an individual and group basis;
- ✦ educating staff, Elders, and community members about two-spirited issues; and
- ✦ monitoring policies, programs, and services to ensure they prevent homophobia and promote acceptance.

Significance of Culture

Addictions prevention and intervention programs grounded in a “culture as healing” approach infuse the healing and recovery process with deeper meaning for participants and service providers alike. Some of the following are traditional methods of promoting health and balanced well-being that communities and programs draw upon for healing:

- ✦ hunting and being on the land
- ✦ planting and harvesting food and medicines
- ✦ games
- ✦ camping
- ✦ canoeing/kayaking
- ✦ carving
- ✦ sewing/beading
- ✦ regalia-making
- ✦ dancing
- ✦ drumming
- ✦ singing
- ✦ seasonal celebrations and ceremonies
- ✦ communal feasts, potlatches, and give-aways
- ✦ life cycle ceremonies
- ✦ talking circles
- ✦ storytelling, and
- ✦ valued roles for Elders, women, and two-spirited people.

Team Qualities and Care

- ✦ Recruiting, hiring, and evaluating staff members according to criteria that determine suitability for the work;
- ✦ building capacity by providing training in addictions and trauma for Aboriginal staff;
- ✦ providing regular opportunities for program staff to debrief;
- ✦ providing opportunities for culturally sensitive clinical supervision;
- ✦ establishing interagency committees that meet regularly to coordinate services and share information;
- ✦ developing protocols outlining each service provider’s role in a full continuum of care for addictions prevention and intervention;

- monitoring the staff team to assess impacts of the work and effectiveness of self-care plans; and
- valuing Elders and traditional healers/teachers as respected addictions specialists in their own right.

Opportunities for Learning

Reflections From a Key Informant

“Self-care is a way of honouring ourselves as well as honouring the clients. We need to be healthy and we need to model what health looks like - that means building in the support we need as workers, not seeing this as a sign of failure but as doing what you need to do just for you. That will make it alright for the clients to do self-care for themselves without seeing it as selfish.”

Shiningwater Diabo

- Legacy education is provided for all clients, staff, and community members aimed at stopping the intergenerational cycle of trauma and addictions;
- information about the holistic health impacts of substance abuse and addictive behaviours is provided to clients, staff, and community members;
- relationships skill-building that counters the Legacy: parenting, couples, social skills, and peer support;
- problem-solving skills to identify and self-manage triggers while reframing “problems” as “opportunities” for ongoing learning and growth;
- traditional life cycle teachings—what the mind, body, heart, and spirit need for healthy development throughout life;
- program activities that increase self-esteem by restoring pride in cultural identity and ancestry; and
- stories and legends that illustrate the humor, strength, and resilience of Aboriginal people to build capacity.

Engaging the Community

- Healing programs are community and client-driven;
- programs are flexible, holistic, and multi-dimensional in response to evolving client and community needs;
- Elders, women, and youth have meaningful roles in planning and decision-making;
- seasonal ceremonies and communal meals bring people together to celebrate culture;
- employment and education opportunities are enhanced through community and economic development plans;
- recreational activities are provided for families, children, and youth;
- partnerships are created between elementary and high schools and Aboriginal services;
- human service providers (police, health practitioners, social workers) are educated about Aboriginal culture and history; and
- the capacity of communities to address their own social, health, and economic needs is enhanced.

Collaboration and Partnerships

- Restorative justice models for youth drug offences integrate early intervention programs; and
- partnerships between police and Aboriginal addictions outreach services divert people who are homeless with chronic addictions away from the prison system.

Lane and colleagues (2002) propose that the development of planning agreements be guided by answers to the following set of questions:

1. How will the work support healing as a long-term process?
2. How can some of the capacity of the partner be transferred to the community as part of the working relationship?
3. How does the proposed work fit into the community's overall plan and defined process for healing?
4. How will the community be stronger and more able to carry on healing work when the outside resource leaves?

Reflections From a Key Informant

“The process of working together is bigger than just one person and sometimes you can't be the driver of it. One has to step back and let the spirit of the process navigate the direction, and this requires patience and flexibility as well as recognition and appreciation of the historical context and the cultural relevance of an action. Then the meaning will create itself.”

Dr. Nancy Comeau

Table 5) Checklist for Implementing Promising Practices in Addictions Prevention and Intervention

Promising Practices	Yes	In Progress	No
1. Our program is effective in creating a place of safety, unity, belonging, and trust for Aboriginal participants: <ul style="list-style-type: none"> ✦ procedures for prevention and intervention programs reflect an Aboriginal approach to holistic health; ✦ the physical environment of our program visibly welcomes and celebrates all Aboriginal people; and ✦ client safety,¹⁰ confidentiality policies, and a code of ethics are in place and evaluated regularly by clients and staff; and ✦ resource materials and staff members are available to provide service in the first language of participants. 			
2. Each staff person and volunteer associated with our program has received education on the legacy of residential school abuse and its intergenerational impacts.			
3. Our program educates participants about the legacy of residential school abuse and its intergenerational impacts.			
4. Our program educates other service providers and community members about the legacy of residential school abuse and its intergenerational impacts.			
5. Survivors of residential schools are invited to share their stories with program participants and community members.			
6. Our program either provides or is able to bridge participant's family members and significant others to family therapy.			
7. Our program provides or bridges participants to cultural healing specialists such as Elders and traditional teachers or Aboriginal services for traditional healing supports such as: <ul style="list-style-type: none"> ✦ life cycle teachings; ✦ healing, talking, or sharing circles; ✦ on-the-land camps; ✦ a range of expressive arts and crafts; and ✦ ceremonies (Qulliq lighting, smudging, sweat lodge). 			

¹⁰ For further information on client safety and confidentiality policies, refer to *Conducting Assessment in First Nations and Inuit Communities: A Training and Reference Guide for Front Line Workers*, National Native Addictions Partnership Foundation Inc. (Restoule, 2004).

Promising Practices	Yes	In Progress	No
<p>8. Our addictions intervention program provides or bridges participants to culturally appropriate, gender-sensitive mental health programming supports such as:</p> <ul style="list-style-type: none"> + trauma recovery; + anger management; + grief and loss counselling; and + healthy sexuality. 			
<p>9. Our program provides or bridges participants to other services in a continuum of planned care that includes:¹¹</p> <ul style="list-style-type: none"> + prevention; + outreach and engagement; + assessment and referral; + diagnosis; + secondary prevention (including early intervention); + pre-care; + treatment (or intensive intervention) goal plans and success indicators, including discharge goals and success indicators; and + continued care/relapse prevention. 			
<p>10. Our program has mechanisms for Aboriginal-driven, interagency collaboration and case management for all service providers in a continuum of care. For example:</p> <ul style="list-style-type: none"> + we have developed a shared vision and plan for case coordination and management; + we hold regularly scheduled meetings with all major service providers involved with the clients; and + our plan includes monitoring, coordination, and advocacy. 			
<p>11. Our addictions prevention program includes (Korhonen, 2004):</p> <ul style="list-style-type: none"> + information about addictions and their impacts; + guidelines for self-assessing level of risk; + opportunities to develop coping, life, relationship, and social skills; and + opportunities to strengthen family relationships. 			
<p>12. Program participants are provided opportunities to learn new skills and contribute back to the program or community.</p>			

¹¹ See *Continuum of Care Fact Sheet* in Appendix A for additional information.

Promising Practices	Yes	In Progress	No
13. Our program has a team care plan to monitor the impacts of the work on staff to prevent burnout: <ul style="list-style-type: none"> ♦ our staff debrief regularly after programming; and ♦ we provide regular staff retreats to reflect on and share promising practices and lessons learned. 			
14. Our program has mechanisms in place for ongoing monitoring and evaluation to assess impact and emerging needs.			
15. Our human resource plan builds Aboriginal capacity through: <ul style="list-style-type: none"> ♦ recruitment and retention strategies and goals; ♦ characteristics and skills assessment specific to addictions work for all screening and performance reviews; ♦ staff training and development in addictions and trauma on an ongoing basis; and ♦ staff appreciation. 			

Checklist of Characteristics and Skills of Addictions Workers

Personally suitable for the work demonstrated by:

- a a non-judgmental attitude
- a ability to demonstrate compassion and empathy, which “means the counsellor listens well, accepts what the client says, does not judge or deny the client’s views, and helps clients understand themselves through their own words” (Korhonen, 2004:25)
- a ability to set and maintain clear boundaries
- a self-care skills (knowledgeable about and practices holistic stress management)
- a proven commitment to personal lifelong learning and own healing path

Culturally suitable for the work demonstrated by:

- a Aboriginal descent
- a Aboriginal language skills
- a knowledge of Aboriginal cultural beliefs, practices, and principles concerning health
- a knowledge of Aboriginal diversity
- a receives guidance and support from respected Elders and traditional teachers

Knowledge of addictions demonstrated by:

- a knowledge of types of addictions and their impacts, assessment skills, treatment planning skills, relapse prevention and harm reduction strategies, and experience with a range of treatment modalities (Aboriginal and Western)
- a knowledge of intergenerational legacy of residential school abuse
- a practicing team debriefing and team support
- a seeking clinical guidance and supervision from qualified source
- a experiential knowledge of some aspect of the field

Other Helping Skills Based on Inuit Traditional Values (Minor, 1992):

- a Inuktitut language skills
- a able to listen carefully and intently
- a able to demonstrate empathy, warmth, and positive regard
- a able to give advice and receive respect for the wisdom of that advice, and
- a able to employ *Ajurnarmat*, the strategic use of silence (whether to communicate concern and understanding or build strength in group contexts)

Conclusion and Continuation of the Journey

A Client's Story Continued

"I needed to know that you can walk away from being damaged goods but you need those role models that have been through the same things. Now my voice is needed in the mix because what I have to say is so important. I feel that I have an ability and an obligation to take what I've learned and pass it on. I have a yearning to do this and I have to get my self better in order to do it. I feel like I'm 18 again and the veil is off and things are clearer than they've ever been in my life. For the first time I see it and other people see it too; I shine."

From an Aboriginal perspective, the history of Aboriginal people is more than stories of mass trauma. All Aboriginal communities in Canada (Inuit, Métis, and First Nation) have managed not only to preserve but also to cherish the beauty and distinctiveness of their cultural identities throughout centuries of cultural genocide, displacement, forced relocation, and assimilation. Deeply rooted resilience and determination sustains the Aboriginal healing movement.

Inuit, Métis, and First Nation cultural teachings have not only survived but increasingly are being recognized for their practical wisdom. It is now widely accepted that contemporary social values, such as competition and consumption, must be replaced by mutual respect, sharing, and cooperation in order to build a more humane and sustainable society. Inuit, Métis, and First Nation communities in all parts of Canada have created a revolutionary approach to healing that is grounded in their cultural teachings. A cornerstone of this approach is validation:

1. Validation of the social and historical injustices underlying addictive behaviours.
2. Validation of the collective human suffering brought about by these injustices.
3. Validation of the strength, resilience, and continued relevance of cultural teachings and practices.
4. Validation of the value of each person and each person's capacity for change.

Information provided by key informants and the literature review underscores the crucial need to build capacity all along the continuum of care. Some of the most urgent gaps in services include assessment programs that identify high-risk children and youth and direct them and their families to a range of community supports. As well, organizations and providers of health and social services for Aboriginal people should clearly demonstrate a commitment to addictions prevention and intervention in their mandates, guiding principles, and work plans.

Gaps in intervention include:

- a full range of services for the North from detoxification and treatment to continuing care programs staffed by qualified Inuktitut-speaking Inuit;
- education and prevention resource materials available in Inuktitut;
- pre-care services for Aboriginal youth that provide a safe place to withdraw from alcohol and/or drugs and to stabilize mentally, physically, emotionally, and spiritually before entering treatment;

- detoxification and treatment services for Aboriginal women and their children;
- more “brief” detoxification services as an alternative to overnight incarceration or emergency room admission for people who are intoxicated but do not require medical attention;
- mobile services that outreach health and addictions intervention for Aboriginal people who are homeless and/or street-involved;
- cross-training for staff in an Aboriginal approach to addiction and mental illness; and
- communications that directly impact access to resources and the capacity of front-line workers.

Reflections From a Key Informant

“Research and production of reports is often the end of the road; there is not as close attention paid to distributing what has been produced. There is a level at which this information circulates and it’s not filtering down to the front lines of addiction work.”

Pam Stellick

Long-term recovery from addictive behaviours requires both the capacity to envision a future of hope and the practical means to make that vision a reality. Community-based prevention and intervention is just one aspect of a long-term solution. Restoring balanced, holistic health in the Aboriginal population also requires significant improvements to the social and economic conditions impacting health.

“Healing” needs to go (conceptually) far beyond ending hurt and dysfunctional patterns. It also needs to include building a new pattern of life that is healthy and pursuing visions and dreams of possibility. In so far as healing is restoring balance to a people and society that were thrown out of balance by what happened to them in the past, then that restoration must go far enough to return the people to a form of life that extends beyond meeting the basic minimum requirements for survival. “*Healing as restoration*” must also mean creating the conditions within people and their society that will support and enhance the realization of human potential (Lane et al., 2002:56).

As the healing journey continues to unfold, the enduring wisdom of culture and “Good Medicine” stories are creating a new future for the next generation.

A Client's Story Continued

“My children are the first in generations of my family to be raised at home. Each generation now will do better than the last.”

Fact Sheet: Current Definitions and Conceptual Models

Addiction: increasingly, this term is used to describe “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’s life, and is perceived as extremely difficult to overcome” (National Native Addictions Partnership Foundation [NNAPF], 2000:67).

Continuum of Care: a full continuum of care includes the following services:

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 intervention goals	Anticipatory advice & counsel; family support; assistance with practical affairs; making transportation arrangements	Intensive intervention, whether: a) out-patient counselling from Traditional Healer or Counsellor; b) short-term residential care (1–2 wks.); c) Intermediate 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) voluntary 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 (NNAPF, 2000:43).

Continuum of Problems: although substance abuse problems vary widely, they can be grouped into the following categories along a continuum of behaviours:

- ✦ 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 (NNAPF, 2000:41).

Disease Model: refers to the substance abusing client as a “patient” with a disease who needs to be cured through treatment, preferably in a specialized facility where experts are responsible for planned and managed recovery. The advantage of this model is that it has greatly helped to change negative attitudes about addictions as a “sin” or a character flaw. The disadvantage of this model is that it does not take into account underlying social or behavioural factors. “In effect, the medical/disease model tends to “medicalize” what is really a behavioural problem strongly, often overwhelmingly, influenced by social-environmental factors” (NNAPF, 2000:29).

Harm Reduction Model: refers to healing efforts that are aimed at reducing drug-related harm without the need to quit the use of the drug. An example is a methadone program, where a substance-addicted individual replaces the opioid, such as heroine, with methadone to help change their behaviour and to discontinue heroin use.

Population Health Model: “emphasizes self-exploratory assessment of both the routine and exceptional challenges posed in different spheres of basic living ... 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” (NNAPF, 2000:30).

Substance Abuse: refers to the “use of mood-modifying, psycho-active substance[s] in a fashion that places the physical and/or emotional safety of the user and/or others at risk due to the poor judgment 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 heavy drinking or impairing doses of other drugs or learn to control the amount and style of their use within risk-free limits” (NNAPF, 2000:69).

Substance Dependence: 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” (NNAPF, 2000:69–70).

Healing From Addictions: involves 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 (NNAPF, 2000:67).

Fact Sheet: Recognizing and Treating Addictive Behaviours and Substance Abuse¹²

The array and availability of mood-altering substances are growing whether on-reserve, in remote and Northern communities, and on urban streets. While some substances are far more dangerous in the short-term, others can become increasingly more dangerous over time. The effects of each specific substance may vary widely depending on:

- the user's age, body weight, and gender;
- their state of physical and mental health;
- how much they use, how often, and for how long;
- whether the substance was smoked, swallowed, inhaled, or injected;
- the user's state of mind, expectations, and environment; and
- whether the user has combined the substance with alcohol or other drugs (whether illicit or prescription, over-the-counter, or herbal).

Combining drugs can also change or magnify their effects. Many drugs become more dangerous when they are mixed. For example, people who are prescribed drugs such as codeine for pain or benzodiazepines for anxiety may combine them with another depressant like alcohol. This can lead to confusion, depressed breathing, and risk of coma or death. Some people using illegal drugs may mix drugs unknowingly because they do not know what is in the drugs they are taking, while other users mix drugs intentionally even when they know the risks. The chart on the next fact sheet shows the major drug groups and their key signs and symptoms.¹³

¹² Unless otherwise stated the source for these fact sheets is the Centre for Addiction and Mental Health (2001) *Do You Know...* series of information brochures.

¹³ Increasing attention is being paid to mandatory and coerced treatment of substance abuse especially for youth. For further information see the Canadian Centre on Substance Abuse information fact sheets at: www.ccsa.ca

Fact Sheet: Types of Substances, Signs, and Symptoms¹⁴

Substance	Signs and Symptoms
<p>Depressants: <i>drugs that cause a slowing down or depression of the central nervous system:</i></p> <ul style="list-style-type: none"> + Alcohol (ethyl or ethanol) + Inhalants + Opioid analgesics + Benzodiazepines 	<ul style="list-style-type: none"> + Relaxation, slowed breathing + Slurred speech, lack of coordination + Impaired memory and judgment + Slowed heart rate, dizziness + Inappropriate emotional responses + Depression + Drowsiness, sedation, or coma + Constipation + Needle marks (if injecting drugs)
<p>Stimulants: <i>drugs that excite or stimulate the central nervous system:</i></p> <ul style="list-style-type: none"> + Amphetamines + Methamphetamines + Methylphenidate (Ritalin®) + Cocaine + Caffeine + Commercial Tobacco 	<p><i>Signs and symptoms vary depending on type:</i></p> <ul style="list-style-type: none"> + Euphoria + Decreased appetite, weight loss + Rapid speech, irritability, restlessness + Depression as the drug wears off + Nasal congestion and damage to the mucous membrane of the nose in users who snort drugs
<p>Cannabis: <i>mind-altering drug that produces depressant effects as well as increased heart rate:</i></p> <ul style="list-style-type: none"> + Marijuana + Hash or hash oil + Marinol® and Cesamet® are trade names of synthetic forms prescribed for people with AIDS or cancer to relieve pain and muscle cramps 	<ul style="list-style-type: none"> + Sense of relaxation, may be more talkative and/or giggly + Heightened taste, touch, and smell + Impaired memory + Increased heart rate and appetite + Decreased blood pressure, impaired balance + Red eyes and dry throat and mouth + Difficulty concentrating, poor judgment, or paranoid thinking
<p>Hallucinogens: <i>mind-bending drugs that distort perceptions, emotions, and thoughts causing people to see, hear, smell, taste, or feel things that are not there:</i></p> <ul style="list-style-type: none"> + Plant hallucinogens are cacti (mescaline), mushrooms (psilocybin), and other plants (cannabis, salvia) + Synthesized hallucinogens are LSD, Ecstasy, Phencyclidine (an animal tranquilizer), and Ketamine (an anesthetic) 	<p><i>Signs and symptoms vary depending on type:</i></p> <ul style="list-style-type: none"> + Increased heart rate, blood pressure + Impaired perception of reality + Flashbacks <p><i>Synthesized and “designer” hallucinogens</i></p> <ul style="list-style-type: none"> + Sweating, flushing, drooling, nausea, or vomiting + Disoriented, numbness + Paranoid, suicidal, or violent behaviour

¹⁴ Source: This chart of signs and symptoms is based in part on information developed by the Mayo Clinic (<http://www.mayoclinic.com>).

Fact Sheet: Alcohol

Alcoholism is a chronic, usually progressive condition involving habitual and/or excessive use of alcohol. Alcoholism has come to be considered a disease in its own right, although some studies show that choosing alcohol as an addictive substance as well as the manner of consuming it is a learned behaviour. Many alcohol-related illnesses, accidents, and offences are caused by *alcohol abuse* behaviours such as binge drinking or severe intoxication that are not necessarily related to alcoholism or physical dependence. Drinking and driving is the largest single criminal cause of death and injury in Canada. (Refer to the *Fact Sheet: Current Definitions and Conceptual Models* for more information about the types and categories of addictive behaviours.)

Effects: Alcohol affects the central nervous system in ways similar to other depressant drugs by slowing down the parts of the brain that control thinking, behaviour, breathing, and heart rate. At low doses, this produces feelings of relaxation and lowers inhibitions. At higher doses, it results in intoxication, impaired judgment and coordination, and at very high doses, coma and even death. Alcohol has toxic as well as sedative effects on the body; therefore, failure to attend to nutritional needs during long bouts of excessive drinking can severely worsen its effects.

Alcohol abuse is associated with serious medical problems including psychosis and anxiety, as well as damage to the digestive system, liver, brain, and nervous system. Alcoholic liver disease is a major cause of illness and death. Chronic use of alcohol can also damage the brain leading to dementia, difficulty with coordination, and loss of feeling in the feet. With continued abuse of alcohol, physical dependency is created and withdrawal symptoms are experienced when drinking is stopped. Dependence often leads to clinical depression; the rate of suicide among people who are alcohol-dependent is six times that of the general population.

Gender and Age Differences: Women are generally more sensitive to the effects of alcohol than men, and all adults become increasingly sensitive to alcohol's effects as they age.

Effects During Pregnancy: Consuming alcohol during pregnancy can cause **permanent and irreversible harm** to the fetus. Fetal alcohol spectrum disorder (FASD), although untreatable, is completely preventable.

Withdrawal Symptoms: These can develop within a few hours after the last drink. Ranging from mild to severe, symptoms may last a few hours to seven days and include anxiety, insomnia, agitation, increased blood pressure, pulse, and perspiration. Tremors, nausea, seizures (grand mal), alcoholic hallucinations, and delusional thinking may also occur. Some people experience delirium tremens, or "the DTs," five to six days after drinking stops. This dangerous syndrome consists of frightening hallucinations, severe hypertension, fever, racing heart, hostility, and fear. Blackouts may also occur. If left untreated, symptoms in this stage can be fatal.

Treatment and Clinical Management: Treatment for alcohol dependence usually begins with the management of the physical withdrawal symptoms at detoxification centres. Benzodiazepines or naltrexone may be prescribed in the acute phase to control seizures and manage symptoms of anxiety. Treatment for recovery from psychological dependence is a longer-term process that may include any

combination of self- or mutual-help programs and individual or group therapy in either residential, outpatient, or community-based treatment facilities. Although there is no single, most effective treatment approach, recovery models are generally divided into two camps. One is the treatment model popularized by the AA movement, which is based on complete abstinence, one day at a time. The other model uses a treatment plan based on harm reduction, which is a phased-in approach leading to either complete abstinence or addictive behaviour management. Since people in recovery may continue to crave alcohol even after long periods of abstinence or reduction, helping them identify and self-manage their own unique triggers is a central feature of relapse prevention programming.

Note: For some examples of Aboriginal-specific, culturally-based approaches to treatment see Chapter 3.

Fact Sheet: Inhalants¹⁵

The term “inhalants” refers to chemical vapours or gas that produce a high when breathed in. Most substances used as inhalants have other everyday uses. These are generally cheap, legal, and easy to find, which give them a high potential for abuse, especially by children and young adults.

Street Names: glue, gas, sniff (solvents), whippets (nitrous oxide), poppers, and sometimes sold under brand names such as Rush, Bolt, or Kix (nitrites). Examples of commonly abused inhalants include:

- *solvents* in products such as gasoline, paint thinners, hobby glue, correction fluid, and felt-tip markers;
- *aerosols* in hair spray, spray paints, cooking spray, and other products containing pressurized liquids or gases;
- *gases* such as nitrous oxide (laughing gas), ether, chloroform, butane lighters, and whipped cream cans; and
- *nitrites* sold as room odourizers or video head cleaners.

Solvents and aerosols used as drugs are either inhaled directly from the container (sniffed), from an inhalant-soaked rag held to the mouth (huffed), or from a bag placed over the nose and mouth (bagged). Aerosols may also be sprayed into a bag or balloon and then inhaled. Gasoline can be sniffed directly from a gas tank.

Effects: Inhalants are absorbed through the lungs and travel very quickly, within five to eight seconds, in the blood to the brain. This produces an immediate and brief intoxication similar to drunkenness, but with more distortion of perception, time, and space. Several breaths of solvents will produce a high that may last up to 45 minutes. Additional breaths will sustain the effects for hours, followed by drowsiness and a hangover with a mild to severe headache that can last up to several days. Habitual users develop a tolerance and need larger amounts to feel the same effects. The effects vary depending upon the type of inhalant used and include loss of inhibitions, euphoria, exhilaration, slurred speech, impaired movement and thinking, dizziness, blurred vision, anxiety, headache, chest or stomach pain, nausea, hallucinations or psychosis, and aggression or violence.

Inhalants are among the most toxic and dangerous substances of abuse. Solvent abuse can cause permanent damage to the brain: even one sniffing session can result in death. Some outcomes include suffocation where some users have passed out with the plastic bag still in place over the nose and mouth. Sudden sniffing death (SSD) can occur when prolonged sniffing leads to a rapid and irregular heartbeat or when stress or strenuous exercise follows several deep inhalations. Mixing solvents with other depressants like alcohol or sleeping pills can also be fatal. Reckless fires and accidents can result from impaired judgment or an altered state due to inhalant abuse as well as destructive, violent, or suicidal behaviours.

Long-term use of inhalants causes pneumonia and other respiratory infections, as well as damage to the liver and kidneys, eyes, bone marrow, heart, and blood vessels. Gasoline sniffing can result in lead

¹⁵ Source: Canadian Paediatric Society (1998).

poisoning and, in extreme cases, can cause dementia and muscle paralysis. Other health impacts include brain damage, memory loss, personality changes, convulsions, deafness, impaired vision, depressed motor skills, and death.

Effects on Pregnancy: The existence of fetal solvent syndrome can potentially cause premature birth, irreversible birth defects, or stillbirths.

Withdrawal: Symptoms begin within a few hours to a few days after stopping the use of inhalants and include irritability, restlessness, depression, lethargy, tiredness, aggressiveness, chills, headaches, and hallucinations. In extreme cases, delirium tremens similar to the DTs of alcohol withdrawal has been reported.

Treatment and Clinical Management: For chronic users, withdrawal can be difficult and is best managed under supervised care. Treatment of withdrawal from inhalants follows a similar model to that for alcohol, starting with supervised detoxification. Detoxification from inhalants, however, takes much longer. Short-term detoxification requires 14–30 days. Long-term detoxification may take another six months, during which time a major focus of treatment is abstinence. Rehabilitation programs for inhalant abusers are especially important because the toxic effects become irreversible with continued use.

Warning Signs and Symptoms That May Indicate Inhalant Abuse:

- Products stored in unusual places, such as jars of gasoline or spray cans under a bed;
- an odour of the inhalant on someone's breath or clothing;
- clothing stained with flecks of paint or glitter on the face;
- small infections on the face where inhalants have dried and allowed bacteria to enter;
- behaviour or personality changes; and
- weight loss, frequent episodes of intoxication, and poor grooming.

For further information see listings in the Annotated Bibliography.

Fact Sheet: Amphetamines and Methamphetamines

Amphetamines and related drugs such as methylphenidate (Ritalin[®]) act like an adrenaline to excite or speed up the central nervous system. Medical use of these drugs is restricted because of their adverse side effects and high potential for abuse. These are commonly used to treat narcolepsy, attention-deficit hyperactivity disorder (ADHD), Parkinson's disease, and in a very limited way, obesity.

Street Names: Speed, Bennies, Black Beauties, Crosses, Glass, Crystal, Crank, Pep Pills, Uppers, Chalk, Ice, Crystal Meth, Jib, Gak, Tina, and Yaba.

Trade Names: amphetamine, dextroamphetamine (Dexedrine[®]), and Methamphetamine (Dexocyn[®]).

Methamphetamine (MA) "crystal meth" was first marketed as a nasal decongestant, and is still medically available in the United States as a treatment for obesity. Street methamphetamine is produced throughout Canada and the United States in illegal labs using inexpensive, often toxic or flammable, ingredients. While pure amphetamines are white, bitter-tasting, odourless powders that dissolve easily in water, illegally produced amphetamines vary in purity, colour, texture, and odour. In smokable form, MA resembles shaved glass slivers or clear rock salt. In addition to tablets or powder, it can take the form of a waxy base, paste, or re-crystallized powder known as "crystal" or "ice." Depending on the form, it can be snorted, smoked, injected, or swallowed (Deguire, 2005). Use has increased especially among young people at raves, clubs, and parties because MA is low cost and easy to make. Its use among homeless youth also appears to be increasing.

Effects: MA stimulates the heart and respiratory system, increasing heart rate and blood pressure. When smoked or injected, it produces an initial surge or rush followed by a heightened state of awareness that can last up to twelve hours. Sniffing or swallowing produces less intense feelings of euphoria. Users feel alert, energetic, confident, and talkative with little need for food or sleep. They are also likely to feel unwanted effects of the drug, including racing of the heart, chest pain, nausea, agitation, tremors, and irritability. Taken in high doses, crystal meth can cause aggressive or violent behaviour, mental confusion, anxiety, and inability to sleep. Long-term use of amphetamines can lead to weight loss, irritability, and anxiousness. In extreme cases, long-term use can also lead to paranoid delusions, hallucinations, aggression, and impulsive violence referred to as *amphetamine psychosis*. Another side effect of regular users is dry mouth and rotting teeth, known as "meth mouth."

The purity and strength of illegal methamphetamine varies so widely, causing difficulty to judge the size of a dose or its effects. An overdose resulting in seizures, high fever, burst blood vessels in the brain (stroke), or heart failure can be fatal. Due to the body's rapid tolerance for amphetamines, users need more and more of the drug to achieve the desired effect, increasing their risk of adverse reactions and overdose.

Warning Signs and Symptoms: Indications of crystal meth abuse include "meth mouth," loss of appetite, and the user is more wakeful, talkative, and active.

Signs of Overdose: These include loss of consciousness, faster breathing, twitching or seizure, overheating, racing or irregular heartbeat, and chest pain.

Other Prescription Drugs: Ritalin® (methylphenidate) is the medication used to treat attention deficit hyperactivity disorder (ADHD), and is widely used to control problem behaviours in children. As a street drug, Ritalin® is generally crushed into a powder and snorted, or dissolved and injected, producing amphetamine-like effects. Some users inject the prescription painkiller Talwin® (pentazocine) together with Ritalin®, a stimulant. This drug combination produces a high similar to the effect of heroin mixed with cocaine followed by an emotional low and physical depression. Combined abuse creates tolerance, requiring more and more of the drugs to feel the same effects. Higher doses can cause dizziness, nausea, vomiting, shakiness, confusion, constipation, anorexia, insomnia, paranoia, and even hallucinations. Very high doses can lead to coma and death.

Withdrawal: Dependent users who stop taking methamphetamine have strong cravings and, within a few days, experience withdrawal symptoms including stomach pain, hunger, headaches, shortness of breath, tiredness, and severe depression. Symptoms of withdrawal from Talwin® and Ritalin® abuse include insomnia, abdominal cramps, nausea, anxiety, and severe depression.

Treatment and Clinical Management: Detoxification generally follows the same procedure as with other chemical addictions. A period of supervised physical detoxification followed by a “Matrix” treatment model combining cognitive-behavioural therapy, social support, family education groups, individual counselling, and urine testing has shown positive outcomes (Deguire, 2005).

Fact Sheet: Opioids¹⁶ **(Heroin, Morphine, Codeine, Methadone, and** **Other Prescription Painkillers such as Oxycodone)**

Opioids are drugs that give morphine-like effects, used primarily to treat severe, acute pain. Some opioids such as morphine and codeine are natural products of the opium poppy. Heroin is made from morphine that has been chemically processed.

Trade Names: Synthetic prescription opioids, such as oxycodone (in OxyContin®, Percocet), Demerol®, and methadone, are manufactured in the laboratory.

Street Names: H, horse, smack, shit, skag (for heroin); M, morph, Miss Emma (for morphine); meth (for methadone); percs (for Percodan®, Percocet®); and oxy, OC, oxycotton, killer, kicker, and hillbilly heroin (for oxycodone).

Commonly abused opioids include oxycodone, codeine (in Tylenol #s 1, 2, and 3; 292s; Atasol 8, 15, and 30; Exdol 8, 15, and 30), hydrocodone (in cough syrups such as Tussionex and Hycodan), hydromorphone (as Dilaudid), morphine, and heroin.

In its pure form, heroin is a fine white powder; but when sold on the street, its colour and appearance depends on the type of additives used to cut it. A “rush” heroin is commonly injected because it produces stronger, faster effects. It may also be snorted, smoked, or crushed and ingested. Other opiates commonly injected include morphine, meperidine (Demerol®), and increasingly for its heroin-like effects, oxycodone.

Effects: Opioids produce feelings of calm, euphoria, and detachment from physical and emotional pain. Physical effects include slowed breathing, pinpoint pupils, itchiness, and sweating. Higher doses are required to have the same effects as tolerance to the drug develops. This can increase risk of death from overdose. Risk is further increased by the unknown purity of the drug, by injection, and by combining heroin with other depressants. Tolerance to opioids can develop very quickly, along with psychological and physical dependence; regular use can lead to dependence within two to three weeks. Once dependent, users must have a “fix” every six to twelve hours to prevent symptoms of withdrawal. The long-term medical, social, and legal effects can be devastating.

New users may experience nausea and vomiting. Regular users experience constipation, moodiness, loss of sexual interest and sex drive, and in women, irregular or stopped menstrual cycles. These effects disappear after withdrawal. Chronic users may also develop serious lung problems. Long-term use results in changes to the way the brain works; therefore, it may take months or years for brain functioning to return to normal after withdrawal. Chronic, long-term users no longer experience pleasure, but continue using the drug to avoid symptoms of withdrawal and to control their powerful cravings for it.

¹⁶ Source: Alberta Alcohol and Drug Abuse Commission (2002b).

Using dirty needles to inject can cause infections either at the injection site or in the lining of the heart (endocarditis). Sharing needles has resulted in high rates of liver infection (hepatitis), tetanus, HIV (human immunodeficiency virus) infection, and AIDS (acquired immune deficiency syndrome) in intravenous users.

Effects During Pregnancy: Using short-acting opioids such as heroin during pregnancy can result in premature delivery, low birth weight, infant withdrawal, or infant death. Pregnant addicted women are generally treated with methadone, which improves the chances of having a healthy baby because opiate withdrawal can induce contractions of the uterus.

Withdrawal: Once physically dependent on opiates, abrupt withdrawal use causes sickness. Withdrawal symptoms begin 4–5 hours after the last dose, usually peaking at 2 to 3 days, and lasting one week to ten days. Withdrawal is characterized by flu-like symptoms including sweating, muscle aches, abdominal cramps, diarrhea, runny nose and eyes, chills, goose bumps, and nausea. Depression, anxiety, mood changes, irritability, aggression sleep disturbances, and loss of appetite are also common.

Treatment and Clinical Management: The most effective treatment available for heroin or other opioid addictions is methadone maintenance. Methadone is a relatively safe, synthetic opioid that is prescribed to prevent withdrawal symptoms. Possible side effects from methadone treatment include sweating, constipation, and weight gain. While it is safe when taken as prescribed, methadone is nevertheless a powerful drug and extremely dangerous to people who do not take it regularly. For this reason, the dispensing of methadone is carefully monitored and controlled.

Emerging Trends: Abuse of oxycodone, a prescription painkiller, is increasing. Oxycodone is a form of time-release morphine used in pain management for terminal illness, but is increasingly prescribed for non-terminal chronic pain such as back pain. “It’s highly addictive. People who started out on heroin are now doing oxycodone because it’s easier to get. People get hooked on it so quickly and can’t get off” (Susan Dahlseide, key informant). Managed withdrawal under medical supervision is recommended for treating oxycodone dependence. Counselling and support to promote lifestyle changes and improve stress management is another important aspect of long-term recovery.

Fact Sheet: Benzodiazepines

Benzodiazepines are sedative drugs prescribed primarily to relieve anxiety and sleep disturbance, relax muscles, control seizures, and treat alcohol withdrawal. About one in ten Canadians, many of them older adults, report using benzodiazepines at least once a year, with one in ten people continuing regular use for more than a year.

Generic and Trade Names: alprazolam (Xanax®), clonazepam (Rivotril®), diazepam (Valium®), flurazepam (Ativan®), temazepam (Restoril®), triazolam (Halcion®), and others.

Street Names: benzos, bennies, tranks, and downers.

Effects: Benzodiazepines calm the central nervous system, producing feelings of relaxation. At higher doses, these can relieve severe emotional distress and panic attacks. Benzodiazepines are highly addictive—the higher the doses are the greater the risk of dependence—and, taken regularly for more than a few months, benzodiazepines can create psychological and physical dependence. Side effects include drowsiness, dizziness and light-headedness, reduced alertness and gait problems (unsteady on the feet), acute stomach cramping, digestive problems, vision problems, lassitude, concentration and memory problems, and sleep disturbances. Benzodiazepines can also contribute to confusion, depression, and rebound insomnia. For some people, prolonged use can aggravate these symptoms, leading to memory impairment, phobias, and suicidal tendencies. Benzodiazepines can greatly increase the risk of automobile accidents, confusion, falls, and fractures in the elderly because these impair learning, memory, reasoning, balance, gait, coordination, and motor control.

Death due to an overdose of benzodiazepines alone is rare. This risk increases when these are taken in combination with other sedative drugs such as alcohol or with medications containing codeine or certain antihistamines. In this context, benzodiazepines are sometimes abused either to intensify the kick of other abused drugs such as opiates or to ease symptoms of withdrawal from opiates, barbiturates, cocaine, amphetamines, or alcohol. Using benzodiazepines to enhance the effects of other drugs or to decrease anxiety or agitation caused by stimulants such as ecstasy or cocaine is extremely hazardous. Combining benzodiazepines with methadone is especially dangerous and can be fatal. Warning signs of overdose include severe drowsiness, slurred speech, weakness, and staggering.

Benzodiazepines should be used with great caution, especially in treating alcohol or other addictions, because of the high risk of tolerance and physical dependence. Those who simply switch their dependency from alcohol to benzodiazepines continue to have an addiction problem that disrupts their life. As with other antidepressant drugs, a drug-free period is usually recommended before the treatment for anxiety is started in alcoholics or other drug abusers, as it may no longer be a problem once the withdrawal phase is over.

Effects on Women: The over-prescribing of benzodiazepines to women is well documented. In Canada, women are prescribed benzodiazepines twice as often as men, and Aboriginal women may be especially vulnerable:

In 2000, 1 in three status Aboriginal women over [the age of] 40 in western Canada were prescribed benzodiazepines. The number receiving benzodiazepines through Health Canada's Non-Insured Health Benefits increased by 25% in four years (1996–2000). In another study of Aboriginal prescription drug use in Canada, 48% of those accessing addiction treatment services used prescription drugs inappropriately and of these 74% used benzodiazepines. Over 60% were poly-prescription drug users (Currie, 2003:4).

Withdrawal Symptoms: These can be mild to severe depending on dosage and length of time taking the drug. Withdrawal symptoms in patients stopping therapeutic doses can include confusion, problems sleeping, anxiety attacks, acute hypersensitivity to sound, touch, taste, and smell, skin crawling sensations, difficulty breathing, gastric upset, sensory disturbances, and tremors. Withdrawal from regular use in higher doses may also include paranoia, agitation, delirium, rage, and seizures. Withdrawal from long-term benzodiazepine use can take 4–6 months for the initial detoxification and another 6–18 months for recovery.

Treatment and Clinical Management: Withdrawal and recovery from long-term, regular use of benzodiazepines should involve managed, gradual reduction and/or drug substitution under medical supervision. Patients should be monitored for depression and/or suicide ideation and provided with therapeutic supports. Anxiety reducing alternatives include exercise, relaxation therapies, stress management, and counselling.

Fact Sheet: Cannabis¹⁷

Cannabis does not fit into the usual classification of drug groups. It acts as a stimulant to increase the heart rate although it has depressant effects. First-time users often report no effects, although repeat cannabis smokers feel the high very quickly and it generally lasts from 2–4 hours. When eaten in foods, the high takes longer, but the effects also last longer.

Cannabis is the most widely used illegal drug in Canada. Like alcohol, it may be used because of its ability to relieve anxiety, stress, or boredom. Cannabis can be used in three forms: as marijuana (the dried leaf of the plant), hashish, or hash oil (both from the plant resin). Hashish is usually stronger than marijuana and hash oil is even more potent. Cannabis can be smoked or mixed in foods such as brownies.

Marijuana can decrease nausea caused by anti-cancer drugs and increase appetite in people with AIDS because of its analgesic, anti-nausea, and muscle relaxant properties. Permission must be granted for medicinal use of cannabis through Health Canada's Special Access Program.

Trade Names: Marinol® and Cesamet® are trade names of synthetic forms prescribed for people with AIDS or cancer to relieve pain and muscle cramps.

Street Names: grass, weed, pot, dope, ganja, hash, weed oil, and honey oil.

Effects: At low doses, cannabis produces feelings of euphoria and relaxation. It can mildly distort perception and the senses, enhancing sound, sight, taste, and body awareness. Heart rate and appetite increase while blood pressure and balance decrease. Larger amounts may intensify these effects, but are also more likely to produce unpleasant reactions. Severe intoxication can trigger anxiety or panic attacks and rapid heartbeat or, in some cases, temporary psychosis. Using cannabis heavily for a long time can damage the lungs, contributing to chronic cough and lung infections. Smoking both marijuana and tobacco may increase the risk of developing lung, neck, and head cancers at a younger age. Short-term memory, concentration, and abstract thinking are also affected. Most of these problems disappear after a few weeks without drugs, but some can last for years.

Withdrawal Symptoms: Dependent users who quit may feel mild withdrawal symptoms such as sleep disturbance, irritability, anxiety, nausea, sweating, and loss of appetite. These physical symptoms usually last less than a week, although the psychological craving can last longer. Sudden withdrawal after heavy, chronic use may cause nausea, tremor, anxiety or emotional volatility, and sleep disorders generally lasting 1–2 days.

Impacts on Pregnancy: Women who use cannabis during pregnancy are more likely to have premature or underweight babies. As these children grow, they may have some learning and behaviour problems, although it is not clear whether these problems are caused solely by use of cannabis during pregnancy or from a combination of factors.

¹⁷ Source: Alberta Alcohol and Drug Abuse Commission (2004).

Treatment and Clinical Management: Withdrawal from cannabis does not require medical supervision. As with other addictive behaviours, self or peer support, counselling, or therapy to address the underlying emotional issues is recommended. Anxiety-reducing alternatives to prevent relapse include exercise, relaxation therapies, stress management, and counselling.

Fact Sheet: Commercial Tobacco¹⁸

Tobacco has long been considered one of the most sacred of the ceremonial plants used by First Nation people. Evidence shows it has been cultivated in North America for over 8,000 years; however, there is no evidence that abuse of tobacco ever took place before European contact.

Nicotine is a stimulant drug derived from the tobacco leaf. Tobacco leaves can be burned and inhaled (cigarettes, cigars, pipe smoke) or absorbed (spit tobacco, snuff). Commercially produced tobacco used for cigarettes, cigars, or pipes contains more than 4,000 chemicals, including tars and carbon monoxide, which are carcinogenic. In high doses, nicotine itself is extremely toxic and is commonly used as an insecticide. A 1988 US Surgeon General's report concluded that nicotine is as physically addictive as cocaine or heroin, which is the main reason it is so widely used. Overall, 33–50 per cent of people who experiment with tobacco become regular users, and 90 per cent of people who smoke regularly are addicted to nicotine.

Effects: Nicotine travels quickly to the brain where it acts as a stimulant, increasing blood pressure, heart rate, and breathing. It also reduces the level of oxygen in the bloodstream causing lower skin temperatures. The mood-altering effects of nicotine are complex; studies show that smoking raises levels of dopamine, increasing feelings of pleasure and the desire to continue smoking.

First time smokers are likely to feel dizzy and sick and to cough or gag when they inhale. They may also experience weakness, abdominal cramps, and headaches. These symptoms lessen as tolerance to nicotine develops. The risks of long-term effects increase according to how much and for how long a person continues to smoke. Smoking impairs the body's respiratory, digestive, immune, and cardiovascular systems. It is the main cause of lung cancer in most cases of chronic bronchitis and emphysema, and a major cause of heart disease and stroke. Smoking also increases the risk of cancer of the colon, mouth, throat, pancreas, bladder, and cervix. It causes smoker's cough, osteoporosis, and for men, doubles the risk of erectile dysfunction. Many of these risks also apply to people who are exposed to second-hand smoke. Commercial tobacco is the primary cause of preventable diseases and deaths in Canada.

Effects on Pregnancy: Women who smoke during pregnancy increase the risk of miscarriage, premature delivery, or stillbirth. Babies carried to term have lower birth weight and are smaller than average. Some studies link smoking with the risk of sudden infant death syndrome (SIDS).

Impacts on Youth: "Research suggests there is a strong link between age of onset of smoking and nicotine dependence" (Alberta Alcohol and Drug Abuse Commission, 2002a:2). Most people who smoke begin between the ages of 11 and 15. Once a person begins to smoke, especially at a young age, the chances of becoming addicted are very high.

Withdrawal Symptoms: "Symptoms of nicotine withdrawal include irritability, depression, insomnia and fatigue, anxiety, difficulty concentrating, restlessness, decreased heart rate, increased appetite and craving for nicotine. Symptoms peak from 24–48 hours after stopping, and can last from three days up to four weeks, although the craving for a cigarette can last for months" (Alberta Alcohol and Drug Abuse Commission, 2002a:3).

¹⁸ Source: Alberta Alcohol and Drug Abuse Commission (2002).

Treatment: Nicotine replacement therapies (NRTs) can be used to treat the initial stages of physical withdrawal from nicotine addiction. Support programs and/or counselling are also effective, although many smokers make 3–4 attempts to stop before becoming long-term non-smokers. Similar to other addictive behaviours, relapse is common and must be viewed as part of the process of quitting. Ongoing support includes relapse prevention and anxiety reducing alternatives such as exercise, relaxation therapies, stress management, and counselling. There are now culture-based, smoking cessation self-help resources available.

Fact Sheet: Compulsive Behaviour: Gambling¹⁹

Although gambling has long been part of traditional Aboriginal cultures, it has become seriously misused in modern life. As with other addictive behaviours, impacts of problem gambling can range from relatively minor to very serious and life-threatening. For some, gambling may cause only occasional difficulty—paying a monthly bill or covering the rent. For others, it can cause serious harm to personal and social functioning. Warning signs that gambling has become a problem include lying and deceit, frequent absences, neglect of family and community responsibilities, and increasing financial hardship due to a mounting debt. This results in family, community, and work relationships becoming seriously impaired. Depending on the situation and level of financial desperation, some people may become involved in illegal activities as a result of gambling debts. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* of the American Psychiatric Association (2000), the following criteria apply in diagnosing pathological gambling.

Persistent and recurrent maladaptive gambling behaviour is indicated by five (or more) of the following:

1. preoccupation with gambling;
2. the need to gamble with increasing amounts of money in order to achieve the desired excitement;
3. repeated unsuccessful efforts to control, cut back, or stop gambling;
4. restless or irritable when attempting to cut down or stop gambling;
5. gambles as a way of escaping from problems or of relieving a dysphoric mood;
6. after losing money from gambling, often returns another day to get even;
7. lies to family members, therapist, or others to conceal the extent of involvement with gambling;
8. has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling; and
9. relies on others to provide money to relieve a desperate financial situation caused by gambling.

Treatment: Some Aboriginal treatment facilities such as Poundmaker's Lodge in Alberta offer 14-day inpatient treatment programs for recovering from gambling based on the 12-step recovery model. A major focus of treatment for problem gambling is providing resources and services to help individuals and families cope with underlying issues such as grief, loss, and unresolved trauma.

Gambler's Anonymous self-help programs are based on this model and are also available in communities across Canada. Many Aboriginal communities are addressing the social factors contributing to problem gambling through alternative, healthy recreational activities for both youth and adults.

¹⁹ Source: Barlow (2004).

Fact Sheet: Compulsive Behaviour: Sexuality

Healthy sexuality is an important aspect of mental, physical, emotional, and spiritual health. According to Aboriginal educators and Elders, pre-contact cultures understood the relationship of sexuality in the context of a balanced, healthy life and a value system based on openness, mutual consent, and respect.

There were no separate traditional teachings about sexuality, these teachings were just a natural part of all the other teachings about life. That is the way that the sexual energy and being of a person was viewed is that it was natural and in balance with all the other activities of life (National Native Association of Treatment Directors, 1992:78).

The impacts of European religious beliefs and customs on Indigenous sexuality have been profound. Introduction of a shame-based sexuality and religious beliefs that denigrate homosexuality and devalue women have destroyed the sense of sacredness that was central to healthy sexuality. “Native individual self-expression and self-esteem were nourished by sexual freedom and acceptance, which contributed to women’s spiritual power and celebration of the body” (Anderson, 2000:88).

The most damaging impact of colonization is the legacy of physical and sexual abuse of generations of Aboriginal children in residential schools. As well as being abused physically and sexually, Aboriginal children in residential schools were strictly forbidden to interact with children of the opposite sex. They were taught that sex is sinful and dirty and to feel embarrassment and shame in their physically maturing bodies. Many Survivors of residential schools came out of the experience traumatized with deeply conflicted and dysfunctional beliefs about sexuality.

Sexual intimacy can evoke powerful feelings of euphoria and connection both to self and the other person, but in compulsive sexual relationships those feelings cannot be sustained. As with other addictive behaviours, the positive, euphoric affects are short-lived; eventually, the unresolved, underlying feelings of emptiness, anxiety, fear, or loss resurface. People can become caught up in a cycle of obsessive sexual behaviour as a way of re-enacting past harm or self-soothing. The National Council on Sexual Addiction and Compulsivity (NCSAC) defines it as “a persistent and escalating pattern or patterns of sexual behaviors acted out despite increasingly negative consequences to self or others” (n.d.: para. 1).

Some clinicians and researchers have attempted to define sexual addiction using the following criteria based on that of chemical dependency:

- frequently engaging in more sex and with more partners than intended;
- being preoccupied with or persistently craving sex;
- wanting to cut down and unsuccessfully attempting to limit sexual activity;
- thinking of sex to the detriment of other activities or continually engaging in excessive sexual practices despite a desire to stop;
- spending considerable time in activities related to sex, such as cruising for partners or spending hours online visiting pornographic websites;
- neglecting obligations such as work, school, or family in pursuit of sex;
- continually engaging in sexual behaviour despite negative consequences, such as broken relationships or potential health risks;

- escalating scope or frequency of sexual activity to achieve the desired effect, such as more frequent visits to prostitutes or more sex partners; and
- feeling irritable when unable to engage in the desired behaviour (Herkov, Gold, and Edwards, 2001).

Estimates indicate that 3 to 6 per cent of Americans are affected by some form of sexual addiction. Sexual addiction appears to be common among the population who also suffer from addictive disorders, such as drug abuse, even though it affects both men and women and both heterosexual and homosexual (Herkov, Gold, and Edwards, 2001).

According to psychologist Dr. Dennis Kimberly, a key informant, the expression of excessive and compulsive sexual behaviour is damaging when it impairs the person's personal and social functioning, puts others at risk, and sexualizes children and/or teaches children to define themselves primarily in terms of their sexual value. As with other addictive behaviours, minimizing, denying, or maintaining silence becomes part of family and community norms that prevent healing. When a society or a community minimizes or denies the problem or dismisses it in terms of cultural differences, Dr. Kimberly cautions "that then becomes part of the self-perpetuating, transgenerational aspect of addictions and trauma."

Prevention and Treatment: Key informants for this report suggest treatment for sexual addiction generally follows the same model as treatment for other addictive behaviours. A treatment plan that includes harm reduction in the context of counselling or therapy allows the client to explore underlying emotional issues contributing to the addictive behaviour. Increasingly, Aboriginal health advocates are calling for healthy sexuality education to be integrated into community health promotion and for sexual health and healing to be part of all core addictions programming.

Viewing oneself as a sacred being has implications for healing. It has implications for prevention as well, for sacred beings do not act in this manner toward other sacred beings (as cited in Anderson, 2000:201).

Fact Sheet: Compulsive Behaviour: Eating Disorders

Many Survivors of residential school experienced hunger on a daily basis, and food deprivation was used as a form of punishment. Much of the food that was provided for Aboriginal children in the schools was unfit for human consumption; as well, it was high in fats and carbohydrates. Residential schools did not teach children about the importance of healthy nutrition, nor were children provided opportunities to practice healthy food choices. On the rare occasions when children were rewarded with treats, it was generally foods high in sugar or starch such as white bread, candy, or ice cream. These foods that were associated with treats or pleasure in childhood became comfort foods in adulthood.

To cope with chronic hunger, many children in residential schools learned to either hoard food or to binge whenever extra food became available. According to Susan Dahlseide, a key informant, the most common compulsive eating disorders impacting the Aboriginal population are bulimia, food hoarding, and addiction to convenience foods and super-size meals high in sugar and fats.

Elder Eric Shirt, also a key informant, asserts that food has always been used as a weapon against Aboriginal people, and the key to healing from addictions and restoring health is “food wisdom—people need to start demanding better food.”

Our approach has to be comprehensive in scope. The body is created for growth and maintenance if it has the nutrition it needs - but right from the start we were moved into reservations and were fed prison food. We’ve become heavy and listless and we couldn’t handle the difficulties we were faced with. Food was always used as a weapon against us. If you didn’t move where you were told, they starved you; if you didn’t go to residential school they didn’t give you food and there they didn’t feed you either and many kids starved to death. Washington fought the Iroquois by burning their corn; history is full of stories of Indian people begging for food outside the forts. So right from day one our nutritional status was compromised and we’ve never totally recovered—and now we’re dealing with the junk food era (Elder Eric Shirt).

Prevention and Treatment: There are now many culture-based health promotion programs to educate children, youth, and adults about healthy nutrition and wise food choices because of the growing high rates of diabetes and heart disease in the Aboriginal population. Healthy eating and nutrition should also be a core part of addictions programming to ensure people recovering from one addiction, such as alcohol or drugs, do not merely substitute another addictive behaviour, such as compulsive eating, as an emotional self-soothing strategy.

List of Key Informants

1. Aboriginal client who shared her story with the author.
2. Elder Jim Albert (Bear Clan), Lanark County, Ontario, former chair, Department of Social Work, Carleton University, now associate with the Social Work Program at First Nation Technical Institute, Tyendinaga, Ontario.
3. Dr. Nancy Comeau, Department of Psychology, Dalhousie University, Halifax, Nova Scotia, and project member of “Nemi’simk, Seeing Oneself” Youth Early Intervention Pilot Program.
4. Connie-Gail Crowder, M.S.N., R.N., R.N.-E.C., Health Services Director, Coordinator of Sacred Smoke Pilot Program, Wabano Centre for Aboriginal Health, Ottawa, Ontario.
5. Inspector Shirley Cuillierrier (Mohawk), officer-in-charge, National Aboriginal Policing Services, Community, Contract and Aboriginal Policing Services; and Inspector David Wojak, Royal Canadian Mounted Police.
6. Susan Dahlseide (Métis), Director of Marketing and Health Promotion for the Nechi Training, Research and Health Promotions Institute in Edmonton, Alberta.
7. Shiningwater Diabo (Cherokee/Lakota), former director, Oshki Kizis Lodge, serving homeless and abused Aboriginal women in Ottawa, Ontario.
8. Bernice Downey (Cree), former executive director, National Aboriginal Health Organization, Ottawa, Ontario.
9. Jennifer Jesty, Co-Chair, Eskasoni Interagency, Eskasoni First Nation, Nova Scotia.
10. Dr. Dennis Kimberley, St. John, Newfoundland, former director of the Addiction Research Foundation of Ontario, now a professor at Memorial University of Newfoundland. He has a private clinical practice specializing in dual disorders-concurrent disorders where his caseload includes Aboriginal, gay, and youth clientele.
11. Marja Korhonen, Ph.D., researcher and author on Inuit and northern issues with the Ajunnginik Centre, National Aboriginal Health Organization, Ottawa, Ontario.
12. Dr. Len Moore, physician, Centre 454 and Wabano Centre for Aboriginal Health, serving the Aboriginal population including those who are homeless and street-involved in Ottawa, Ontario.
13. Dan Printup (Algonquin), addictions case manager for the Mobile Health Outreach program serving Aboriginal people who are homeless in the City of Ottawa through the Wabano Centre for Aboriginal Health in Ottawa, Ontario.

14. Dr. Brenda Saxe, therapist specializing in trauma and addictions at the Centre for Treatment of Childhood Trauma and Sexual Abuse in Ottawa, Ontario. Clients include Inuit from Nunavut, Algonquins from Kitigan Zibi First Nation in Quebec, as well as urban Aboriginal people from the City of Ottawa. Dr. Saxe also provides clinical supervision for Aboriginal counsellors and therapists.
15. Barbara Sevigny (Inuk), Trauma and Addiction Therapist; Pam Stellick, Director of Counselling Program; and Ginette Chouinard, Trauma and Addictions Coordinator, Mamisarvik Healing Centre, a national Inuit addictions treatment centre located in Ottawa, Ontario.
16. Elder Eric Shirt (Cree), Saddle Lake First Nation, Alberta, educator specializing in addictions recovery and nutrition.

Annotated Bibliography

Books, Manuals, and Reports

- Barlow, Kevin (2004). *Escaping the Legacy: Understanding Addictive Behaviours in Aboriginal Communities in Canada*. Ottawa, ON: Aboriginal Healing Foundation, unpublished. This discussion paper provides an overview of the relationship between contemporary Aboriginal issues such as addictions, family violence, children in care and incarceration rates, and the legacy of residential school abuse. The scope and impacts of a range of addictive behaviours are outlined as well as current interventions and challenges.
- Brunen, Lynda (2000). *Aboriginal Women With Addictions: A Discussion Paper on Triple Marginalization in the Health Care System*. Prince George, BC: The Northern Secretariat of the BC Centre of Excellence for Women's Health. This paper examines mistreatment within the health care system of Aboriginal women who abuse substances. Interviews with informants reveal the ways in which Aboriginal women are marginalized as well as the implications of this mistreatment.
- Buller, Ed (2001). *Community Healing Processes: Investments and Benefits*, a paper presented at the Best Practice Interventions in Corrections for Indigenous People Conference, Australia. Aboriginal Corrections Policy Unit, Solicitor General Canada. The proven success of the Hollow Water community healing model is used as a case study illustrating the central role of traditional cultural values and practices in improving treatment outcomes for Aboriginal offenders and their victims, families, and communities.
- Centre for Addiction and Mental Health (2002). *CAMH and Harm Reduction: A Background Paper on its Meaning and Applications For Substance Use Issues*. Toronto, ON: Centre for Addiction and Mental Health. This paper provides a useful and practical definition of harm reduction as well as recommendations for primary focus and guiding principles. It places harm reduction in a larger context as one approach within a broad spectrum of treatment options.
- Comeau, M. Nancy, Sherry H. Stewart, Christopher Mushquash, David Wojcik, Cheryl Bartlett, Murdena Marshall, Jerry Young, and Doreen Stevens (2005). *Community Collaboration in Developing a Culturally-Relevant Alcohol Abuse Early Intervention Program For First Nation Youth*. Ontario Association of Children's Aid Societies Journal 49(1) (available online at: <http://www.oacas.org/resources/OACASJournals/2005April>). This article describes the results of a unique, collaborative project involving Elders, youth, Aboriginal community members, and academics in the development of a culturally specific alcohol abuse early intervention program. The report underscores the importance of getting at the "root" level of alcohol abuse by strengthening a sense of identification, belonging, and pride in Aboriginal youth and engaging them in a solution to their own problems.
- Correctional Service Canada (1999). *Aboriginal Spirituality: The Aboriginal Healing Movement* (available online at: <http://www.csc-scc.gc.ca>). This paper produced for "Restorative Justice Week" provides a concise yet very informative overview of key elements and influences in

the contemporary Aboriginal healing movement. Grounded in an Aboriginal perspective, it emphasizes the crucial role of cultural reawakening and traditional spirituality in healing while acknowledging the influence of other addictions and human potential movements.

Currie, Janet, C. (2001). *Best Practices: Treatment and Rehabilitation for Women with Substance Abuse Problems*. Ottawa, ON: Minister of Public Works and Government Services (available online at: <http://www.cds-sca.com>). This report reviews general patterns of substance abuse among women in Canada including summary information on Aboriginal women. The report describes barriers to treatment access and elements of best practices in treatment approaches, client retention, treatment organization, critical adjunctive services, and strategies for measuring effectiveness of treatment.

——— (2001). *Best Practices: Treatment and Rehabilitation for Youth with Substance Abuse Problems*. Ottawa, ON: Minister of Public Works and Government Services (available online at: <http://www.cds-sca.com>). Based on a literature review and interviews with key experts, this report describes barriers to treatment for substance abuse specific to youth (including Aboriginal youth) and best practices in the continuum of services from outreach and engagement to client retention, methods, and treatment organization. The report also includes model program elements and strategies for measuring treatment outcomes.

Dion Stout, Madeleine and Gregory Kipling (2003). *Aboriginal People, Resilience and the Residential School Legacy*. Ottawa, ON: Aboriginal Healing Foundation. In the context of literature on resilience, this report considers the cultures, lived experiences, and social circumstances of Aboriginal Survivors of residential schools. The findings about risk and protective factors serve as the basis for recommendations in the areas of planning, research, interventions, and evaluation.

Fournier, Suzanne and Ernie Crey (1997). *Stolen From Our Embrace: The Abduction of First Nations Children and the Restoration of Aboriginal Communities*. Vancouver, BC: Douglas & McIntyre Ltd. Using powerful personal accounts, this book underscores how systemic racism and ignorance among non-Aboriginal child welfare authorities led to the devastation of Aboriginal families, communities, and nations in Canada. These stories capture the urgency of the struggle against unjust systems as well as the restorative power of healing journeys undertaken by Aboriginal communities.

Health Canada (2002). *Best Practices - Concurrent Mental Health and Substance Use Disorders*. Ottawa, ON (available online at: <http://www.cds-sca.com>). This discussion paper includes definitions and a range of best practices categorized by service delivery level, assessments, treatment/support, as well as mechanisms and models for system-level integration and coordination.

——— (2004). *Literature Review: Evaluation Strategies in Aboriginal Substance Abuse Programs—A Discussion*. First Nations and Inuit Health Branch, National Native Alcohol and Drug Abuse Program (available online at: www.hc-sc.gc.ca/fnihb-dgspni/fnihb/cp/nnadap/publications/index.htm). This report provides an overview of evaluation strategies for a range of substance abuse programs from prevention to early intervention and treatment. It includes characteristics and indicators of effectiveness, types of evaluation, sources of information, and current evaluation models.

- Herman, Judith Lewis (1992). Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma. *Journal of Traumatic Stress* 5(3). "This paper reviews evidence for the existence of a complex form of post-traumatic stress disorder in survivors of prolonged and repeated trauma where the victim is in a state of captivity, under the control of the perpetrator" (Abstract 1992:377). It is an extremely helpful resource for understanding the long-term psychological impacts of residential school abuse.
- Hodgson, Maggie, Paul Hanki, John Paul, Virginia Toulouse, and Richard Jock (1998). National Native Alcohol and Drug Abuse Program General Review—Final Report. Muskoday, SK: National Native Addictions Partnership Foundation (NNAPF). This major report provides a comprehensive overview of the NNADAP program including treatment, prevention, maintenance and training, research and development, and management and support. It also identifies general trends including North-South issues, treatment issues, and the impacts of health and social cutbacks.
- Hylton, John H. (2002). Appendix C—Aboriginal Health and Healing: A Review of Best Practices. Improving First Nations and Métis Health Outcomes: A Call to Collaborative Action. Working Together Towards Excellence Project. Regina, SK: Regina Qu'Appelle Health Region. This review describes Aboriginal concepts of health and healing, contrasting differences in values and approaches between Aboriginal and Western healing models. Seven characteristics that are unique to Aboriginal health and healing programs are outlined.
- Kishk Anaquot Health Research (2002). Journey and Balance: Second Interim Evaluation Report of Aboriginal Healing Foundation Program Activity. Ottawa, ON: Aboriginal Healing Foundation. This report is a very useful resource for anyone interested in developing healing programs for Aboriginal people. For this evaluation, healing projects are selected that fully represent all target groups, Aboriginal groups, and regions. These projects are then examined for their impacts on clients and communities. The data is then used to identify promising practices as well as recommendations for continuous improvement in healing and training programs funded by the AHF.
- (2003). Third Interim Evaluation Report of Aboriginal Healing Foundation Program Activity. Ottawa, ON: Aboriginal Healing Foundation. This report assesses impacts of healing programs from 13 case studies, a review of 36 files, and a national process evaluation survey. Issues related to sustainability, partnerships, addressing needs, best practices, challenges, and lessons learned are identified. Also created for this report is a "performance map" template based on the logic model for service delivery. This map is a useful tool for showing at-a-glance the relationship between project activities and outputs, reach, short- and long-term outcomes, and short- and long-term measures for change.
- Korhonen, Marja (2004). Alcohol Problems and Approaches: Theories, Evidence and Northern Practice. Ottawa, ON: National Aboriginal Health Organization. This paper provides an Inuit perspective on alcohol abuse as well as practices in treatment and prevention. Theories about causes, characteristics in the North, and best practices for treatment are summarized. Current gaps in approaches to prevention and training are identified.

- Lane, Phil, Jr., Michael Bopp, Judie Bopp, and Julian Norris (2002). *Mapping the Healing Journey: The Final Report of a First Nation Research Project on Healing in Canadian Aboriginal Communities*. Ottawa, ON: Aboriginal Corrections Policy Unit, Solicitor General Canada. This comprehensive report is based on a study of six First Nation communities that achieved notable success in healing from the impacts of the legacy of residential school abuse including addictions and abuse. It includes a summary of findings from a literature review, community profiles, interviews, lessons learned, and recommendations. A cultural model is presented that describes four “seasonal” stages of the healing journey and the characteristics and needs of each stage.
- Mussell, W.J. (2005). *Warrior-Caregivers: Understanding the Challenges and Healing of First Nations Men*. Ottawa, ON: Aboriginal Healing Foundation. Drawing from interviews with community leaders and front-line workers, this guide explores the impacts of historical experiences of multiple loss, trauma, and dislocation of First Nation men. The crucial role of grief in healing and recovery is underscored and promising strategies in family and community reconstruction are presented.
- National Centre on Addiction and Substance Abuse (1999). *No Safe Haven: Children of Substance-Abusing Parents*. National Center on Addiction and Substance Abuse. New York, NY: Columbia University. A comprehensive discussion paper focusing on the impacts of substance-abusing parents (both mothers and fathers) on the psychosocial and emotional development of their children.
- National Native Alcohol and Drug Abuse Program Treatment Centre Directory (7th Edition) (available online at: www.hc-sc.gc.ca). This important resource provides an explanation of current definitions and terminology as well as a comprehensive listing of inpatient, day program, and solvent abuse treatment centres for Aboriginal people in all provinces and territories of Canada.
- National Native Association of Treatment Directors (1992). *The Right to be Special: Native Alcohol and Drug Counsellor’s Handbook Working with Sexual Abuse Disclosure*. Calgary, AB: National Native Association of Treatment Directors. Chapter 4 of this training manual entitled *Human Sexuality* contrasts the differences between attitudes toward sexuality in non-Native society, Native society today, and traditional Native society from an Aboriginal perspective. Indicators of healthy sexual development throughout the lifespan are presented as well as indicators of sexual abuse.
- Pine-Cheechoo, Karen and Dr. Richard Thatcher (2001). *A Program Model to Address Child and Youth Substance Abuse Crises*. Muskoday, SK: National Native Addictions Partnership Foundation. A revised working draft prepared for discussion purposes only by NNAPF Inc. (available online at: http://www.nnapf.org/english/pdf/cerp/FNI-CERP_Model_Youth.pdf). This report proposes a multi-level crisis intervention model to address group substance abuse patterns that threaten the health of Aboriginal children and youth. The core of the program is mobile intervention capacity to provide immediate emergency response to communities lacking the resources to adequately respond. The model promotes an approach to intervention that builds on the strengths and assets of families, personal development, and healing from the past.

- Restoule, Brenda (2004). *Conducting Assessments in First Nations and Inuit Communities: A Training and Reference Guide for Front Line Workers*. Muskoday, SK: National Native Addictions Partnership Foundation (NNAPF). This practical guide offers a range of assessment tools for front-line workers to support effective treatment including individual assessment, risk assessment, abuse disclosure, confidentiality, and record keeping. The appendix contains numerous helpful templates for referral and intake forms, consent forms, suicide assessment, service agreements, and sample letters for reporting suspicion of child abuse.
- Rutman, Deborah, Marilyn Callahan, Audrey Lundquist, Suzanne Jackson, and Barbara Field (2000). *Substance Use and Pregnancy: Conceiving Women in the Policy-Making Process*. Ottawa, ON: Status of Women Canada. This paper focuses on issues that impact women, specifically on how Canadian policy presently deals with substance use during pregnancy. Drawing from the case *Supreme Court vs. Ms. G.* (31 October 1997) “in which a judge ordered mandatory drug treatment for a young, low-income Aboriginal woman addicted to sniffing solvents” (2000: i), it describes one Aboriginal community’s approach to effective treatment and underscores the importance of policy based on a gender and culture framework.
- Smye, Vicki and Bill Mussell (2001). *Aboriginal Mental Health, What Works Best: A Discussion Paper*. Vancouver, BC: University of British Columbia. This paper describes effective community approaches to suicide prevention, alcohol and drug programs, and abuse responses.
- Tait, Caroline L. (2003). *Fetal Alcohol Syndrome Among Aboriginal People in Canada: Review and Analysis of the Intergenerational Links to Residential Schools*. Ottawa, ON: Aboriginal Healing Foundation. This report provides a comprehensive review of fetal alcohol syndrome (FAS) including definition, diagnosis, and contributing factors. It includes an overview of what is known about alcohol use among Aboriginal people in Canada including levels and historical, political, and economic factors underlying contemporary alcohol abuse patterns.
- Thatcher, Richard (2001). *Deadly Duo, Tobacco and Convenience Foods: The Other Substance Abuse Epidemics Afflicting the First Nations and Inuit of Canada*. Muskoday, SK: National Native Addictions Partnership Foundation (NNAPF). This report examines historical, social, and medical factors associated with abuse of convenience foods and commercial tobacco among Aboriginal people. Because of the scope and urgency of these problems and their serious health implications, the author suggests tobacco abuse and compulsive eating be treated with the same priority as other types of substance abuse such as alcohol and drugs. It includes recommendations for policy as well as personal and community strategies.
- Volpicelli, Joseph, Geetha Balaraman, Julie Hahn, Heather Wallace, and Donald Bux (1999). *The Role of Uncontrollable Trauma in the Development of PTSD and Alcohol Addiction*. In *Alcohol Research and Health (Feature)* 23(4) (available online at: www.niaaa.nih.gov/Publications/AlcoholResearch/default). This article associates the use of alcohol with symptom relief of anxiety, irritability, and depression to compensate for deficiencies in endorphin activity following a traumatic experience, especially for women. It includes an overview of post-traumatic stress disorder (PTSD), trauma and learned helplessness, learned helplessness and PTSD, and post-stress alcohol consumption. The article also underscores the need for integrated treatment of PTSD and alcoholism.

Wesley-Esquimaux, Cynthia C. and Magdalena Smolewski (2004). *Historic Trauma and Aboriginal Healing*. Ottawa, ON: Aboriginal Healing Foundation. This study examines intergenerational transmission of historic trauma and proposes a new model, Historic Trauma Transmission (HTT), to better understand and treat it. An analysis of the nature and scope of traumatic experiences suffered by Aboriginal people from the time of contact in 1492 to the 1950s reveals five key areas of impact: physical, economic, cultural, social, and psychological. These are examined chronologically according to the characteristics of each stage of colonization. A range of healing models and therapeutic interventions based on Aboriginal knowledge and values are presented.

White, Jennifer and Nadine Jodoin (2003, Revised 2004). *Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies*. Calgary, AB: Centre for Suicide Prevention. Because of the strong association between addictive behaviours and suicide among Aboriginal youth, this manual is an important resource for workers in either field. Best practices are categorized according to strategies for community education, schools, and youth and family programs. Also included is a practical step-by-step plan for developing a community-wide approach.

Zamparo, JoAnne and Donna Sprasson (2005). *Echoes and Reflections: A Discussion of Best Practices in Inuit Mental Health*. Iqaluit, NU: Government of Nunavut Task Force on Mental Health. Mental health problems as defined by Inuit participants in this research study include alcohol abuse, drug abuse, family violence, and suicide. This paper provides a comprehensive, cross-jurisdictional analysis of the literature on services, program models, and best practices in mental health with a focus on interdisciplinary, intersectoral approaches. A compelling case is made for community ownership and empowering communities to care for each other in support of a shared vision of wellness.

Education and Prevention Resources: Fact Sheets, Pamphlets, and Interactive Websites

A Self-Help Guide to Gambling Responsibly, Gambling Fact or Myth Quiz, and Signs & Phases of Gambling (available online at: www.metisnation.org/programs/health/health_gambling.html). This website resource provides telephone numbers to 24-hour confidential crisis counselling as well as a guide to responsible gambling, an interactive quiz, and the continuum of behaviours or phases of compulsive gambling.

Aboriginal Youth Network (1996). *Aboriginal Youth Net Solvent Abuse Module* (available online at: <http://ayn.ca/modules/solvent/indx.html>). Targeting Aboriginal youth, this interactive website addresses the questions: What is sniffing? Why do kids do it? What does it do to your body? What does it do to your spirit? Are your friends in trouble? How can you help them? Information on helpful resources for youth is also provided. The Aboriginal Youth Network Website at <http://ayn.ca> also provides information on a comprehensive array of health issues including addictions and eating disorders. Definitions, interesting facts, and statistics relevant to youth, warning signs, and links for further information and where to go for help are provided.

Addiction Recovery Guide (<http://www.addictionrecoveryguide.org>). This Internet resource is designed to assist anyone struggling with drug or alcohol addiction find the type of information and help that best suits their needs.

Alberta Alcohol and Drug Abuse Commission Fact Sheets: ABCs Fact Sheets; Beyond the ABCs; Effects Series; and Additional Information (available online at: www.corp.aadac.com). The ABCs series of online fact sheets provides 1- and 2-page information sheets that cover the basics about drug abuse and related issues. *Beyond the ABCs* is designed to provide more in-depth information for those who require more than the basics. Includes fact sheets on: *Crystal Meth; Methamphetamine: What to Expect When Someone Quits; Relapse Prevention: Planning for Success, Leisure and Recovery; What a Woman Should Know: Alcohol and Other Drugs; A Drug Problem: How Can I Tell?; and When Someone You Know Has a Drug Problem*. *Effects Series* and *Additional Information* are designed to provide women with certain information about the health effects of various drugs and how drug use may affect pregnancy, birth, and child development.

Canadian Centre on Substance Abuse Fact Sheets (available online at: www.ccsa.ca). A full range of fact sheets is available at this website. Recent additions include: Mandatory and Coerced Treatment; OxyContin®; Girls, Women and Substance Use; Methamphetamine; Hepatitis C Virus (HCV) infection; and illicit drug use.

Do You Know...Centre for Addiction and Mental Health (2001) (available online at: www.camh.net) (to order pamphlets by phone: 1-800-661-1111; or by email: marketing@camh.net). This is a series of 20 easily readable information brochures that provide comprehensive information on substances most commonly abused and their effects including: alcohol; alcohol, other drugs, and driving; amphetamines, barbiturates, benzodiazepines, caffeine, cannabis, cocaine, ecstasy, GHB, hallucinogens, heroin, inhalants, ketamine, LSD, methadone, methamphetamine, opiates, rohypnol, steroids, and tobacco.

Gambling and the Aboriginal Community: It's Only A Game - A Quick Guide to Low-Risk Gambling (available online at: www.responsiblegambling.org/articles/aboriginalCommunity.pdf). This pamphlet introduces gambling as an aspect of traditional culture and skills development that has become badly misused. Helpful tips on low-risk gambling and where to go for help are provided.

Health Canada (2000). *Straight Facts about Drugs & Drug Abuse*. Ottawa, ON: Minister of Public Works and Government Services Canada (available online at: www.hc-sc.gc.ca). Provides detailed information on a wide array of substances commonly abused as well as the relationship between substance abuse and HIV/AIDS, hepatitis, and concurrent disorders.

National Native Addictions Partnership Foundation (2005). *Keeping the Sacred in Tobacco: A Tool Kit for Tobacco Cessation*. Muskoday, SK: National Native Addictions Partnership Foundation. This education and prevention manual for First Nation and Inuit communities uses traditional teachings about tobacco to promote respectful, traditional use of tobacco and smoking cessation.

Journals and Newsletters

Aboriginal Healing Foundation. *Healing Words*. Ottawa, ON: Aboriginal Healing Foundation (available online at: www.ahf.ca). This publication features articles, project profiles, history briefs, research reports, poetry, Survivor stories, community profiles, residential school resources, and reports of gatherings related to AHF-funded activities.

CrossCurrents: The Journal of Addiction and Mental Health, a publication of the Centre for Addiction and Mental Health (CAMH), Toronto, Ontario (available online at: www.camh.net/publications/Cross_Currents). This journal provides important information about current approaches and recent news concerning addictions, addictive behaviours, and a range of other mental health problems.

NNAPF Traveller (available online at: www.nnapf.org). This newsletter highlights best and promising practices, articles of interest, discussion papers, news, and resources.

Other Bibliographies

Centre for Addiction and Mental Health (2004). *Aboriginal Peoples: Mental Health & Substance Misuse Selected Bibliography*. Toronto, ON: Centre for Addiction and Mental Health. This bibliography is a useful resource that provides current information on publications available from the CAMH Library collections supplemented with select Internet resources and journal articles. It serves as an introduction to the topic with a focus on Aboriginal people of North America and is not intended as an in-depth literature review.

Za-Geh-Do-Win Substance Abuse Annotated Bibliography. Naughton, ON: Za-Geh-Do-Win Information Clearing House (available online at: www.zagehdowin.com). This comprehensive bibliography covers a wide array of print and audiovisual resource materials relevant to training, as well as substance abuse prevention and intervention programming.

Videos and CD-ROMs

Aboriginal Healing Foundation (2003). *Where are the Children? Healing the Legacy of the Residential Schools*. Ottawa, ON: Aboriginal Healing Foundation. This compelling documentary interweaves archival photographs and interviews with residential school Survivors. Their deeply moving personal accounts reveal the scope and tragedy of the suffering as well as their resilience and determination to heal.

Makivik Corporation (2005). *The Echo of the Last Howl*. Dorval, QC: Taqramiut Productions. This film interweaves documentary material and re-enactments with interviews that tell the story of the slaughter of Arctic sled dogs by police and government officials during the mid-1950s to 1960s.

National Film Board (1997). *The Cultural Renewal Package*. Montreal, QC: National Film Board. Includes the following titles: *Broken Promises: The High Arctic Relocation*; *Place of the Boss: Utsimassits*; and *The Washing of Tears*. To order call 1-800-267-7710. This educational package

documents the experiences of Inuit and First Nation people who endured the trauma of forced relocation by governments and churches. Combining interviews with survivors and archival footage, the films show how the despair of sickness, alcoholism, and violence resulting from dislocation is transformed through cultural renewal.

——— (1998). *First Nations, The Circle Unbroken Series*. Montreal, QC: National Film Board. Information about these films is available at the National Film Board website: www.nfb.ca or by telephone at 1-800-267-7710. A package of seven 20-minute educational films that provide insight into First Nations' perspectives on a wide range of issues and topics including cultural genocide, the environment, spirituality, and self-government.

Useful Websites

- † Aboriginal Healing Foundation: www.ahf.ca
- † Alberta Alcohol and Drug Abuse Commission: www.aadac.com
- † Assembly of First Nations: www.afn.ca
- † Canadian Centre on Substance Abuse: www.ccsa.ca
- † Centre for Addiction and Mental Health: www.camh.net
- † First Nations and Inuit Health: www.hc-sc.gc.ca
- † Information Centre on Aboriginal Health: www.ica.h.ca
- † Inuit Tapiriit Kanatami: www.itk.ca
- † Métis Nation of Ontario: www.metisnation.org
- † Métis National Council: www.metisnation.ca
- † Métis National Council of Women: www.metiswomen.ca
- † National Aboriginal Health Organization: www.naho.ca
- † National Inuit Youth Council: www.niyc.ca
- † National Native Addictions Partnership Foundation: www.nnapf.org
- † Native Women's Association of Canada: www.nwac-hq.org
- † Nechi Training, Research and Health Promotion Institute: www.nечи.com
- † Pauktuutit Inuit Women's Association: www.pauktuutit.ca

References

- Aboriginal Healing and Wellness Strategy (2005). Draft Interpretive Framework: For Phase 3. Research and Evaluation Activities. Toronto, ON: Aboriginal Healing and Wellness Strategy [unpublished paper].
- Aboriginal Healing Foundation (2006). A Healing Journey: Final Report Summary Points. Ottawa, ON: Aboriginal Healing Foundation.
- (2001). Program Handbook, 3rd Edition. Ottawa, ON: Aboriginal Healing Foundation.
- (1999). Program Handbook, 2nd Edition. Ottawa, ON: Aboriginal Healing Foundation.
- Alberta Alcohol and Drug Abuse Commission (2004). Cannabis Fact Sheet. Retrieved on 9 September 2006 from: <http://www.corp.aadac.com>
- (2002a). Beyond the ABCs: Tobacco. Retrieved on 27 March 2005 from: <http://www.corp.aadac.com>
- (2002b). Beyond the ABCs: Opioids. Retrieved on 27 March 2005 from: <http://www.corp.aadac.com>
- American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR). Washington, DC: American Psychiatric Association.
- Anderson, Kim (2002). Tenuous Connections: Urban Aboriginal Youth Sexual Health and Pregnancy. Toronto, ON: Ontario Federation of Indian Friendship Centres (OFIFC).
- (2000). A Recognition of Being: Reconstructing Native Womanhood. Toronto, ON: Second Story Press.
- Arnakak, Jaypetee (2000). Commentary: What is Inuit Qaujimagatuqangit? In Nunatsiaq News, August 25. Retrieved on 22 May 2006 from: http://www.nunatsiaq.com/archives/nunavut000831/nvt20825_17.html
- Barlow, Kevin (2004). Escaping the Legacy: Understanding Addictive Behaviours in Aboriginal Communities in Canada. Ottawa, ON: Aboriginal Healing Foundation [unpublished].
- Benoit, Cecilia, Dena Carroll, Lisa Lawr, and Munaza Chuadhry (2001). Marginalized Voices from the Downtown Eastside: Aboriginal Women Speak About Their Health Experiences. Toronto, ON: Centre of Excellence on Women's Health, York University.
- Bavelas, Janet (2004). An Analysis of Formal Apologies by Canadian Churches to First Nations, Occasional Paper No. 1. Victoria, BC: Centre for Studies in Religion & Society, University of Victoria.

Buller, Ed (2001). *Community Healing Processes: Investments and Benefits*. Paper presented at the 'Best Practice Interventions in Corrections for Indigenous People' conference, Sydney, Australia. Aboriginal Corrections Policy Unit, Solicitor General Canada.

Canadian Broadcasting Corporation (2005). *CBC Radio: Sounds Like Canada: Andrea Webb – Nunatsiavut* (26 January 2005).

Canadian Centre for Justice Statistics (2005). *Family Violence in Canada: A Statistical Profile 2005*. Ottawa, ON: Minister of Industry.

——— (2001). *Family Violence in Canada: A Statistical Profile 2001*. Ottawa, ON: Minister of Industry.

Canadian Paediatric Society (1999). *Tobacco use among Aboriginal Children and Youth*. *Paediatrics & Child Health* 4(4):277-281. Retrieved on 17 August 2006 from: <http://www.cps.ca/english/statements/II/ii99-01.htm>

——— (1998). *About Inhalants*. *Paediatrics & Child Health* 3(2):123-126. Retrieved on 17 August 2006 from: <http://www.cps.ca/english/statements/II/ii99-01.htm>

Centre for Addiction and Mental Health (2001). *Do You Know... pamphlet series*. Retrieved from: http://www.camh.net/Publications/CAMH_Publications/do_you_know_index.html

Chansonneuve, Deborah (2005). *Reclaiming Connections: Understanding Residential School Trauma Among Aboriginal People*. Ottawa, ON: Aboriginal Healing Foundation.

Chrisjohn, Roland and Sherry Young (1997). *The Circle Game: Shadows and Substance in the Indian Residential School Experience in Canada*. Penticton, BC: Theytus Books Ltd.

Corrado, Raymond R. and Irwin M. Cohen (2003). *Mental Health Profiles for a Sample of British Columbia's Aboriginal Survivors of the Canadian Residential School System*. Ottawa, ON: Aboriginal Healing Foundation.

Currie, Janet C. (2003). *From Manufacturing Addiction: The Over-Prescription of Benzodiazepines and Sleeping Pills to Women in Canada*. Vancouver, BC: Centre of Excellence for Women's Health.

——— (2001). *Best Practices: Treatment and Rehabilitation for Youth with Substance Abuse Problems*. Ottawa, ON: Minister of Public Works and Government Services Canada.

Deguire, Anne-Elyse (2005). *Fact Sheet: Methamphetamine*. Ottawa, ON: Canadian Centre on Substance Abuse.

Department of Indian Affairs and Northern Development (1998). *Indian Residential Schools (IRS) Data Project*. Ottawa, ON: Department of Indian Affairs and Northern Development [unpublished].

Dickason, Olive Patricia (2002). *Canada's First Nations: A History of Founding Peoples from Earliest Times*, 3rd Edition. Don Mills, ON: Oxford University Press.

Dion Stout, Madeleine, Gregory D. Kipling, and Roberta Stout (2001). *Aboriginal Women's Health Research Synthesis Project: Final Report*. Winnipeg, MB: Centres of Excellence for Women's Health.

Four Worlds International Institute (1998). *Community Healing and Aboriginal Social Security Reform: A study prepared for the Assembly of First Nations - Aboriginal Social Security Reform Strategic Initiative*. Retrieved on 5 September 2006 from: www.4worlds.org/4w/ssr/Partiv.htm

Fournier, Suzanne and Ernie Crey (1997). *Stolen from our Embrace: The Abduction of First Nations Children and the Restoration of Aboriginal Communities*. Vancouver, BC: Douglas & McIntyre Ltd.

Government of Canada (1998). *Statement of Reconciliation*. Ottawa, ON: Indian and Northern Affairs Canada. Presented on January 7, 1998 by The Honourable Jane Stewart, Minister of Indian and Northern Affairs Canada. Retrieved on 26 May 2006 from: http://www.ainc-inac.gc.ca/gs/rec_e.html

Health Canada (2003). *A Statistical Profile on the Health of First Nations in Canada*. Ottawa, ON: Health Canada.

——— (2002). *Best Practices - Concurrent Mental Health and Substance Use Disorders*. Ottawa, ON: Retrieved on 1 September 2006 from: www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogues/bp_disorder-mp_concomitants/index_e.html

——— (1998). *National Native Alcohol and Drug Abuse Program: General Review*. Ottawa, ON: Health Canada.

——— (n.d.). *Literature Review: Evaluation Strategies in Aboriginal Substance Abuse Programs: A Discussion*. Retrieved on 30 August 2006 from: http://www.hc-sc.gc.ca/fnih-spni/alt_formats/fnihb-dgspni/pdf/pubs/ads/literary_examen_review_e.pdf

Herkov, Michael, Mark S. Gold, and Drew W. Edwards (2001). *Understanding More About Sexual Addiction*. Dr. John Grohol's Psych Central. Retrieved on 28 August 2006 from: http://psychcentral.com/library/sexaddict_general.htm

Herman, Judith Lewis (1992). *Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma*. *Journal of Traumatic Stress* 5(3):377–391.

Hylton, John H. (2002). *Appendix C - Aboriginal Health and Healing: A Review of Best Practices. Improving First Nations and Métis Health Outcomes: A Call to Collaborative Action. Working Together Towards Excellence Project*. Regina, SK: Regina Qu'Appelle Health Region.

Indian Affairs and Northern Development (1998). *Gathering Strength – Canada's Aboriginal Action Plan. A Progress Report, Year One*. Ottawa, ON: Minister of Public Works and Government Services Canada.

Kirmayer, Laurence J., Gregory M. Brass, and Caroline Tait (2000). The Mental Health of Aboriginal Peoples: Transformations of Identity and Community. *Canadian Journal of Psychiatry* 45(7):607–616.

Kishk Anaquot Health Research (2003). Third Interim Evaluation Report of Aboriginal Healing Foundation Program Activity. Ottawa, ON: Aboriginal Healing Foundation.

——— (2002). Journey and Balance: Second Interim Evaluation Report of Aboriginal Healing Foundation Program Activity. Ottawa, ON: Aboriginal Healing Foundation.

Korhonen, Marja (2004). Alcohol Problems and Approaches: Theories, Evidence and Northern Practice. Ottawa, ON: National Aboriginal Health Organization.

Kulchyski, Peter, Don McCaskill, and David Newhouse (1999). In the Words of Elders: Aboriginal Cultures in Transition. Toronto, ON: University of Toronto Press.

Lane, Phil, Jr., Michael Bopp, Judie Bopp, and Julian Norris (2002). Mapping the Healing Journey: The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities. Ottawa, ON: Aboriginal Corrections Policy Unit, Solicitor General Canada.

Latimer, Jeff and Laura Casey Foss (2004). A One-Day Snapshot of Aboriginal Youth in Custody Across Canada: Phase II. Ottawa, ON: Department of Justice Canada.

Levan, Mary Beth (2003). Creating a Framework for the Wisdom of Community: A Review of Victim Services in Nunavut, Northwest and Yukon Territories. Ottawa, ON: Department of Justice Canada. Retrieved on 19 May 2006 from: http://canada-justice.ca/en/ps/rs/rep/2003/rr03vic-3/rr03vic-3_01.html

Mailloux, Louise (2002). First Nations and Inuit Health System Renewal: Gender-Based Analysis. Ottawa, ON: Pauktuutit Inuit Women's Association.

Makivik Corporation (2005) Part II: Submission to the Minister of Indian and Northern Affairs for the Government of Canada and to the Ministre délégué aux Affaires autochtones for the Government of Québec: Regarding the Slaughtering of Nunavik "Qimmiit" (Inuit Dogs) from the mid-1950s to the late 1960s. *The Fan Hitch: Journal of the Inuit Sled Dog International* 7(3).

Marlatt, G. Alan and Katie Witkiewitz (2002). Harm reduction approaches to alcohol use: Health promotion, prevention and treatment. *Addictive Behaviours* 27(6)867–886.

Marshall, W.L. and Y.M. Fernandez (1997). Treatment Of Sexual Offenders: Current Approaches With Non-Aboriginals And Their Relevance For Aboriginal Offenders. In Aboriginal Corrections Policy Unit, *The Four Circles of Hollow Water, Aboriginal Peoples Collection*. Ottawa, ON: Public Works and Government Services Canada.

Miller, Christine and Patricia Chuchryk (1996). *Women of the First Nations: Power, Wisdom and Strength*. Winnipeg, MB: University of Manitoba Press.

-
- Minor, Kit (1992). *Issumatuq: Learning from the Traditional Helping Wisdom of the Canadian Inuit*. Halifax, NS: Fernwood Publishing.
- Morrison, R. Bruce and C. Roderick Wilson (eds.) (1995). *Native Peoples: The Canadian Experience*, 2nd ed. Toronto, ON: McClelland and Stewart Inc.
- National Centre on Addiction and Substance Abuse (1999). *No Safe Haven: Children of Substance Abusing Parents*. New York, NY: Columbia University.
- National Council on Sexual Addiction and Compulsivity (n.d.). *Sexual Addiction*. Retrieved on 9 September 2006 from: www.ncsac.org/general/papers_sexual_addiction.aspx
- National Crime Prevention Council (n.d.). *Offender Profiles*. Retrieved from: http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/html/fvprofil_e.html
- National Native Addictions Partnership Foundation Inc. [NNAPF] (2000). *NNADAP Renewal Framework for Implementing the Strategic Recommendations of the 1998, General Review of the National Native Alcohol and Drug Abuse Program, Draft, Working Paper Prepared-For Discussion Purposes Only*. Muskoday, SK: National Native Addictions Partnership Foundation Inc.
- (2005). *Keeping the Sacred in Tobacco*. Muskoday, SK: National Native Addictions Partnership Foundation Inc.
- National Native Association of Treatment Directors (1992). *The Right to be Special: Native Alcohol and Drug Counsellor's Handbook Working with Sexual Abuse Disclosure*. Calgary, AB: National Native Association of Treatment Directors.
- Nechi Training, Research and Health Promotions Institute (2005). 'FIREWATCH' - Aboriginal Youth Gambling Research Project, AADAC Partnership. Retrieved from: <http://www.nechi.com/research/gambling.php#link3>
- Pauktuutit Inuit Women's Association (2002). *First Nations and Inuit Health System Renewal Gender-Based Analysis*. Ottawa, ON: Pauktuutit Inuit Women's Association.
- Poole, Nancy and Colleen Anne Dell (2005). *Girls, Women and Substance Use*. Ottawa, ON: Canadian Centre on Substance Abuse.
- Public Health Agency of Canada (2005). *Public Health Goals for Canada: A Federal, Provincial and Territorial Commitment to Canadians*. Public Health Goals Secretariat.
- Restoule, Brenda (2004). *Conducting Assessments in First Nations and Inuit Communities: A Training and Reference Guide for Front Line Workers*. Muskoday, SK: National Native Addictions Partnership Foundation, Inc.
-

Royal Commission on Aboriginal Peoples (1996). Report of Royal Commission on Aboriginal Peoples, Volume 1 - Looking Forward Looking Back. Ottawa, ON: Minister of Supply and Services Canada.

Saakvitne, Karen W., Sarah Gamble, Laurie Anne Pearlman, and Beth Tabor Lev (2000). Risking Connection: A Training Curriculum for Working With Survivors of Childhood Abuse. Lutherville, MD: Sidran Press.

Statistics Canada (2003). 2001 Census: analysis series, Aboriginal Peoples of Canada: A demographic profile. Ottawa, ON: Ministry of Industry.

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

United Nations (1948). Convention on the Prevention and Punishment of the Crime of Genocide. Retrieved on 11 July 2006 from: <http://www.hrweb.org/legal/undocs.html>

Volpicelli, Joseph, Geetha Balaraman, Julie Hahn, Heather Wallace, and Donald Bux (1999). The Role of Uncontrollable Trauma in the Development of PTSD and Alcohol Addiction. *Alcohol Research and Health (Feature)* 23(4):256–262.

Wesley-Esquimaux, Cynthia C. and Magdalena Smolewski (2004). Historic Trauma and Aboriginal Healing. Ottawa, ON: Aboriginal Healing Foundation.



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