

Creating accessible addictions treatment for First Nations youth: Gwekwaadziwin Youth Mental Health and Addiction Treatment Program

A capstone project toward the degree of Master of Arts in Community Development (MACD)

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EXECUTIVE SUMMARY

INTRODUCTION

Manitoulin Island's Aboriginal communities are in the midst of a social crisis that includes high unemployment and school dropouts, low income, housing problems, elevated hospitalization rates, and increasing police involvement for break-ins, violence and homicides. A local consortium of six First Nations, the United Chiefs and Councils of Mnidoo Mnising (UCCMM), has linked this crisis to elevated rates of drug and alcohol addiction and mental health problems among their youth and young adults, and the lack of accessible and culturally sensitive treatment options. UCCMM has responded with a plan to build an addictions and mental health treatment centre for First Nations youth and young adults on the island, called Gwekwaadziwin Youth Mental Health and Addiction Treatment (Gwekwaadziwin).

This project was undertaken to assist the progression of Gwekwaadziwin's planning by providing supportive documents. The first activity was to provide an annotated bibliography for the purposes of supporting Gwekwaadziwin's approaches to treatment for stakeholders, and to orient new staff to the Gwekwaadziwin philosophy. Secondly, the project was to develop a form for potential Gwekwaadziwin clients to complete for the intake and screening process, to help staff determine eligibility for the program. To develop these materials, the project was undertaken to discover:

1. Best practices today in the treatment of Aboriginal youth with concurrent addiction and mental health disorders
2. Literature resources that can inform stakeholders and practitioners about the approaches used for the Gwekwaadziwin treatment model
3. What information is currently obtained on application forms to facilitate screening of applicants for residential addictions and mental health treatment

METHODOLOGY AND METHODS

Literature that included published academic literature, media reports, books, and grey literature was searched initially, and a foundation of best practices for treating addictions and

mental health problems in First Nations youth was searched for review. Additional literature that pertained to the two distinct documents was also searched, including references that were requested by the project client for inclusion in the annotated bibliography, and application forms from operational Canadian addictions treatment centres. Flowing from the literature reviews, a conceptual framework was developed that helped to frame the activities of the project and to derive recommendations for moving forward.

FINDINGS

The concurrence of mental health and substance use disorder is a common phenomenon, particularly for young people. While no single factor appears to cause concurrent disorders in youth, a number of factors contribute, that frequently include poor socioeconomic status and immature development. The experience of generational trauma as a result of colonization, ubiquitous for Indigenous youth, emerged as a strong contributor to concurrent disorders. While best practices can address treatment from a western medicine perspective, these practices appear insufficient to meet the need for decolonization that can only begin with culturally informed practices and teachings.

RECOMMENDATIONS

The Application for Residential Treatment that was created as part of this project can serve as a screening tool for clinical use, in conjunction with other professional admission assessments. The application should be viewed as a living document, and part of an overall package for the admission team to consider the applicant's suitability for treatment at Gwekwaadziwin.

Recommendations for moving forward include:

1. Recommendation #1: Develop supporting documents that will fully inform consent to treatment.

Applications that were reviewed for this project did not always make the consent process clear, raising concern in the researcher that consent to treatment could be inadvertently under informed. Fully informed consent is legally required and will benefit from ancillary documents such as parent or client handbooks, grievance policies and confidentiality policies.

2. Recommendation #2: Project deliverables will benefit from iterative development.

In the environment of continually evolving treatment best practices and decolonization efforts, project deliverables herein are considered living documents that can be enhanced using knowledge gleaned from regular program evaluations. For this purpose, deliverables were provided to the client in editable format.

3. Recommendation #3: Access national cultural resources.

Cultural care is recognized as a highly effective approach to promote mental wellness among Indigenous people in Canada. Gwekwaadziwin's efforts in this direction can be supported with a growing body of research and practice materials through websites such as the Thunderbird Partnership Foundation and Addictions Management Information System.

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1.0 INTRODUCTION

1.1 DEFINING THE PROBLEM

Manitoulin Island's First Nation leaders have detected a social crisis in their communities. They report rising rates of drug and alcohol addiction, criminal activity and police involvement, school dropouts, high unemployment and low income, mental health problems, suicidality, hospitalization and housing issues, and unnecessary deaths from street drugs among their people (United Chiefs and Council of Mnidoo Mnising, 2015). First Nations communities are seeing increases of illicit drugs like fentanyl and methamphetamine entering their neighborhoods, and have concerns surrounding drug-related violence, homicides (Editorial, 2011, 2014; Moodie, 2015) and impaired driving (McCutcheon, 2015). Local First Nation leader organization United Chiefs and Councils of Mnidoo Mnising (UCCMM) relates the prevalence of these problems to untended addiction and mental health problems, particularly among their youth and young adults (personal communication, Sam Gilchrist, September 30, 2015).

In the face of these social problems, the chiefs also identify a lack of suitable treatment options for the island's young people. They note only two residential treatment options for First Nation youth in Ontario, and neither are geographically accessible to island residents. Further, these facilities do not provide comprehensive treatment beginning with stabilization, and moving through treatment and aftercare (2015). UCCMM has proposed the creation of a residential treatment facility located on Manitoulin that will serve First Nation youth and young adults, aged 13-30 years, named Gwekwaadziwin Youth Mental Health and Addiction Treatment (Gwekwaadziwin), and have submitted a proposal to government to build the centre (United Chiefs and Council of Mnidoo Mnising, 2015).

Gwekwaadziwin development is now well underway but not yet complete. Limited capital funding has been secured, however funders requested literature and references regarding the efficacy of Gwekwaadziwin's proposed treatment approaches in order to further assess funding suitability. Additionally, Gwekwaadziwin required a form which is geared toward their unique type of program and clientele, to enable the screening and intake of applicants for treatment. To provide further data and produce these documents, the project coordinator required the assistance of a researcher with medical expertise. As a nurse with special interest in both community and Indigenous health issues, this author was invited to contribute to the development of these documents.

1.2 PROJECT CLIENT

The client for this MACD project is Mr. Sam Gilchrist, Project Manager at United Chiefs and Councils of Mnidoo Mnising (UCCMM) for the developmental phase of Gwekwaadziwin. Mr. Gilchrist has been key in the refinement of the project up to this point, creating the main structure of the program while also pulling in key collaborators from health, justice, education, as well as provincial, federal, and First Nations Government representatives.

Gwekwaadziwin is unique in its approach to treatment for First Nations youth and young adults in Ontario. By employing a blend of traditional Anishinabek and western medicine practices, it will promote healing in all areas of a person's life—physical, spiritual, emotional and intellectual aspects—through intake and stabilization, treatment, and aftercare. The program will be staffed with Anishinabek Elders and professional treatment staff to provide essential life skills modeling and training in supportive atmospheres, and education will be provided during treatment to address academic and occupational needs. From the beginning, each individualized care plan will incorporate personal, family and community participation in the care of the young person, so that the client is returned from treatment to an environment that is equipped to support continued healing. This important program will be located on Manitoulin Island, so that participants do not have to leave their home community for help.

1.3 PROJECT OBJECTIVES AND RESEARCH QUESTIONS

In response to the client's needs, this project seeks to answer the main question,

What are the best practices today in the treatment of Aboriginal youth with concurrent addiction and mental health disorders?

Flowing from this main question, additional questions were asked:

- 1. What literature resources can inform stakeholders and practitioners about the approaches used for the Gwekwaadziwin treatment model?*
- 2. How is information currently obtained on application forms to facilitate screening of applicants for residential addictions and mental health treatment?*

This project was initiated to support the progress of Gwekwaadziwin development, and two areas have been identified that require research assistance. In order to demonstrate the suitability of treatment approaches,

Mr. Gilchrist requested an annotated bibliography to provide to funders. The annotated bibliography will permit funders to better understand the value of Gwekwaadziwin's treatment approaches, and it will also help orient new staff to the methods and treatment approaches that will be used in the facility. The client's second request was the construction of an intake application that will reflect the unique needs and structure of the program. The purpose of the intake application will be to provide sufficient information about a client for intake workers to assess suitability for treatment at the facility, and it will also serve as a record of important medical, social, cultural and substance use history once a client is admitted to the program. Furthermore, information gathered on the intake application can be used as a reflective or comparison tool during the program evaluation process. Finally, this project will provide further recommendations to the client which flow from the research efforts.

In response to Mr. Gilchrist's requests, this project provided the following deliverables:

- 1) *Annotated bibliography* This document provides stakeholders and otherwise interested parties with an overview of literature from academic, professional and government sources that is relevant to the Gwekwaadziwin model. It contains recent information regarding best practices, information on the models that Gwekwaadziwin has chosen, and an overview of the areas in which the Gwekwaadziwin model addresses reconciliation as recommended by the Truth and Reconciliation Commission of Canada.
- 2) *Application/Intake form* The application/intake form was developed by surveying the intake packages of twelve operating Canadian residential treatment centres. By building upon current best practices for addictions treatment as determined in the literature review and the Annotated Bibliography, and through ongoing consultation with the client, this form includes health-related data that are required for admission, while also capturing the cultural, social and personal needs of the individual.

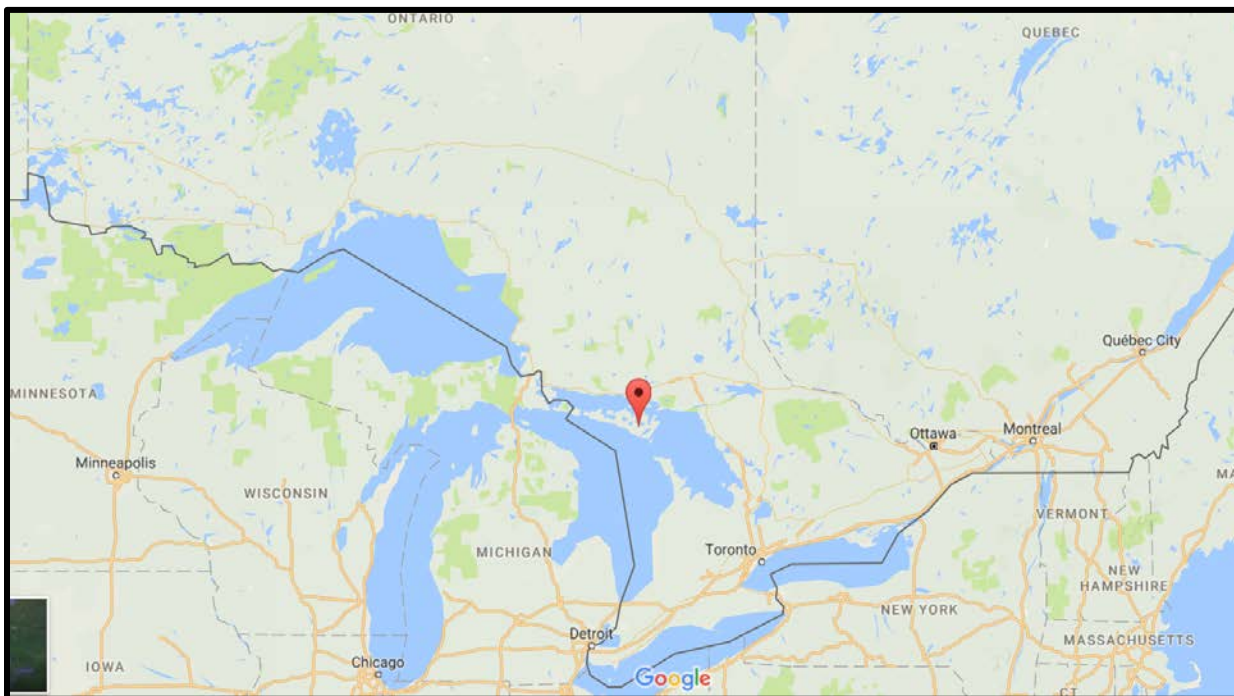
1.4 BACKGROUND

Manitoulin Island is located in Lake Huron in Ontario, Canada (Figure 1). It has two small public airports, but no commercial flights onto the island. Bridges permit year round access by vehicle, and summer months allow boat access to numerous ports, while a commercial ferry, MS Chi-Cheemaun, offers a variety of transport and tour options (Our Manitoulin, 2017). With an area of 2765 km² it is the largest freshwater island in the world (Francois, 2015), and it is also home to rich cultural diversity in both European and Indigenous traditions. There are seven Anishinabek First Nations communities on the island, and in the last year for which statistics

are available, over 41% of its 12,905 citizens identified as Aboriginal people (Statistics Canada, 2015). With over one hundred inland lakes including beaches, fishing and beautiful landscapes, tourism and outdoor recreation are plentiful year-round (Manitoulin Tourism, 2012). Nonetheless, Manitoulin's economy is diverse: Its top three employers in 2006 were in the areas of retail trade (12.8%), health care and social assistance (12.4%) and manufacturing (9.0%) (The Ontario Trillium Foundation, 2008, chart 29).

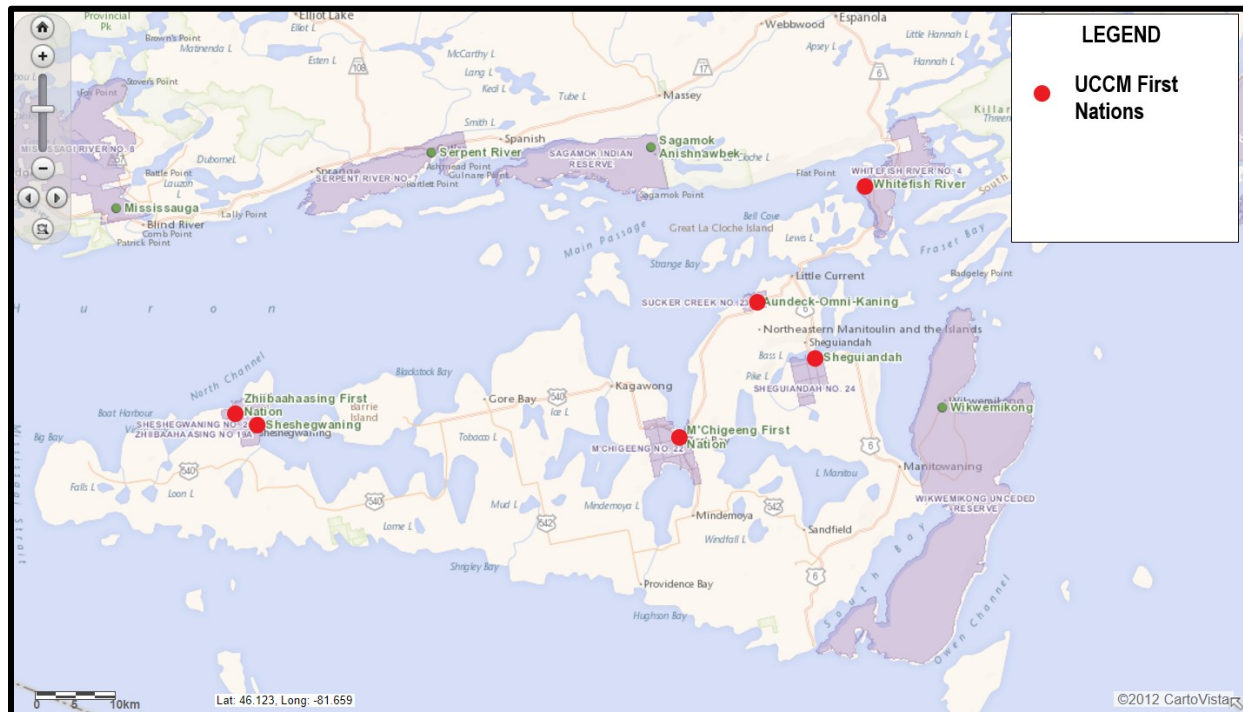
UCCMM is a consortium of six First Nations communities in the Manitoulin Island district that was founded to benefit the Anishinabek First Nations communities in the area. UCCMM is committed to promote the rights, customs, health and good governance of the membership nations and includes Aundeck Omni Kaning, M'Chigeeng, Shequandah, Sheshegwaning, Whitefish River, and Zhiibaahaasing (Figure 2). The consortium accomplishes its objectives through organized events such as powwows and seasonal community meetings, education, and information seminars for community, with a strong focus on strengthening families. UCCMM has developed a tradition of community action in building housing, supporting youth involved in the justice system, organizing community harvests, as well as advocating for environmental protection and action (United Chiefs and Council of Mniidoo Mnising, n.d.).

Figure 1 Map of Manitoulin Island Location in Ontario



(Google Maps, 2017)

Figure 2 **Map of Manitoulin Island First Nations**



(Government of Canada, 2012)

United Chiefs and Council of Mniidoo Mnising has now drawn attention to the specific problems of mental health and addiction of youth in their communities and the social consequences felt by all. Building upon the claims of UCCMM's report to stakeholders (United Chiefs and Council of Mniidoo Mnising, 2015), the author found that Manitoulin Island experiences unusually high rates of addiction and mental health problems among its youth when compared to the province's general population (Editorial, 2011; Ontario Drug Policy Research Network, 2016a; Rush, Kirkby, & Furlong, 2016). Furthermore, when compared with the rest of Ontario, Manitoulin citizens are arrested more frequently per 100,000 population for serious assault, break and enter, impaired driving, and drug violations (Statistics Canada, 2016), crimes which First Nations community leaders link to increased drug use and poor states of mental health. Considering then that Canadian Aboriginal populations suffer higher rates of mental health and substance use problems than the general population (Health Canada, 2012) and its high proportion of Aboriginal people (41%) (Statistics Canada, 2015), it would appear that Manitoulin Island's young Aboriginal people are more likely to face extraordinary challenges in the areas of mental health and addiction.

Again building upon the UCCMM report, the researcher found gaps in comprehensive, culturally appropriate treatment options for young First Nations people. On Manitoulin Island, Ngwaagan Gamig Recovery Centre Inc. offers culturally informed residential or community addictions treatment to First Nations adults over the age of 18 (Connex Ontario, 2017). Limited addictions care for all ages is available from Health Sciences North and offered on the island in Little Current, however this program offers only community-based, non-residential treatment or methadone case management (Health Sciences North, 2017). Withdrawal support services and help with planning and advocacy can be accessed for those 16 and older via Noojmowin Teg Health Centre (Connex Ontario, 2017).

In an innovative and community-centred initiative, UCCMM has proposed one solution to target the aforementioned social problems that plague some Aboriginal young people. The organization has brought together addictions and mental health treatment, community involvement, education and culture, to create Gwekwaadziwin (United Chiefs and Council of Mnidoo Mnising, n.d., 2015). Gwekwaadziwin's proposed model of individualized addictions treatment to First Nation youth and young adults from stabilization through treatment and aftercare, which is grounded in traditional teachings and within safe travel distance of Manitoulin treatment, will fill treatment gaps for this demographic (United Chiefs and Council of Mnidoo Mnising, 2015).

1.5 ORGANIZATION OF REPORT

This report is organized to provide the reader with an understanding of the complex variables that inform addictions and mental disorders as they affect First Nations youth on Manitoulin Island, and the activities of this project. In the following section, a literature review uncovers key themes that pertain to the development and treatment of these problems, from both western bio-medical and traditional points of view. The first theme is the presence of a high prevalence of concurrence among mental health and substance abuse disorders, and the tremendous negative impacts of these conditions upon individuals and society. Next, it appears that concurrent disorders appear to share similar etiological factors, and those which are pertinent to the Gwekwaadziwin clientele will be discussed. Another theme that emerged from the literature review is the existence of a low overall social determinant of health status and high levels of substance use in the Manitoulin area. Finally, the literature revealed that although outcomes measurement is not yet optimized, researchers and practitioners agree that treatment for concurrent disorders works. Upon completion of the literature review, a conceptual framework that privileges both Indigenous and Western ways of knowing was derived and is presented in diagram and text format.

Using the conceptual framework derived from the literature review, the annotated bibliography and the application for admission to Gwekwaadziwin were created. Both activities were informed by the best practice findings of the literature review, further influenced by additional data collection, and adjusted according to the needs of the project client. The approach and processes will be discussed further in the Methodology section.

The fourth section concerns the development of an application for admission to Gwekwaadziwin. It will outline the review of twelve Canadian admission forms, consider relevance to the Gwekwaadziwin model, and discuss the evolution of the Gwekwaadziwin form.

In chapter five, recommendations that flowed from the work of this project will be offered for consideration by the client.

Finally, this report will conclude with a brief summary. References and appendices will follow.

TERMINOLOGY USED IN THIS REPORT

Addiction: behaviour focused around the use of substances, with the presence of craving, loss of control of the frequency or amount of use, compulsion to use, and use despite consequences (Centre for Addiction and Mental Health, 2012a, para. 3); addiction is considered a chronic condition in which relapse is common (American Psychiatric Association, 2013); also referred to as substance use disorder (SUD)

Concurrent disorder: the presence of at least one emotional, mental or psychiatric problem together with abuse of at least one substance such as alcohol or other psychoactive drug; also referred to as dual disorders, co-occurring, or co-existing disorders (Centre for Addiction and Mental Health, 2010)

2.0 METHODOLOGY AND METHODS

2.1 METHODOLOGY

Indigenous methodology demands that the researcher position herself in the inquiry and self-locate with transparency and an open heart (Kovach, 2009; Wilson, 2008). As a descendent of Scandinavian and German immigrants, this author's early education was steeped in Eurocentrism and empiricism. However, in the experience of this writer, modern baccalaureate nursing education and professional practice actively invite the practitioner to appreciate unique patient definitions of wellness, even when they vary from the medical or positivist model. Although this more inclusive way of thinking has been evolving in the workplace, it has been

the experience of this author that positivism remains the dominant theme in many settings, and it is left to the individual practitioner to acknowledge power imbalances that influence mental health and addictions behavior as well as healthcare seeking behavior. While working in community health care and in acute care tertiary facilities, the author has become sadly aware that Indigenous people suffering mental health and addiction problems have more and greater hurdles to overcome and fewer suitable resources to help them. After 17 years of attempting to help people navigate and find solutions within service models that do not fit the patient or client, this author is encouraged by the opportunity to participate in the development of a model designed for the care recipient. It is hoped that this work contributes in some way to that end.

The author visited Manitoulin Island to meet with Mr. Gilchrist, tour the sites that will be home to the Gwekwaadziwin facility, and put into context the ways that the community will contribute to, and benefit from, the activities of Gwekwaadziwin. During this visit, the author had the opportunity to observe meetings with officials from stakeholders Ontario Ministry of Health and Long Term Care, Ministry of Indigenous Relations and Reconciliation, and Ministry of Children and Youth Services (personal communication, November 16, 2016). Later, driving to the facility's future site and as if on cue for the author's benefit, a young man emerged sleepy and ill-kempt from the roadside bush, and flagged a ride with Mr. Gilchrist and the writer "to meet a friend in town"—a euphemism, Mr. Gilchrist explained, for meeting his drug dealer. This visit helped to clarify the level of need for treatment in the community, as well as to cement the author's understanding of Gwekwaadziwin's future contributions to Indigenous healing in the area.

This project was undertaken with a decolonization lens applied within the context of systems theory. The purpose of decolonization is to "...create space in everyday life, research, academia, and society for an Indigenous perspective without it being neglected, shunted aside, mocked, or dismissed" (Kovach, 2009, p. 85). Therefore, a conscientious effort was made throughout the project to privilege both Euro-Canadian treatment best practices and Indigenous ways of knowing and healing. Furthermore, by ensuring the inclusion of practitioner-respected healing practices from both worldviews, the resultant deliverables can most closely represent the blended approach planned for Gwekwaadziwin.

Literature materials identified current best practices of western medicine and addictions treatment that support decolonization. Where literature was not explicitly supportive of decolonization, the author considered whether the identified practice would honor a decolonization effort and act as a suitable practice for Gwekwaadziwin. Similarly, Indigenous-specific approaches to treatment were considered for their

suitability at the facility, given Gwekwaadziwin's stated model (United Chiefs and Council of Mnidoo Mnisging, 2015) and consultation with project client Mr. Gilchrist (personal communication, November 17, 2016). Findings from the literature review were then applied to the project deliverables as described in the following sections.

2.2 METHODS

Wellness for the Aboriginal person is recognized as a balance of spirit, mind, emotion, and body that is expressed through relation to others and to the world (Dumont, 2014; Health Canada, 2015; National Native Addictions Partnership Foundation, 2015). This relational state of wellness underpinned the activities of building the Annotated Bibliography and Application for Residential Treatment. The activities involved in completing these two deliverables is described below.

Annotated Bibliography

Mr. Gilchrist requested an annotated bibliography that would recommend literature to a reader to elucidate the theory behind Gwekwaadziwin and the treatment models it will be using in the facility. The bibliography is needed to serve the dual functions of a reference for new staff orientation as well as lending academic support to the ongoing negotiations for funding and resources for the centre. This section will describe the process and selections made for the annotated bibliography (Appendix A).

References for the annotated bibliography were selected for relevance, breadth, and readability. An original working list for this purpose was derived from the literature review and then rounded out with materials suggested by the client. Broad themes for readings included prevalence of addictions and disordered mental health in youth, causes of addiction and mental health disorders, and treatments that will be used at Gwekwaadziwin.

The bibliography was populated with twenty-six titles. Individually, each title contributes information about some aspect of either the theoretical or practical underpinnings of Gwekwaadziwin, with some overlap of content. Taken together, they offer a snapshot of the centre's approach to treatment.

The annotated bibliography was begun with broad information to establish the national state of substance abuse treatment in Canada, and then moved on to more specific resources. The *National Treatment Indicators Report* (Canadian Centre on Substance Abuse, 2014) provided the reader with a general introduction to the current state of Canadian substance abuse treatment which was undertaken to inform the development of

improved treatment options. With this basis provided, aspects of the Gwekwaadziwin model could then be addressed. At the core of Gwekwaadziwin's treatment philosophy is the maturity model which asserts that normal adolescent development is impeded by early substance abuse, and that treatment approaches should facilitate healthy maturation (United Chiefs and Council of Mnidoo Mnising, 2015). McKinnon's two works (2008, 2011) were included for their neuroscientific perspective as well as readability by a lay audience. For practitioners, a clinical guide based upon the developmental approach was chosen to aid the professional in caring for clients using this theory (S. Brown, Anderson, Ramo, & Tomlinson, 2005). Gwekwaadziwin will be using SNAP® programming in their Four Directions program to support emotional self-regulation and problem solving. The annotated bibliography therefore includes SNAP® program information (Child Development Institute, 2016a), and an evaluation of the original program's effectiveness (Burke & Loeber, 2014). A SNAP® program developed for Aboriginal populations will be used at Gwekwaadziwin, however further specific program information was not available at the time of writing.

The literature revealed complex relationships between treatment environment, therapeutic approaches, and a host of socioeconomic factors. Three readings were included in the annotated bibliography that discuss this complexity from differing perspectives. Rush et al. (2016) put addiction and mental health treatment strengths and challenges into local context with the *NE LHIN Addiction Services Review*. Then, the Canadian Centre on Substance Abuse (2007) outlined the status of Canadian substance abuse treatment for youth while Murrihy, Kidman and Ollendick (2010) offer an evidence-based clinical text for practitioners wishing to read further detail on therapeutic approaches.

Specific treatment types consistently emerged in the literature review as promising approaches to help youth with SUD and mental health problems. To provide information on the efficacy of these approaches, a meta-analysis of treatment types for youth was included (Tanner-Smith, Jo-Wilson, & Lipsey, 2013) which demonstrated that family therapy, cognitive behavior therapy and motivational enhancement therapy all performed well in treating adolescent addictions. Since each of these approaches will be used at Gwekwaadziwin, they were given further space with additional readings (Latimer, Winters, D'Zurilla, & Nichols, 2003; Rowe, 2012). Cultural care emerged as a necessary pathway toward decolonization, and aspects of this concept are explored in three different offerings. The first discusses the perspectives of Aboriginal people experiencing addiction (Chansonneuve, 2007), the second provides an example of culturally-specific treatment in a Canadian youth solvent abuse treatment centre (C. A. Dell et al., 2011), and the third discusses the healing power of Indigenous culture presented through explorations of an Ontario crown attorney who

recognized a tremendously flawed justice system (Ross, 2014). These arguments for cultural care are then rounded out with information about more specific Indigenous teachings that will be used in the Gwekwaadziwin programming, namely medicine wheel teachings (Gone, 2011; McCabe, 2008; Nabigon, 2006) and the sacred teachings of the Seven Grandfathers (Wesley-Esquimaux & Snowball, 2010).

The literature which addressed treatment environment was then grouped according to the corresponding environment at Gwekwaadziwin. They include residential aftercare for the older 19-30 year-olds (The Society for Community Research and Action, 2013), where they will learn skills to live independently in supervised apartment settings. Wilderness stabilization for the younger 13-19 group (Big-Canoe & Richmond, 2014) will allow detoxification and transition to the treatment setting in residential treatment (Plant & Panzarella, 2009). For both groups, Gwekwaadziwin plans to incorporate a strong element of community aftercare that is guided by a growing understanding of effective approaches outlined by the National Native Addictions Partnership Foundation's Cultural Aftercare Guidebook (2016).

All activities of Gwekwaadziwin will benefit from evaluation, and establishing such processes will be a priority for the centre (United Chiefs and Council of Mnidoo Mnising, 2015). Since the program was modeled after Pine River Institute (PRI) in Ontario, and PRI has demonstrated efficacy in its treatment practices (Mills, Pepler, & Cribbie, 2013), its annual report was included (Pine River Institute, 2016) to illustrate the potential efficacy of a similar programming philosophy in Gwekwaadziwin. Guidelines for substance abuse treatment for Indigenous practitioners in the treatment of substance abuse were also included (National Native Addictions Partnership Foundation, 2013) to provide support for the ways in which treatment can be made culturally specific for this population.

Application for Residential Treatment

Creating Gwekwaadziwin's Application for Residential Treatment began with a review of 12 applications from substance abuse treatment facilities chosen through purposive sampling. Selected applications were then studied to identify common components. Components were grouped into themes, and a draft application form was created using tables populated with prevalent components. As the application began to take shape, consultation with the client provided insight into any additional desired elements. The following paragraphs outline this process in further detail.

Gwekwaadziwin's holistic approach to treatment and its focus upon delivering best practices in a culturally rich environment are important aspects of programming that guided sampling. The application package for PRI was included because its program model inspired the Gwekwaadziwin programming (United Chiefs and Council of Mnidoo Mnising, 2015), and it serves as a model of current best practices (Mills et al., 2013). The eleven remaining application examples were obtained through an online search of substance abuse treatment directories that included provincial and federal government sources as well as non-profit mental health organizations. Via their websites, treatment facilities were reviewed for their philosophy and treatment approach. Facilities were eliminated if residential treatment was not offered; if treatment was religiously based; if treatment was not explicitly holistic to include comprehensive mental health support and family, occupational or environmental supports; if treatment was not explicitly long-term to include plans for aftercare; or, if treatment was directed toward elite clientele.

The Government of Canada Addictions Treatment for First Nations and Inuit database (Government of Canada, 2017) returned 61 First Nations, Inuit or Aboriginal treatment residential treatment facilities in Canada. These were examined for their similarity to Gwekwaadziwin in philosophy and type of clientele, and seven centres were selected. Because Gwekwaadziwin's programming is unlike any other that were found in the literature review, the four remaining applications were subjectively chosen from residential treatment programs for aspects of their treatment approach that were similar to Gwekwaadziwin's approach, as follows. One Ontario facility, Crossroads Centre, was selected because it provided residential pre-treatment and post-treatment support (Crossroads Centre, n.d.) which appeared similar to Gwekwaadziwin's Seven Grandfathers programming. The Addiction Foundation of Manitoba's Compass youth program was selected for its high level of community involvement and multifaceted approach to addictions treatment (Addictions Foundation of Manitoba, n.d.). Last Door Youth Program (Last Door, n.d.) and Dave Smith Youth Treatment Centre (Dave Smith Youth Treatment Centre, 2017) were both selected for their multiple professional partnerships, extensive programming that included concurrent disorders treatment, long-time membership in their respective communities, and ongoing quality improvement measures. Applications for PRI and Dave Smith Youth Treatment Centre were obtained by author request and reviewed with permission. All other applications were publicly available and obtained online. Further information and links to the applications of the selected facilities can be found in Appendix B.

Chosen application forms were reviewed for specific questions asked, layout, application length, reading level and language used. Items were entered into a spreadsheet and grouped according to themes that related to

best practices gleaned from the literature review. Themes were further considered in accordance with an Indigenous lens. Because the Indigenous health perspective emphasises a balanced, holistic view of health, spiritual and personal development questions were grouped into one theme. Final themes included demographics, social history, spiritual and personal development, medical history, substance abuse history, and legal history.

Once the final themes were determined, an application was drafted and populated with the prevalent components from the spreadsheet, based upon relevance to Gwekwaadziwin programming needs. On occasion, it was necessary to obtain data outside of the application sources to satisfy project client needs. For example, further investigation was needed to identify a gender inclusive term (it's pronounced METROsexual, 2017). Mr. Gilchrist also requested an extensive list of medical symptoms that a client may exhibit as a result of chronic drug use, which could cue an assessor that further investigation is necessary. For this purpose, Schuckit's Drug and alcohol abuse: A clinical guide to diagnosis and treatment (2005) was consulted.

Seven sections were developed in all. Demographic information was requested first to provide applicant identification and a quick reference for treatment staff. Remaining sections were ordered from least sensitive to most sensitive topics to help ease the applicant into the necessary process of self-disclosure. Final ordering of sections was as follows: *Client Information, Contact Information, Social History, Spiritual and Personal Development, Medical History, Substance Abuse History, and Legal History.*

Mr. Gilchrist anticipates that in many cases the application for treatment at Gwekwaadziwin will be completed by a young applicant or their family members. The application therefore was not geared toward the professional care provider. With this in mind, language was kept as accessible as possible, and effort was also made to make the questions non-threatening. The application length was kept as low as possible while capturing enough information to assess probable suitability for the program and leaving some free space for any additional information or comment the client would like to share. The final application was twelve pages in length.

2.3 PROJECT LIMITATIONS AND DELIMITATIONS

This project was influenced by factors that were inherent in the author and in the undertaking. The personal disclosure at the beginning of this chapter was important to place the author in terms of professional and personal practice, experience and intention, and to approach this work in accordance with Indigenous methodology. It is acknowledged that this self-location could also serve to bias the discovery of best practices

for addiction and mental health treatment. Furthermore, the client required support for Gwekwaadziwin's treatment approaches, so the suggested practices were already selected by the client, also creating potential confirmation bias. While the author's position and world view has certainly had influence upon the project's course, effort was made to bracket any presuppositions and maintain an iterative and reflexive stance throughout the project.

Another limitation of the current work was identified in estimating the mental health and addictions treatment needs of Manitoulin Island residents. This is a common challenge that arises due to disconnects between health care providers and the data systems used and non-participation in surveys by some regions (Rush et al., 2016) and because data is often collected by Statistics Canada or within schools using methods that do not capture residents of First Nations (Canadian Centre on Substance Abuse, 2014; Rush et al., 2016). Figures used in this paper were therefore applied cautiously, although it is believed by researchers that in the areas not captured, estimates of prevalence or service use are conservative and suggestive of higher mental health and substance abuse treatment needs (Canadian Centre on Substance Abuse, 2014; Rush et al., 2016).

The lack of availability of comparative addictions treatment facilities delimited this project. There is currently no known addictions treatment model that offers the same configuration of treatment and support that Gwekwaadziwin proposes to provide. Furthermore, there remain tremendous differences in programming, evaluation and reporting that render program-to-program comparison exceedingly complex and beyond the scope of this project. For these reasons, the selection of treatment program applications for review was a subjective effort based upon the author's professional judgment, literature review, and client input, and the selection of materials for inclusion in the Annotated Bibliography reflected the specific requirements for Gwekwaadziwin.

A second delimitation was imposed regarding the Application for Admission for Residential Treatment in particular. This document constituted the initial tool for a clinician to use during the eligibility process, and it is beyond the scope of this project to include all materials that will be required for admission to Gwekwaadziwin. For example, the need for a medical form completed by a physician or nurse practitioner is anticipated, and consent forms, admission agreements or other inclusions are typical components of an application process that will need to be developed outside of this project.

3.0 LITERATURE REVIEW

3.1 INTRODUCTION

The first major activity of this project was to complete a literature review. Its purpose was to understand the development, prevalence and treatment of addiction and mental health problems focusing, where suitable, upon Manitoulin Island and Ontario. Moreover, the objective was to learn about the impact that the presence of Aboriginal ancestry has on both the development and treatment of addictions and mental health disorders.

While focusing on the primary research question, *What are the best practices today in the treatment of Aboriginal youth with concurrent addiction and mental health disorders?*, a search was conducted within published academic literature, media reports, books, and grey literature. The University of Victoria libraries Academic Search Complete, JSTOR, Google Scholar, Humanities Index, Business Source Complete, Social Sciences Abstracts, LexisNexis Academic, and CINAHL databases were used to ensure a multidisciplinary search.

Literature was searched using the main search terms Aboriginal, First Nations, Four Directions, Seven Grandfathers, tradition, addiction, alcohol, youth, mental health, adolescent, and treatment, using Boolean operators in various combinations, for example, “Aboriginal + youth + addiction”. Additionally, specific treatment approaches such as wilderness therapy, residential treatment, family therapy, maturity model, PRI, and Stop Now and Plan (SNAP)[®] were known components of the Gwekwaadziwin model and were searched in a similar fashion. Pine River Institute, Stop Now and Plan[®], and local tourism and news websites were searched for grey literature and community information. Statistics Canada and local, provincial and federal health websites were accessed for demographic, prevalence, and health behaviour data.

Preference was given to research published within the last decade for currency and relevancy. Literature was read and screened for relevancy to the topics of interest, and was included if it pertained to the development or treatment of addictions or mental illness in youth or young adults or could be generalized to this group. Literature was also included if it pertained specifically to addictions or mental health concerns among Aboriginal populations, or traditional Indigenous approaches to understanding these problems or their treatment.

Literature was excluded if it did not apply to youth or young adults or could not be confidently generalized to these groups, or if it originated outside of Canada and could not be generalized to Canadian citizens due to cultural, social, economic or other factors. Only English literature was reviewed.

3.2 BACKGROUND ON MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Disorders of mental health and substance use commonly occur together

The presence of mental health problems and addiction together in an individual are referred to as concurrent, co-occurring, co-existing or dual disorders (Centre for Addiction and Mental Health, 2010), and the literature revealed that this is a very common phenomenon. Those with a mental health problem are twice as likely as the general population to also have an addiction, and people who have an addiction can suffer mental illness at three times the average (Centre for Addiction and Mental Health, 2012b, pt. Who is affected?). Reported incidence of co-occurrence varies due to differences in diagnostic and data collection methods (Canadian Centre on Substance Abuse, 2009; Health Canada, 2012; Parliament of Canada, 2004), but it is estimated that between 50% (Hawkins, 2009) and 80% (Health Canada, 2012) of people with SUD also have a mental health disorder. In adolescents with SUD, the literature reports concurrence as “the norm” (Plant & Panzarella, 2009, p. 149), and in a large U.S. study, 67% of 14, 776 adolescents in treatment for SUD met the criteria for one or more psychiatric disorder by self-reported criteria (Dennis, White, & Ives, 2009, p. 56). Despite the dearth of consistent measures, it is clear across the literature that the presence of a SUD denotes a higher likelihood of a concurrent mental health disorder and vice versa (Brien, Grenier, Kapral, Kurdyak, & Vigod, 2015; Canadian Centre on Substance Abuse, 2007, 2013; Health Canada, 2012; McKee, 2017; Mental Health and Addictions Leadership Advisory Council, 2015; Ratnasingham, Cairney, Rehm, Manson, & Kurdyak, 2012; Rush et al., 2016).

Costs and consequences of concurrent disorders

Disordered substance use can create the setting for a host of serious problems for young people. Substance abuse can contribute to unplanned, unwanted and unprotected sexual activity (R. Brown et al., 2015; Leslie, 2008), which is further associated with unwanted pregnancy and sexually transmitted infections (Leslie, 2008; Sussman, 2011). Aggression and violence are more common in the environment of substance abuse (Adams, 2008; Brunelle, Cousineau, & Brochu, 2005; C. G. Leukefeld, McDonald, Stoops, Reed, & Martin, 2015; Sussman, 2011) and two thirds of date rapes involve alcohol abuse (Sudbury and District Health Unit, 2017). Researchers report elevated participation in criminal activity (Pagano et al., 2013) and incarceration (S. Brown

et al., 2005): Hawkins (2009) reported that of her 600 recruited participants for her research study of marijuana abuse, 83% had justice-system involvement. An elevated willingness to take risks also results in driving under the influence, leading to accidents (C. G. Leukefeld et al., 2015; Sussman, 2011) and traffic deaths (R. Brown et al., 2015). Youth who abuse substances are vulnerable to vocational and occupational underperformance or non-participation (Dennis et al., 2009; Pagano et al., 2013; Roarty et al., 2012), setting them up for poverty that persists into adulthood (Sussman, 2011).

In the presence of concurrent mental health and substance use disorder, an individual's troubles are compounded and quality of life can deteriorate much more rapidly. Concurrent abuse of psychoactive substances can worsen mental health problems, render mental health treatment less effective, and mask important symptoms of mental health problems (Centre for Addiction and Mental Health, 2010, p. 1). People who have concurrent disorders are more likely to experience public discrimination and stigma, and to internalize feelings of moral and personal failure (National Treatment Strategy Working Group, 2008, p. 26); higher rates of self-harm and suicide are also seen within this group (Canadian Centre on Substance Abuse, 2013; McKee, 2017; McKowen, Tompson, Brown, & Asarnow, 2013). Those with concurrent disorders experience violence (McKowen et al., 2013), poor interpersonal relationships (Canadian Centre on Substance Abuse, 2009; Hawkins, 2009; McKee, 2017), and incarceration (McKee, 2017) at higher rates than people with either SUD or mental illness alone. Economically, a person with concurrent disorders can suffer tremendous losses. Such an individual is very likely to experience poor academic performance and school drop-out (Canadian Centre on Substance Abuse, 2009; Hawkins, 2009; Kirby JL, 2004; Sussman, 2011, p. 3), job instability (Kirby JL, 2004, p. 166; Sussman, 2011, p. 3), and poverty (Kirby JL, 2004). Compared with only one disorder, people with concurrent disorders have more frequent hospitalizations with longer stays (Canadian Centre on Substance Abuse, 2013; McKee, 2017), higher rates of infectious diseases and other health problems that result from not having regular medical care (Addiction and Mental Health Collaborative Project Steering Committee, 2014; McKee, 2017), and shorter life expectancy (Ratnasingham et al., 2013). Ultimately, mental health problems and SUD combined are the leading cause of disability across the world (World Health Organization, n.d., Fact 2).

Mental illness and addiction can also be devastating for families and friends of the suffering individual. Throughout their efforts to support a loved one, caregiving family and friends can experience tremendous relationship conflicts (Canadian Centre on Substance Abuse, 2007) and while carers struggle through the frustration of inadequate or unavailable supports, they are equally branded by stigma as the sufferer (Ontario

Minister's Advisory Group, 2010). Reduced or delayed participation in the economy due to caregiving responsibilities reduces family financial health (Mental Health Commission of Canada, 2013), while family members' overall personal health status is jeopardized by the emotional and physical costs of caring for their loved one (Mental Health Commission of Canada, 2013; Ontario Minister's Advisory Group, 2010).

Concurrent mental illness and addiction also present complex and expensive health issues for the residents of Ontario. The Mental Health and Addictions Leadership Advisory Council of Ontario estimates that the lives of one in five Canadians are impacted by addiction or mental illness every year (2015, p. 3). Conservative cost estimates rank Ontario's burden of mental illness and addiction higher than that of all cancers and infectious diseases combined, for all age groups (Ratnasingham et al., 2012, p. 28); more than 20% of costs incurred by the highest-cost users of Ontario health care services are attributable to people suffering mental health disorders or addiction (Hensel, Taylor, Fung, & Vigod, 2016). In the light of this worrisome state of affairs, Ontario's health region (Rush et al., 2016) and Mental Health and Addictions Leadership Advisory Council (2015) urge the prioritization of mental health and addictions treatment for the province.

3.3 MANITOULIN YOUNG PEOPLE ARE AT HIGH RISK

United Chiefs and Councils of Mnidoo Mnising concerns about the high levels of substance abuse and its sequelae are supported by the literature reviewed for this project. An important review of the strengths and challenges of addiction treatment in the northeastern region of Ontario was commissioned by the North East Local Health Integration Network (NE LHIN), of which Manitoulin Island is a part. The study, *NE LHIN Addiction Services Review*, was informed by health care treatment records, steering committee member input, key informant interviews, a literature and existing data review, site visits, agency profiles, case descriptions and online surveys (Rush et al., 2016). Although the reported results for Manitoulin District have often been combined as a sub-region with Sudbury and Parry Sound, this study represents the most robust published data collation for the region available at this time (2016, Chapter 2). It found that the most abused substances when entering addictions treatment among Manitoulin District residents are alcohol (69.6%), cannabis (38%), opioids such as fentanyl (33.9%), tobacco (22.1%), cocaine (18.6%), crack (11.1%) and amphetamines & other stimulants (3.7%) (2016, p. 19). These numbers are thought to be fairly consistent with the rest of the region with the exception of opioids, where the incidence of treatment in the Manitoulin region is significantly higher than the greater region's 24.5% (2016, p. 232). This higher sub-regional rate for opioid use is in keeping with the concerns expressed by Manitoulin Island's First Nations community (United Chiefs and Council of Mnidoo

Mnising, 2015), media reports (Moodie, 2015; Ontario Provincial Police, 2011; Stranges, 2016), and client Sam Gilchrist (personal communication, Sept. 30, 2015).

Aggressive and risk-taking behaviour often follows alcohol abuse (S. Brown et al., 2008; Rush et al., 2016). One common metric for alcohol abuse is rate of heavy drinking, defined as 4 or more servings of alcohol for women or 5 or more servings for men on at least one occasion per month in the past year (Sudbury and District Health Unit, 2017). Manitoulin's heavy drinking rate exceeds the rate for the rest of Ontario at 24% compared to 17% (Sudbury and District Health Unit, 2017). Young people in the region are especially more likely than their provincial peers to abuse alcohol and participate in riskier behaviours while drinking and more likely to operate motorized recreational vehicles while drinking (Rush et al., 2016, p. 20). The region has higher rates of serious assault, break and enter, impaired driving, and drug violations than the rest of Ontario (Statistics Canada, 2016), and substance abuse is treated in hospital emergency rooms at a rate of 18.4 instances per 1000 population, versus 11.5 encounters per 1000 residents in the rest of Ontario (Rush et al., 2016, p. 47).

Similarly, the region's narcotic use is exceptionally concerning. Ontario's narcotic use rate is the highest in Canada, and the NE LHIN has the highest opioid prescribing rates in Ontario (Rush et al., 2016). From 2011 to 2013, there were 27,484 prescriptions per 1,000 population for people aged 15-64 years, versus 12,685 per 1,000 population in the years 2006-2010, representing a 116% increase over two years (Ontario Drug Policy Research Network, 2016a, Table 1). Negative consequences to this high availability are demonstrated in the literature: During those same periods, the rate of opioid-related emergency room visits for people aged 15-64 in the Manitoulin District rose from 3.9 to 11.3 per 10,000 population, representing a nearly four-fold increase from the previous reporting period, and currently the highest rate in Ontario (2016a, Table 2). Deaths linked to opioid use are thought to be underreported due to reporting methods and small population samples (Ontario Drug Policy Research Network, 2016b), but known deaths have increased in Ontario by 1.7 times in the four years between 2009 and 2013 and continue to rise with increased availability of the drugs (Canadian Centre on Substance Abuse, 2015, p. 5). In 2013, the number of opioid related deaths in the NE LHIN was twice the provincial average, and the highest in the province at 1 death per 10,000 (Institute for Clinical Evaluative Sciences, 2016).

3.4 INTRODUCTION TO CAUSES AND TREATMENTS

A good understanding of the causes of addiction and mental illness is critical to identify and develop treatments at the practice level, and can help direct public health and social policies to improve prevention for everyone (Canadian Centre on Substance Abuse, 2007; Mental Health Commission of Canada, 2013; Ontario Minister's Advisory Group, 2010). The literature revealed that the development of mental health or substance abuse problems is impacted by the state of genetic, social, economic, biologic, and psychological influences (Mental Health Commission of Canada, 2013, p. 4), or determinants of health. Factors which can affect day-to-day happiness and ease of living, such as social determinants of health, impose tremendous impact on the risk for developing mental illness or substance abuse, particularly for Indigenous peoples (Health Canada, 2015; King, 2009; Rush et al., 2016). A full review of risk factors is beyond the scope of this paper; a brief discussion of themes is presented here.

Public records indicate poorer social health determinants in the Manitoulin region. Manitoulin's unemployment rate is 61% higher than Ontario's rate, at 10.5% compared with 6.4% (The Ontario Trillium Foundation, 2008, chart 27). The area has higher numbers of people with no certificate, diploma or degree (21.2% vs. 13.6%) and its percentage for university-level graduates (14.9%) number less than half the provincial average (30.7%) (The Ontario Trillium Foundation, 2008, chart 34). Most recently available figures placed Ontario's median income in 2005 at \$27,258, while Manitoulin's median income was \$19,894 (The Ontario Trillium Foundation, 2008, chart 38), however this figure represents a substantial range across the island and First Nations communities tend to fare poorer in this regard. For instance, M'Chigeeng First Nation's median before-tax income is \$12,672, while Central Manitoulin's median before-tax income was \$23,939 (2008, chart 38). Health professionals in the region claim that lackluster social determinants of health in the area compound risk factors and result in increased client complexity and decreased ability of clinicians to meet treatment needs (Rush et al., 2016).

Determinants of health for Indigenous populations warrant particular attention in the discussion of substance use and mental health disorder. It is well documented in the literature that colonization practices have wreaked terrible consequences on many generations of First Nations people, including disproportionately high rates of substance abuse and mental health struggles (Health Canada, 2015; King, Smith, & Gracey, 2009; Lavallee & Poole, 2010; Truth and Reconciliation Commission of Canada, 2015b, 2015c), and that social determinants of health for Indigenous populations the world over, including Canada, rate far poorer for Indigenous people than for settler populations (King, 2009; Rush et al., 2016). For Canadian Indigenous

populations, legally sanctioned environmental dispossession and cultural assimilation practices including residential schools and the Sixties Scoop have meant critical losses of interpersonal, land and animal relationships which had maintained wellness in Indigenous communities for centuries (Truth and Reconciliation Commission of Canada, 2015, 2015). The availability or unavailability of these relationships represents a fundamental, unique determinant of health for Canadian First Nations populations (Health Canada, 2015; Indigenous and Northern Affairs Canada, 2015; King, 2009).

At the individual level, personal experiences also create susceptibility to addiction and mental health disorder. Trauma, for instance, is an especially common contributor (Canadian Centre on Substance Abuse, 2013; Ontario Minister's Advisory Group, 2010), especially among youth (Dennis et al., 2009; C. G. Leukefeld et al., 2015) and Indigenous populations (National Native Addictions Partnership Foundation, 2013; Smillie-Adjarkwa, 2009; Wesley-Esquimaux & Snowball, 2010). Childhood experiences of physical or sexual abuse and other types of childhood victimization are risk factors for both SUD and psychological disorder (S. Brown et al., 2005; Canadian Centre on Substance Abuse, 2007), and youth who are street involved, runaway or homeless are also more at risk (Canadian Centre on Substance Abuse, 2007). Personality traits such as high sensation seeking, disinhibition, low harm avoidance, defiance toward authority figures, aggressiveness, and low impulse control have also been shown to predict SUD during adolescence (S. Brown et al., 2005). Risk factors discussed here can help predict the development of mental health and substance use disorders, and can also suggest ways to address them; the following section will discuss how the literature informed the unique aspects of treatment in the context of youth and Indigenous people.

3.5 TREATMENT STRATEGIES

Until substance use and mental health disorders can be consistently prevented, the provision of age-appropriate, timely and accessible treatment remains the best hope for healthy futures of adolescents and young adults, and a tremendous cost-saving measure for society; this is the focus of Ontario's 2011 mental health strategy (Brien et al., 2015; Canadian Centre on Substance Abuse, 2013). To this end, there is encouraging evidence in the literature to support the treatment of concurrent disorders (Brien et al., 2015; Mental Health and Addictions Leadership Advisory Council, 2015; National Treatment Strategy Working Group, 2008). For the Indigenous young people who will one day be treated at Gwekwaadziwin, it is important to consider each of the unique characteristics of youth, and of First Nations ancestry, that influence both the development of mental health and addiction disorder, as well as the treatment approaches that may be successful in this group.

Unique Traits of Youth

Adolescence is an especially vulnerable period for addiction to begin. The maturity model, or developmental model, asserts that immature biology and the inexperience of youth are thought to contribute toward the development of SUD and psychiatric problems in young people (S. Brown et al., 2008; McKinnon, 2008, 2011; Tapert & Brown, 2000). In adolescence, experimenting with drugs and alcohol are common enough to be considered normative, and generally viewed without concern by young people (Gonzales, Douglas Anglin, & Glik, 2014; Lowman, 2004), or even as essential aspects of maturing (Kerksiek, Bell, & Harris, 2008). However, youth who drink heavily can lack insight into the depth of their problem, display reduced ability to retain information in treatment, and have difficulty transitioning into adult roles (S. Brown et al., 2005). In the environment of frequent substance abuse, the phenomenon of neuroplasticity allows the brain to excavate physical neuronal troughs with repeated similar choices, which then reflexively compel a user to repeated actions that are driven by substance seeking (Lewis, 2012, 2015). The still-developing adolescent brain is highly neuroplastic, and thus particularly vulnerable to cognitive impairment from the neurotoxic effects of substances (S. Brown et al., 2008; Dennis et al., 2009; Kelly, Kazura, Lommel, Babalonis, & Martin, 2009; Smith & Estefan, 2014).

Treatment options for youth

Due to differences in data collection methods and the lack of comparability between treatment programs, efficacy rates for specific youth treatments are difficult to compare. However, positive outcomes have consistently been reported in treating substance abuse and mental health problems of youth with approaches such as cognitive behavioural therapy (Sussman, 2011; Winters, Botzet, & Fahnhorst, 2011), mindfulness (Black, 2014) and motivational interviewing (R. Brown et al., 2015). Such specific treatment approaches are most effective when applied as part of an overall treatment milieu. Family therapy or therapeutic communities, for example, involve important intimates and associates in the treatment process and can help youth achieve and maintain sobriety and healthier behaviours (Rowe, 2012; Sussman, 2011; Winters et al., 2011). For severe behavioural issues in youth, residential therapy of up to a year in duration has been found effective (Hair, 2005; Sussman, 2011), and any number of the above techniques can be incorporated for holistic residential programming. The brain's ability to create new pathways, and the adolescent or young adult's still-elastic brain provide the foundation upon which treatments at Gwekwaadziwin will be based (United Chiefs and Council of Mnidoo Mnisig, 2015).

Younger participants' mental health challenges often manifest as conduct problems and aggressive behaviours (Canadian Centre on Substance Abuse, 2007; Mental Health Commission of Canada, 2013) and require specialized help to address. For 13-19 year olds, Gwekwaadziwin's Four Directions program will use the Stop Now and Plan® (SNAP®) for Aboriginal Communities (Child Development Institute, 2016b). SNAP® programs were developed by Ontario's Child Development Institute to help children with disordered behaviour to think before acting in order to keep them out of trouble and to stay in school (Child Development Institute, 2016a). The newly developed SNAP® for Aboriginal Communities did not have evaluations available for this project, however the basic SNAP® program has proven very successful in the interruption and prevention of problem behaviours that lead to criminality. The modified version will be age-appropriate to the 13-19 year old group, and because SNAP® is manualized, it can be consistently applied (Burke & Loeber, 2014; Child Development Institute, 2016a), leading to results which, for Gwekwaadziwin, can be evaluated in ongoing reviews.

Getting youth who need help to enrol in treatment, and then helping them to actively engage, however, is challenging work. The Canadian Centre on Substance Abuse (2014) conducted a study of substance abuse treatment access across Canada in an effort to contribute to evidence-informed practice, and concluded that since youth aged 15-24 years have higher substance abuse rates than older Canadians but access treatment less often, there may be barriers to treatment for this age group (2014). The role of maturity in the evolution of mental health disorder and addiction is understood to influence the challenges of treatment in young age groups (S. Brown et al., 2008; Canadian Centre on Substance Abuse, 2007; Sussman, 2011). Immaturity can cause poor insight into one's condition and a lack of motivation to seek treatment (Chung & Maisto, 2009; Gonzales, Douglas Anglin, Beattie, Ong, & Glik, 2012), frequently resulting in adolescents and young adults being forced into treatment by parents or courts (Dow & Kelly, 2013, p. 1124), and reducing the effectiveness of treatment due to low participant motivation (Chung & Maisto, 2009; Gonzales et al., 2012). Therefore, treatments which respect the developmental state of the participant are crucial to maximize chances for recovery.

Relationships exert powerful influence in numerous domains of a young person's life. Healthy, mature relationships are not possible for the young person with disordered behavior, resulting in "puppet" relationships with the expectation that others are there to serve one's immature, narcissistic needs (McKinnon, 2008, 2011). Other immature aspects of relationship are reflected in Ballon, Kirst and Smith's findings (2004) that even after acknowledging they have a problem, a young person may avoid treatment due to apprehension about how it will affect the parent-child relationship, or because of low levels of trust in

treatment providers. Moreover, peer influences are profound in this age group and affect early decisions to use substances (Ballon et al., 2004; Gonzales et al., 2012; C. G. Leukefeld et al., 2015), through to the journey of seeking treatment (Ballon et al., 2004), learning to get clean (Sussman, 2011) and staying substance free after treatment (Gonzales et al., 2012).

Once in treatment, however, the profound significance of relationships to the youth presents an opportunity to improve treatment outcomes. In their study of initial therapeutic alliances with Aboriginal and non-Aboriginal youths in residential treatment, Clarkson, Harris, Brazeau, Borwnlee, Rawana and Neckoway found that higher levels of participant engagement enhanced youth involvement in treatment and successful outcomes (2013), and this aspect was also cited by Winters, Botzet and Fahnhorst (2011). In fact, youth's relationship to their leaders or therapists may be even more crucial to successful treatment outcomes than the treatment experience itself (Macgowan & Wagner, 2008). Engaging participants quickly and nurturing their motivation to participate in treatment are therefore crucial for keeping young people in treatment and for successful outcomes (Battjes, Gordon, O'Grady, Kinlock, & Carswell, 2003). Positive initial contact with therapists, confidentiality, diversity of treatment options, and family support have been associated with a high level of engagement (Ballon et al., 2004) and reduced premature drop-out rates (Clarkson et al., 2013), thus potentiating better treatment outcomes. Finally, the physical environment where treatment takes place should be carefully considered. A clinical feeling will deter youth from fully participating, while comfortable shelter, relaxing environment and good food are important for engagement (Ballon et al., 2004).

Unique experiences of Indigenous youth

Indigenous young people are particularly vulnerable to mental health and substance use disorder. Prevalence of mental health disorder was one focus of an 8-year panel study conducted with American and Canadian Aboriginal youth and young adults (Whitbeck et al., 2014), and the authors reported a crisis of mental health among the populations studied, with particularly high rates of substance use and conduct disorders that increased with age (2014). For Canadian First Nation people, higher than average rates of mental health problems are well established in the literature as a result of the colonization experience and the resultant devastation of traditional culture (de Leeuw, Greenwood, & Cameron, 2010; Gone, 2013; Kirmayer et al., 2007; Kirmayer, Simpson, & Cargo, 2003; Truth and Reconciliation Commission of Canada, 2015).

The experience of trauma is common among youth in addictions and mental health treatment (Canadian Centre on Substance Abuse, 2007; Chung & Maisto, 2009; Ontario Minister's Advisory Group, 2010), but it is

particularly so for First Nations groups (Gone, 2013; Health Canada, 2007, 2012; Naseba Marsh, Coholic, Cote-Meek, & Najavits, 2015; Oetting & Beauvais, 1987). Trauma contributes to the development of addictions and mental health problems and it also can predispose youth to leave treatment sooner than non-traumatized youth, and to display more behavioral problems in treatment (Plant & Panzarella, 2009). The experience of trauma is also known to impede the formation of trusting relationships (Chansonneuve, 2007) rendering therapeutic connections more difficult to achieve. This can be particularly ominous for the Indigenous participant, whose level of trauma can be high and whose cultural needs may not be met in mainstream programming. The aforementioned study of participant engagement by Clarkson et al. (2013), for example, found that Indigenous youth did not perceive their connections with care providers as readily as did the non-Aboriginal youth, suggesting a possible cultural divide between caregivers and care receivers.

Among First Nations peoples, trauma is frequently associated with the shadows of residential schools, land dispossession, and other systemic abuses over generations through assimilationist practices (Chansonneuve, 2007; Naseba Marsh et al., 2015; Nutton & Fast, 2015; Truth and Reconciliation Commission of Canada, 2015). This collective and cumulative trauma that spans generations and persists without remedy is known as historical trauma or intergenerational trauma (Gone, 2013; Naseba Marsh et al., 2015, p. 3) and is known to contribute toward higher rates of addiction and mental health problems among First Nations populations (Kirmayer et al., 2003; Nutton & Fast, 2015; Truth and Reconciliation Commission of Canada, 2015). Intergenerational trauma has also been linked to abuse in family and interpersonal relationships (Naseba Marsh et al., 2015; Nutton & Fast, 2015) and poorer socioeconomic determinants of health like housing, education and income (Nutton & Fast, 2015; Truth and Reconciliation Commission of Canada, 2015), plus a host of inequities that span health care access, rates of incarceration, environmental threats, and others (Nutton & Fast, 2015).

Treatment options for First Nations youth

Considering that historical trauma is such a prevalent harmful force upon Canada's Indigenous peoples, it is imperative that treatment is offered in a trauma-informed environment. Trauma-informed care is safe, mindful, open, compassionate and empathetic to the sufferer's experience, and focuses upon the sufferer's resilience rather than problems (Klinik Community Health Centre, 2013). Not only does this approach help to heal the trauma wound, but it can also improve chances for successful substance use disorder and mental health treatment by improving retention (Substance Abuse and Mental Health Services Administration, 2014).

Decolonization strategies are essential to begin to heal the historical trauma wound (Chansonneuve, 2007; Gone, 2013; Naseba Marsh et al., 2015; Nutton & Fast, 2015). The significance of land to the livelihood of traditional people, including spiritual, mental, emotional, and relationship health is well documented in the literature (Big-Canoe & Richmond, 2014; C. Dell, 2012; Health Canada, 2015; Janelle, Laliberte, & Ottawa, 2009; King, 2009; Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2011; Naseba Marsh et al., 2015; Nutton & Fast, 2015; Rowan et al., 2014; Truth and Reconciliation Commission of Canada, 2015). Wilderness therapy, where people live in the wilderness for some time, and learn under supervision to build shelter, pick medicines, and find food by gathering, hunting, and fishing, can also be incorporated into a model of cultural care. Through this method, Big-Canoe and Richmond (2014) report that connection to the land is linked to decreased youth suicides, increased sense of belonging, connection to family, and self-esteem. Cultural care can be infused into all aspects of the treatment milieu through the use of traditional ceremonies, stories, sharing circles, tools, hobbies, and practices, consistent modeling of traditional values (Calliou, 2012; Green, 2010; Smillie-Adjarkwa, 2009), and building of relationships that model traditional formats, such as ‘auntie’ and ‘uncle’ as advisor (Rowan et al., 2014).

Cultural Aftercare is a critical treatment strategy

Aftercare following treatment is healing support, provided in the community from a variety of sources, to welcome a participant back to healthy community life (National Native Addictions Partnership Foundation, 2016). A lengthy period of community aftercare is widely acknowledged as an essential component of a comprehensive treatment plan to support mental wellness after substance abuse program completion and prevent relapse (Godley, Godley, Dennis, Funk, & Passetti, 2007; Gonzales et al., 2014; National Native Addictions Partnership Foundation, 2016; Sussman, 2011; van der Woerd, Cox, Reading, & Kmetc, 2010).

Effective, long lasting outcomes of aftercare are achieved by designing the components of aftercare into the treatment model, and ensuring that the aftercare is then a continuation of learned practices, for example ceremonies and medicines, which constitute a lifelong undertaking (National Native Addictions Partnership Foundation, 2016) and recognized as cultural aftercare (van der Woerd et al., 2010). For the Indigenous young people that will comprise Gwekwaadziwin clientele, this can include, for example, electronic communications like texting (Gonzales et al., 2014), mobile phone apps and therapist avatars (R. Brown et al., 2015) or culturally specific activities like traditional ceremony or meeting with Elders (National Native Addictions Partnership Foundation, 2016) to help keep youth connected to supports.

3.6 CONCURRENT DISORDERS SHOULD BE TREATED TOGETHER

Current best practices indicate concurrent mental health and substance use disorders should be treated together with integrated care (McKee, 2017; Ministry of Health and Long Term Care, 2011; Ontario Minister's Advisory Group, 2010; SAMHSA, 2005). Historically, a person's admission of one condition may disqualify them for treatment for the other, leading to poorer outcomes (Kirby & Keon, 2006; McKee, 2017). For indigenous people with concurrent disorders, additional barriers to treatment include historical trauma, discrimination, marginalization, history of residential school attendance, and poor socioeconomic status "including substandard housing, community isolation, and poverty" (Health Canada, 2012, p. 14). Further, additional unique barriers like child care problems or distance to treatment may be present (Chansonneuve, 2007).

McKee (2017) reviewed concurrent disorder treatment approaches, and found a number of hopeful treatment techniques emerging in Canada. Her findings supported activities such as enhancing knowledge, building social skills and coping strategies, and relapse prevention (2017), which are areas that Gwekwaadziwin intends to address (United Chiefs and Council of Mnidoo Mnising, 2015). In summary, McKee noted that a number of organizations offer supports for implementing concurrent disorder treatment, including the United States Department of Health and Human Services Mental Health Services Administration (SAMHSA), the Canadian Centre on Substance Abuse (CCSA), the Mental Health Commission of Canada (MHCC), and provincial ministries (McKee, 2017, p. 50). To this list, this author would add that the National Native Addictions Partnership Foundation (NNAPF) (2017) website can provide a wealth of information that is specific to the needs of First Nation clients.

3.7 CALLS TO ACTION

Canada's Truth and Reconciliation Commission, in its extensive investigation to the events and effects of colonization, created a nationwide platform for decolonization, upon which Gwekwaadziwin can base its strategies. In 2006 Canada's largest class-action lawsuit was won by over 18,000 survivors of the country's residential school system, resulting in the creation of The Indian Residential Schools Settlement Agreement (IRSSA) (Truth and Reconciliation Commission of Canada, 2015). The IRSSA directed, in part, the establishment of a Truth and Reconciliation Commission (TRC). The TRC organized National Events, Regional Events and town halls and invited all citizens to participate and share their experiences. In the end, more than 6,750 stories of survivors were heard (Truth and Reconciliation Commission of Canada, 2015), and 94 recommendations for redress, called Calls to Action (Truth and Reconciliation Commission of Canada, 2015), were created. Table 1 identifies the Calls to Action that Gwekwaadziwin's activities will help support.

Gwekwaadziwin will provide traditional education alongside mainstream academic programming. With progressive and iterative programming, it will help to reduce educational and vocational inequity for its graduates (10, 10-ii), promote educational and employment equality (7), and improve educational levels (10-iii).

Gwekwaadziwin's program plans will help rebuild individual and community health for Manitoulin Island's Indigenous peoples, and will create treatment strategies that can be shared with other First Nation communities (66) (United Chiefs and Council of Mnidoo Mnising, 2015, p. 11). The program will seek long-term funding to help participants to build healthier families and become positive role models for the next generation (5). The program's employment and training of Aboriginal staff will further contribute to wellness in the community (23-i, 23-ii, 23-iii).

Fetal Alcohol Spectrum Disorder (FASD) is a lifelong condition arising from prenatal alcohol consumption. FASD manifests in impaired cognitive functioning in the areas of memory, judgment, abstract reasoning, and adaptive ability (Truth and Reconciliation Commission of Canada, 2015, p. 174), and its prevalence among First Nations populations has been linked to the residential school system and its associated intergenerational cascade of trauma (2015). FASD is also associated with elevated rates of criminality (Canadian Centre on Substance Abuse, 2007; Truth and Reconciliation Commission of Canada, 2015). By improving participant's relationship with alcohol and substances, Gwekwaadziwin can help prevent the occurrence of FASD (33). Furthermore, because substance use and conduct problems are strongly linked (Murrihy et al., 2010, p. 13), a reduction in substance abuse may reduce rates of incarceration (38), even those First Nations young people who do not suffer from FASD.

Ongoing evaluations that Gwekwaadziwin plans to undertake (United Chiefs and Council of Mnidoo Mnising, 2015) will help to address the Calls to Action 19 and 20, by contributing to the gathering, assessing, and sharing of health data regarding treatment outcomes for those Indigenous people treated at the centre, who may live on- or off-reserve.

Table 1 TRC Calls to Action that will be addressed by Gwekwaadziwin programs

Item Number	Call to Action
5	We call upon the federal, provincial, territorial, and Aboriginal governments to develop culturally appropriate parenting programs for Aboriginal families
7	We call upon the federal government to develop with Aboriginal groups a joint strategy to eliminate educational and employment gaps between Aboriginal and non-Aboriginal Canadians
10	We call upon the federal government to draft new Aboriginal education legislation with the full participation and informed consent of Aboriginal peoples. The new legislation would include a commitment to sufficient funding and would incorporate the following principles:
10-ii	Improving education attainment levels and success rates
10-iii	Developing culturally appropriate curricula
19	We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.
20	In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.
21	We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.
23	We call upon all levels of government to:
23-i	Increase the number of Aboriginal professionals working in the health-care field.
23-ii	Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
23-iii	Provide cultural competency training for all health-care professionals.
33	We call upon the federal, provincial, and territorial governments to recognize as a high priority the need to address and prevent Fetal Alcohol Spectrum Disorder (FASD), and to develop, in collaboration with Aboriginal people, FASD preventive programs that can be delivered in a culturally appropriate manner.
38	We call upon the federal, provincial, territorial, and Aboriginal governments to commit to eliminating the overrepresentation of Aboriginal youth in custody over the next decade.
66	We call upon the federal government to establish multi-year funding for community-based youth organizations to deliver programs on reconciliation, and establish a national network to share information and best practices.

Note. Adapted from "Truth and Reconciliation Commission of Canada: Calls to Action", 2015.

3.8 COLLABORATIVE CARE

From the literature review, it was found that to isolate the individual from system influences is not possible due to the pervasive and persistent nature of these influences. Addictions and mental health treatment, on the other hand, have been operating in Canada as silos that communicate poorly, operate independently of each other, duplicate services and leave gaps in care (Ministry of Health and Long Term Care, 2011, p. 18). Funding is also often provided in silos that focus on time-limited, project-focused initiatives rather than comprehensive and collaborative community efforts for change (Health Canada, 2015). In the systems that matter to the individual's wellbeing—family, schools, community—such contained health care silos stand in isolation and fail to exert lasting environment change, and do not deliver the results that may be possible with more integrated approaches (McKee, 2017).

Collaborative care, however, creates connections across sectors to improve efficiency, build trust, and increase effectiveness of interventions (Addiction and Mental Health Collaborative Project Steering Committee, 2014). It involves schools and communities to help surround youth with healthy environments (Canadian Centre on Substance Use and Addiction, 2017), and thus provides support for the caregivers of young people at risk.

The literature review shows strong support for collaborative, comprehensive and holistic addiction and mental health treatment. For conduct problems in youth, which are strongly associated with substance use disorders, Editors Murrihy, Kidman and Ollendick (2010) have brought together scholarly contributors who, on the whole, urge for the multi-pronged approach to treatment. Ontario's provincial health agencies promote intersectoral collaboration and interagency partnership throughout its mental health and addictions literature (Mental Health and Addictions Leadership Advisory Council, 2015; Ministry of Health and Long Term Care, 2011; Ontario Minister's Advisory Group, 2010), and national organizations such as Thunderbird Partnership Foundation (2017) and Canadian Centre on Substance Use and Addiction (2017) urge multi-systems involvement. A valuable primer on the topic of collaborative care is also provided by Addiction and Mental Health Collaborative Project Steering Committee (2014).

3.9 CONCEPTUAL FRAMEWORK

The conceptual framework for this project was derived through integrating several key principles of Indigenous methodology and complexity science. Although the activities of this project involved no direct

research subjects, the author sought a research perspective that would honor the Indigenous heritage of future clients of the Gwekwaadziwin treatment centre who will be the beneficiaries of this project's deliverables. This section will demonstrate that contemporary complexity thinking is compatible with the Indigenous approach to research and community building in several fundamental areas. The creation of an Indigenous methodology as explored by Kovach (2009), Streit and Mason (2017), and Wilson (DeVerteuil & Wilson, 2010) will be discussed in this section. Complexity theory has become widely applied in community development initiatives; authors Auspos and Cabaj, in partnership with the Aspen Institute¹ (2014) created a primer which is useful for its distillation of key theoretical concepts. Onyx and Leonard (2011) have demonstrated the application of complexity theory through emergent leadership in five community development projects, while Meadows' work (1999) provides a discussion of feedback loops and introduced the value of leverage points in change efforts. In this section, the key concepts of Indigenous and complexity lenses will be explored, followed by a discussion of how they can relate to each other. A description and illustration of the resulting conceptual framework will conclude this section.

There is no single Indigenous culture, however Kovach (2009), Wilson (2008), Streit and Mason (2017) acknowledge that all North American Indigenous cultures share common values that distinguish them from the dominant Euro-Canadian mainstream. These overarching values are then uniquely expressed on a tribal level, that is, locally and contextually (Kovach, 2009; Wilson, 2008). Similarly, there is no single Indigenous research methodology. However by considering common values, First Nation researchers have identified elements that work toward the development of an Indigenous framework (Kovach, 2009; Wilson, 2008). Tribal knowledges guide an Indigenous inquiry, and such a lens aims for decolonization by upholding these knowledges through the entire research process (Kovach, 2009). According to Kovach (2009), Wilson (2008), Streit and Mason (2017) such a framework privileges not just empirical but also spiritual, emotional and experiential ways of knowing. Relationality is a strong theme in such a framework. Culture, language and land-based learning are vital expressions of relationality, and through these practices, traditions are honored; this revitalization of tradition in turn contributes toward decolonization (Kovach, 2009; Ross, 2014; Streit & Mason, 2017; Wilson, 2008). Inquiry with an Indigenous lens gives back to the community what the community identifies as valuable and continually seeks community feedback for reframing and adjusting the approaches. Ultimately, the Indigenous approach to inquiry answers to all relations and must do good (Kovach, 2009; Streit

¹ The Aspen Institute is an international nonpartisan forum that promotes values-based community development and leadership initiatives. Its focus is to improve the health of marginalized communities and to put into action new ideas to solve complex, challenging problems, and invites participation from scholarly, public, and leadership sources (The Aspen Institute, 2017).

& Mason, 2017; Wilson, 2008). To prepare for good to come from the inquiry, the researcher must approach any undertaking with an open heart, transparency and constant reflexivity, including self-location and declaration of insider or outsider status (Kovach, 2009; Wilson, 2008).

Using the complexity lens, complex community problems are addressed with improvement efforts in a specific geographic area, known as place-based change efforts (Auspos & Cabaj, 2014, p. 1). Place-based change efforts are born of community wants and needs, and constant feedback is crucial to the ongoing management of the project. Place-based change efforts are characterized by first getting to know and appreciate the culture, values, ways of knowing, and needs of a community (Auspos & Cabaj, 2014; Onyx & Leonard, 2011). They are also characterized by engaging with all available systems and levels to develop good relationships that can support the intended change. This means developing supportive organizational, financial, physical and social structures, and empowering community members with competencies that they can continue after leaders have gone (Auspos & Cabaj, 2014). Under this paradigm, leaders are acknowledged as visionaries that inspire, motivate and facilitate, ready to change course according to feedback, and “prepared to hold their plans lightly” (2014, p. 22). Complexity theories value intuition in determining a course of action when evidence is sparse and new problem-specific ideas have not been tried (Auspos & Cabaj, 2014). As “a large living organism” (Auspos & Cabaj, 2014, p. 2), the world is viewed by complexity theorists as non-linear and comprised of unpredictable cause and effect relationships in both problem creation and problem solving (2014).

Both Indigenous and complexity lenses explicitly invite the use of multiple approaches to create a custom-made, blended model that can be adapted to suit a particular project, and each perspective advocates privileging data from a combination of sources and styles to suit the problem at hand (Auspos & Cabaj, 2014; Kovach, 2009). Similar intentions for cultural upholding, relationship building and doing good are places where Indigenous and complexity approaches resonate. By explicitly inviting a community to express its culture, its ways of knowing, and its strengths (Auspos & Cabaj, 2014; Onyx & Leonard, 2011), complexity theory can hold space for decolonization. Place-based change efforts mesh well with the notion of locality that denotes unique tribal relationships. By keeping values of decolonization and relationality at its heart (Kovach, 2009; Streit & Mason, 2017; Wilson, 2008), the Indigenous lens can serve as a spiritual and practical guide through a complexity-focused inquiry. Gwekwaadziwin was conceived and developed with an Indigenous lens, and it can be conceptualized as a place-based change effort with local, community-driven and multiple-stakeholder investment. Applying both these lenses permits Gwekwaadziwin to be viewed in systems theory as the

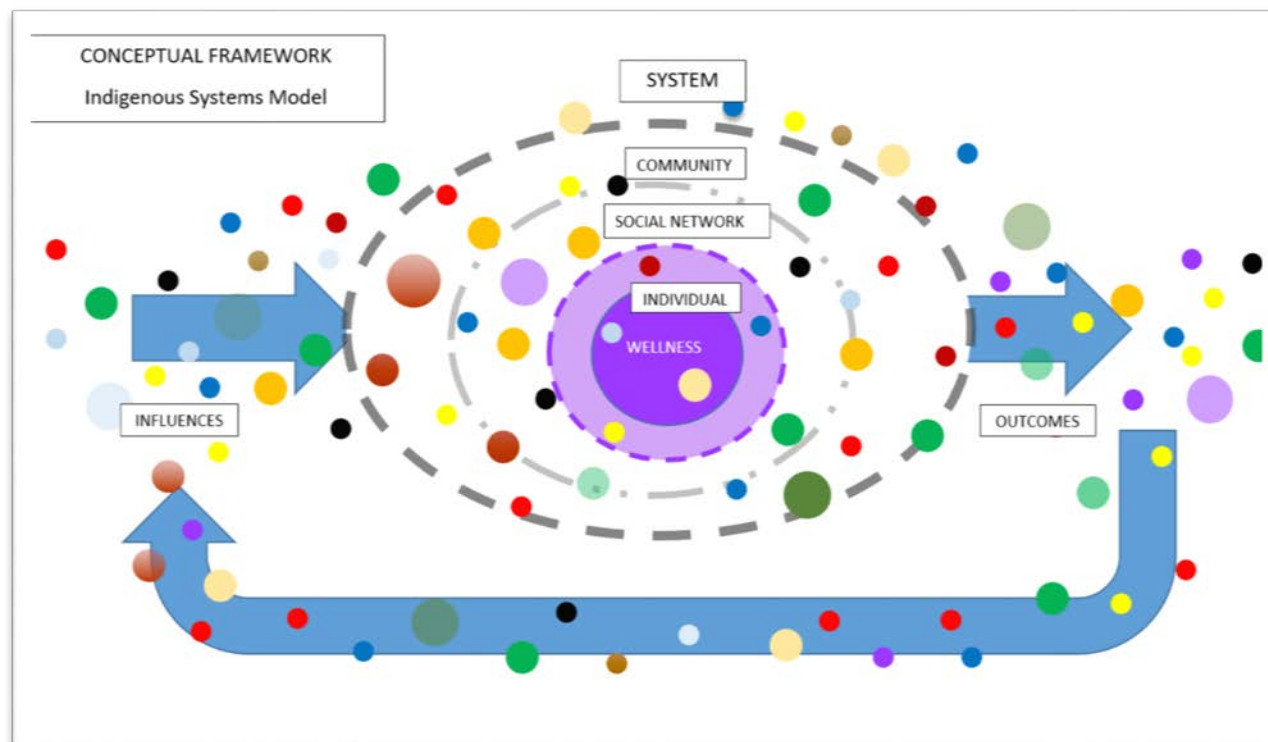
adaptive, responsive and relational model (Auspos & Cabaj, 2014) that can provide for holistic, culturally informed treatment (United Chiefs and Council of Mnidoo Mnising, 2015) envisioned by its founders.

Indigenous Systems Model

Auspos and Cabaj (2014) described that systems conceived in complexity science are nested, layered and overlapping so that their boundaries can be quite fuzzy. Because they are open and permeable, systems are vulnerable to any variety of input which produces any number of outcomes. All systems are related in innumerable and non-linear ways, so that effects in one system may have unforeseen consequences in other areas. Further, the output from each system can contribute further input for the influence of any number of systems, including its own.

Figure 3 below represents the conceptual framework that guided this project. In this diagram, the system of an individual is represented by the centre circle, nested within a greater system of social network including family, friends, and activities of private life. Within the individual is also their unique state of wellness, which is a product of all influences from all greater systems. These systems in turn are located within the community which is a unique context of physical, social and political environments. Viewing left to right, arrows depict the flow of input (influences) and output (outcomes) through the systems. Dots represent all various influences including physical, social and political environments, genetic makeup, experience, and personality. Influences enter any or all of the systems with no discernible linearity, affecting all systems in somewhat unpredictable ways. The resultant outcomes may continue on to exert their influence elsewhere, or they may return into the system and further effect changes within it, depicted by the bottom, right-to-left arrow.

Figure 3 Indigenous Systems Model



The following chapter will outline the methodological approach used to create Gwekwaadziwin's Annotated Bibliography and Application for Residential Treatment, using this Indigenous Systems Model as a guide.

4.0 REVIEW OF INTAKE FORMS

A review of treatment centre application or intake forms was undertaken to help inform the creation of an application form for treatment at Gwekwaadziwin. Characteristics of overall appearance, length, organization, language level, language style or voice, and information requested were evaluated for their suitability in the Gwekwaadziwin application form. It is important to note that an estimation of treatment program efficacy or overall quality of treatment program applications is beyond the scope of this project. Therefore, this discussion represents perceptions and observations of application forms on the part of this reviewer only, as they relate to Gwekwaadziwin programming.

4.1 A DISCUSSION OF REVIEWED INTAKE FORMS

When focusing primarily on content, this reviewer looked at applications from the perspective of a health care professional with an understanding of best practices for First Nations youth as revealed in the literature review. When considering elements such as language and format, effort was made to view the applications

from the perspective of a young person seeking treatment, with compassion for the applicant. The practice of compassion in nursing compels the author to apply “the ability to recognize and be aware of the suffering and vulnerability of another, coupled with a commitment to respond with competence, knowledge and skill” (Canadian Nurses Association, 2017, p. 20). Both perspectives were filtered through the lens of the Indigenous Systems Framework discussed in Section 3.9.

Twelve Canadian application forms for substance abuse treatment were downloaded from program websites or requested with permission (Appendix B), and reviewed for content and format. Upon first glance, applications that were not dense with text and that provided space for writing appeared more engaging to this reviewer. Those that were covered with a page containing either an organization logo (BHF, Ka-Na-Chi-Hih) or introductory or informative text (Dave Smith, Last Door, Pine River, Sunrise) helped to set the tone for the content within. Reading ease ranged from moderately easy language, for example in the Crossroads or Mamisarvik applications, to post-secondary level vocabulary with the PRI application. Application forms were intended for completion either by agency representative (agent) only (Last Door, Nelson House Medicine Lodge, Walgwan Centre), by applicant or guardian only (Crossroads, Dave Smith, Mamisarvik, Wilp Si’Satxw, PRI), either applicant or agent (BHF, Sunrise), or by both applicant and agent (Compass, Ka-Na-Chi-Hih).

The length of application forms varied. The length of the basic application forms averaged 13.92 pages, ranging from 5 pages (Crossroads and Last Door) to 31 pages (PRI). However, application packages contained a variety of supplemental materials such as change readiness assessments, requests for additional social or education history, family or parent evaluations, medical forms, consent to release of information, consent to treatment, confidentiality agreements, and others, which rendered the direct comparison of their lengths difficult. In addition, two intake forms (Sunrise and Crossroads) fully satisfied admission requirements for suitable clients whereas other applications represented only a portion of an intake process that was augmented with supporting assessments. Application form length therefore did not reflect the total amount of information required for admission. Following the applicant’s submission of the application form and with the two exceptions noted above, the applicant would then be contacted by an intake for a follow-up interview, either by telephone or in person before an intake decision was made. Two treatment centres, Nelson House Medicine Lodge and Compass, required applicants to stay in the facility for orientation and assessment before acceptance for full treatment, for a period of 10 days and two weeks, respectively. In all cases, the application form was screened by an intake coordinator or addictions counsellor.

Information that was included in the printed application forms was studied. All application forms requested demographic and next of kin or emergency contact information. Legal status or criminal history were also requested for every intake form, and most applications requested family history (11 of 12 applications), previous treatment history (11 of 12 applications), and substance use history (9 of 12 applications). Other common elements were requests for medical data and behavioral information (8 of 12 applications), academic history (7 of 12 applications), client goals or motivation for treatment (5 of 12 applications), and mental health history (5 of 12 applications). Applications that provided some information about the program's philosophy or treatment approach suggested to the reader what type of treatment environment to expect; this information was provided in three of the applications, but was available on all program websites. The inclusion of information that explained the process for intake helped the reviewer to understand the context of the application form, and to suggest whether there would be a wait for admission to treatment. This information was included in only one third of the applications, however information could be obtained online for another third; in the remaining third the admission process was not clearly explained. Of the ten application forms that required other materials to be included, five of them itemized the necessary components in a concise list. Two facilities, Dave Smith and PRI, required online completion of forms and the process was fully described online. Where online completion was not required, application submission by mail, fax or email was noted on all but one form.

The use of language emerged as an important aspect to convey a supportive or clinical approach to treatment. Those applications requiring agent completion tended to phrase questions more objectively when asking about client substance abuse or mental health history. Agent-completed applications also appeared to have less space to write freely. This was seen, for example, in the agent-completed Nelson House Medicine Lodge form that allowed four lines to discuss family support for treatment, whereas Dave Smith's applicant-completed application contained four pages of questions about family functioning with expansive space for writing. The occasional use of open spaces was more visually appealing, and simple font styles made reading easier. Gender identification was requested on nine of the 12 forms, in the form of *Male* or *Female* or simply, *Gender*.

Successful substance abuse and mental health treatment requires clear understanding of problems to ensure a client-specific care plan is developed. Additionally, viewing the applicant through the Indigenous Systems Framework allows the reviewer to see that in order to help the applicant achieve balance, a comprehensive understanding of their life is also required. To this end, applications that demonstrated a strengths-based

approach by asking questions about the applicant's interests, strengths, talents, and sources of inspiration were perceived as interested in helping the applicant to attain balance in her unique way.

4.2 THE GWEKWAADZIWIN APPLICATION FOR RESIDENTIAL TREATMENT

In order to construct the Gwekwaadziwin application form, the 12 reviewed treatment centre application forms were contrasted and compared with the underlying philosophy of holistic and client-centred care that has been central to Gwekwaadziwin's development. Furthermore, the lens of decolonization was applied with the Indigenous Systems Framework developed in Section 3.9. The resultant application can be viewed in Appendix C.

Mr. Gilchrist advised that the clientele expected to apply for Gwekwaadziwin residential treatment will be people experiencing social and cultural marginalization and usually with interrupted education and a moderate to low literacy level (personal communication, November 16, 2016). He further advised that the organization will invite completion of the form by any person involved in the client's life, potentially including family members, professional care providers, or the client herself, to promote accessibility. Therefore, he specified that Gwekwaadziwin's application form should be easily read and understood, and non-threatening.

Basic English language that expressed the key idea of a question was used, avoiding jargon where possible. Questions were phrased to remain as neutral as possible. For gender identification, Mr. Gilchrist requested a term that would allow for the free expression of the applicant. To avoid restricting choices, an open statement was chosen, "*I identify my gender as: ____*". In sections where sensitive questions, such as those regarding emotional health, were asked, space was allowed for the applicant to write a response. Three sections were provided throughout the application for the youth to add anything that is not included in the questions: "*Use this space to write anything else you'd like to share with us*". Lines were not provided, to permit the applicant to use the space freely. Following the applicant signature line at the end of the document is the suggestion to attach a separate piece of paper with comments if desired.

The Gwekwaadziwin application form was framed around content derived from the best practices found in the literature review and the twelve applications reviewed for this project. Content was also considered in terms of evaluative criteria. Asking about the presence and type of co-occurrence, for example, is important for care providers because understanding these aspects may suggest treatment approaches and impact future outcomes (Dow & Kelly, 2013). Items which could be evaluated upon completion of the program, such as amount of substance use, types and frequency of hospitalization, and police involvement (United Chiefs and

Council of Mnídoo Mnising, 2015) were of particular interest for their potential to contribute to outcomes measurement. Furthermore, as the Gwekwaadziwin program matures and evaluation demonstrates areas for development, the application can be adjusted to accommodate evaluative criteria as needed.

4.3 HOW TO USE THE GWEKWAADZIWIN APPLICATION FORM

The Gwekwaadziwin Application for Residential Treatment form is designed to be used as part of a complete intake assessment process. As such, the completed form should be screened by an intake coordinator or addictions counsellor at Gwekwaadziwin, and it should be augmented with intake assessments, preferably in person at the Gwekwaadziwin facility to permit the applicant to tour the site, thus also facilitating the process of informed consent.

The information sought on the Gwekwaadziwin application is informative enough to provide intake staff with a sufficient understanding of applicant status regarding social history, spiritual and emotional development, medical history, substance abuse history, and legal status to be able to screen the candidate's potential suitability for Gwekwaadziwin admission. Information from this initial application can then cue staff of the need for further assessments that may be appropriate.

5.0 RECOMMENDATIONS

From the activities of this project, areas for development have been identified for Gwekwaadziwin as it moves forward through accepting its first clients and using the newly developed application form. The application form, as noted previously, should be viewed as one tool in the process of an informed and thorough admission process. In this context, the following recommendations have been identified.

Recommendation #1: Develop supporting documents that will fully inform consent to treatment

It was unclear from this program application review whether all program application processes provided mechanisms to obtain informed consent from participants or their guardians. The Canadian Nurses Association cautions that it is legally necessary to obtain informed consent from health care recipients, and that this consent can be withdrawn at any time (2017). Indeed, communications from client Mr. Gilchrist (personal communication, October 29, 2015) indicated that multiple documents that will inform client rights and responsibilities such as confidentiality regulations, grievance policies, and parent/client handbooks, are

under consideration, with the PRI documents as a model. The development of these documents will aid in the process of informed consent.

Recommendation #2: Project deliverables will benefit from iterative development

Both the Annotated Bibliography and the Application for Admission developed for this project were created in a period where treatments, policies, and best practices have been constantly evolving, and continue to improve with research, advocacy, praxis, and further decolonization. Further, the documents prepared from this project will constitute the beginning documents to aid the furthering of Gwekwaadziwin's development. As such, the documents will benefit from periodic review that is informed from learnings through evaluations of the operating Gwekwaadziwin programs. The documents provided herein are living documents, and to this end they are provided to the client in editable formats.

Recommendation #3: Access national cultural resources

By privileging Indigenous ways of knowing, it is clear that much of the research reviewed for this report affirms that cultural care works to relieve the distress of many of the problems that lead to addiction and mental illness. However, this research has also revealed gaps in the provision of culturally relevant service for Indigenous people in Canada (Health Canada, 2012, 2015; National Native Addictions Partnership Foundation, 2016). This author therefore recommends that Gwekwaadziwin make use of information repositories such as the Thunderbird Partnership Foundation (2017) for cultural and professional support, including the Addictions Management Information System (2017a) that brings together the knowledge of national leaders in the area of First Nations addiction and mental health treatment. Reciprocal participation with such resources will benefit not only Gwekwaadziwin as it begins operations, but will also contribute to the growing database for achieving wellness among all Canadian Indigenous people.

6.0 CONCLUSION

Gwekwaadziwin Youth Mental Health and Addictions Treatment Program is founded upon Indigenous methodologies and incorporates Western best practices. The activities of this project were focused upon creating an Annotated Bibliography and an Application for Residential Treatment for the program. Through a literature review and a study of application forms for Canadian substance abuse treatment facilities, current best practices were identified and compared with the sample, and an application form was created. The

literature review also provided the basis for the annotated bibliography which touches on the major areas of treatment that Gwekwaadziwin intends to address, as well as several Truth and Reconciliation Calls to Action. The bibliography will serve to inform stakeholders for Gwekwaadziwin's developmental stages, as well as to orient new staff to the philosophy of the program. The activities and learning that flowed from this project led to suggestions that Gwekwaadziwin may wish to consider while moving forward.

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APPENDICES



Gwekwaadziwin Miikan

Annotated Bibliography

United Chiefs and Councils of Mnidoo Mnising's Gwekwaadziwin Youth Mental Health and Addiction Treatment program has been conceived by community and for the community. It represents one response to the tragic stories told through police reports, emergency room visit data, newspaper headlines, and justice statistics about alcohol and drug addiction, colonization, broken family ties and lost lives.

This report provides background on substance abuse in Canada and reviews current best practices which inform the therapeutic approaches of Gwekwaadziwin.

The scope of the problem of substance abuse has been investigated by the Canadian Centre on Substance Abuse:

Canadian Centre on Substance Abuse. (2014). National Treatment Indicators Report.

<http://www.ccsa.ca/Resource%20Library/NTS-2014-National-Treatment-Indicators-Report-en.pdf>

Youth aged 15-24 receive up to 45% of all treatment, and Ontario has a high and increasing demand for service. The number of people who meet the criteria for a substance use disorder in Canada represents less than one tenth of the number of people aged 15 and over seeking treatment for such disorders, representing a significant lack of access to services. Furthermore, there is a lack of reliable outcome data from treatment programs across the country. Considering these apparent challenges to provide consistent, effective treatment, the National Treatment Indicators project was undertaken by the Canadian Centre on Substance Abuse to survey Canadian publicly funded treatment programs in order to standardize information, provide a repository for data that supports best practices, promote information sharing, and ultimately build capacity. Using multiple data sets, researchers reported on core indicators that could be reasonably captured across jurisdictions. Indicators include, but are not limited to, detail regarding the substances used and those who use substances, types of treatment sought, and frequency of treatment seeking. This report demonstrated that funding for new programs is often allocated largely in response to the urgency of political or public calls to action. Approaches to treatment which employ collaborative, accessible and evidence-based perspectives that appreciate and support the unique needs of the individuals seeking help are viewed as critical to community wellbeing, and urgently needed in Canada.

Maturity Model

The maturity model identifies delayed maturation as the fundamental challenge to adolescents' ability to thrive in social, academic and family spheres. Through a number of proven treatment approaches, the Gwekwaadziwin programs will help the young person develop the qualities of maturity such as:

- ***Demonstrating a future orientation that is based on reality***
- ***Moving from narcissism to consideration of others***
- ***Empathy for others***
- ***Emotional regulation***
- ***"Individuating" from "puppet" to separate relationships***
- ***Social ethics***
- ***Abstract thinking***

Gwekwaadziwin is based upon the maturity model with programs designed to provide the environment and expertise to promote emotional and cognitive growth. With individualized programming informed by multidisciplinary best practices, clients will be met at their unique developmental stage and supported through their journey to healthy maturity.

The following resources provide further information about this modality.

McKinnon, J. (2008). *An unchanged mind: The problem of immaturity in adolescence*. New York: Lantern Books.

Author John McKinnon is a psychiatrist and professor who specializes in treating adolescents. After years of flourishing hospital and private practices, and with a successful academic career, he grew troubled by his experiences within the managed care approach to service. He gave up his practice, and he and his wife created the Montana Academy—an expansive ranch for youth to grow and mature with peers under adult supervision, free from the confines of psychiatric wards. Using case studies and specific examples, this book details the common errors of categorizing childhood and youth behavior problems with diagnoses of pathology and then treating them pharmacologically. Contrasting disorder with immaturity, McKinnon argues that while psychiatric diagnoses can describe the presentation of the breakdown with which a youth presents, the problem of conduct disorder and substance abuse in youth must be understood as the consequence of a lack of maturity. McKinnon details the characteristics of maturity and immaturity, and helps the reader to understand the developmental state behind seemingly illogical negative behaviors. Furthermore, this developmental perspective allows compassionate treatment approaches that are uniquely tailored to the needs of the individual, involving family, and considerate of the youth's history. McKinnon's work is supported by successful outcomes at the Montana Academy as judged by parents, adolescents and clinicians, who have witnessed global functional decline in clients give way to global recovery once maturity is enabled.

McKinnon, J. (2011). *To change a mind: Parenting to promote maturity in teenagers*. New York: Lantern Books.

In this follow up to his first book, *An Unchanged Mind*, John McKinnon offers a guide for parents of adolescents aimed at preventing behavioral issues through promoting maturity in their children. For both parents and professionals, this is a highly readable book; realistic examples from McKinnon's personal and professional years of experience are included throughout, and concepts are explained in lay terms and without judgment. McKinnon argues that parents and caregivers must understand that their roles are to set limits to their children's behavior, and to recognize the child as an individual. Recognition is a complex set of actions, words and gestures designed to generate and constantly recreate intimacy, rooted in an understanding of the unique character of the child and the circumstances of the engagement. Recognition is imperative for the development of identity, self-esteem, healthy relationships and the sense of belonging that are so important to human beings at every stage of development. Limit-setting is described as the necessary reigning in of the naturally narcissistic tendencies of the immature young person. McKinnon explains for the reader how and why it is crucial to the healthy maturity of the adolescent that a parent practices compassionate, consistent, and thoughtful limit-setting. Each of the parenting strategies of recognition and limit-setting occupies one third of this book. In the final section, the two approaches are brought together to demonstrate their mutual and necessary dependency upon each other, and the final chapter includes a discussion of treatment options when outside help is required.

Brown, S., Anderson, K., Ramo, D., & Tomlinson, K. (2005). *Treatment of adolescent alcohol-related problems*. In M. Galanter (Ed.), *Recent developments in alcoholism: Alcohol problems in adolescents and young adults* (Vol. 17, pp. 327–350). New York: Kluwer Academic/Plenum Publishers.

In this chapter of Galanter's clinical guide to treatment, Brown, Anderson, Ramo and Tomlinson offer a theoretical primer grounded in the developmental approach for treating addiction in young people. The authors have highlighted addictions research that describes the social, environmental, biological, and behavioral reasons youth participate in risk taking and drinking behaviors, as well as the problems and harms that can result from the activities. The developmental achievements of gaining independence and autonomy, experiencing new environments, learning impulse control, developing coping skills, and attaining academic and occupational success are present in higher levels among youth who

do not participate in risky behaviors than those who do, suggesting that to improve maturity in adolescents may reduce their inclination towards using alcohol or risk-taking to cope with life challenges. Numerous pathways lead to drinking and drug abuse in adolescence, and outcomes must be measured in ways that are meaningful to adolescents considering their personal history and developmental stages. The concept of equifinality should be contemplated to inspire a variety of alternative approaches founded in developmental theory to address multiple needs for treatment as well as post-treatment supports.

SNAP®

Gwekwaadziwin's engagement with the families of its youngest participants will be based on behavioral approaches that more closely align with their developmental stage. In Ontario, the SNAP® (Stop Now And Plan) program has been functioning in schools and other therapeutic milieu for several decades with an excellent success rate for helping older children to reduce conduct associated difficulties. The program has built upon its success to develop Aboriginal-specific programming which Gwekwaadziwin will employ in its Four Directions program for youth aged 13-19 years.

Child Development Institute. (2016). About SNAP®. Retrieved from <https://childdevelop.ca/snap/about-snap>

Stop Now And Plan (SNAP®) is an evidence based program of gender-specific cognitive-behavioral training directed toward children aged 6-12 who engage in aggressive, antisocial and criminal behaviors. Conceived in the 1970s, it has improved with input from various leaders and through learning from evaluations. Originally designed for boys, the program is now expanded to include services for girls, a youth leadership component as well as justice system, Aboriginal, and summer camp specialties. The model's goal is to prevent later criminal activity in at-risk youth through the development of emotional regulation and self-control. SNAP® is delivered through a combination of individual and group settings, in a manualized format which permits portability with fidelity. Designed by Toronto's Child Development Institute, SNAP® employs group and individual treatment components which may include individualized family interventions, individual befriending, school advocacy, academic tutoring, crisis counseling, and Leaders in Training modules to effect changes in problem solving, family management, parenting, social skills, self-control, and cognitive self-instruction.

Burke, J. D., & Loeber, R. (2014). The Effectiveness of the Stop Now and Plan (SNAP) Program for Boys at Risk for Violence and Delinquency. Prevention Science, 16(2), 242–253. <http://doi.org/10.1007/s11121-014-0490-2>

Using a sample of 252 boys who demonstrated aggressive behavior, rule breaking behavior, conduct problem or externalizing behavior, Burke and Loeber tested the efficacy of SNAP®, compared to treatment as usual at 3, 9, and 16 months. Important factors to note in this study are firstly that it was conducted without the original SNAP® development team in an effort to eliminate bias. Secondly, the treatment as usual group was given the most intensive community treatment available. Considering the paucity of programs and the common under-treatment of conduct and behavioral disorders even once identified, this represents an unlikely advantage for the treatment as usual group. Participation in the SNAP® program was found to lower scores of aggression, conduct problems and externalizing disorder when compared to treatment as usual. These benefits were most profound in the first twelve weeks, where parents and children worked in separate groups to learn and practice new skills, and children were given individualized care plans including tools to help with their particular needs. This study also found that youth with the most severe behavioral problems benefited the most from SNAP® participation.

Treatment Best Practices

Perhaps the most predominant theme across the literature is the need for collaborative, multifaceted approaches to youth treatment. Recognition of unique needs is particularly important with this group, who vary considerably in terms of living arrangements, maturity level and school or work situation. Regardless of individuality, however, an overarching characteristic of youth and young adulthood is the importance of social connection and ongoing social engagement.

Treatment options which have repeatedly emerged as most effective with youth populations are family therapy, culturally sensitive care and cognitive-behavior therapy. These approaches are best applied in the context of a therapeutic environment where all members of the treatment community (staff, peers, family and community) are engaged in the healing process, so that each interaction can be supportive. Further, the duration of treatment is important because longer treatments provide the best, and longest lasting, benefit.

In all of its programs, Gwekwaadziwin will offer a variety of treatment options concurrently that can build upon each other and that can be adjusted to meet client needs throughout phases of personal growth.

Best practice treatment approaches to conduct disorders mirror those used with substance abuse treatment. Gwekwaadziwin will support youth with co-occurring substance use and conduct disorders; indeed, the two are highly correlated.

Canadian Centre on Substance Abuse. (2007). Substance abuse in Canada: Youth in focus. Canadian Centre on Substance Abuse. Retrieved from <http://www.ccsa.ca/Resource%20Library/ccsa-011521-2007-e.pdf>

This report from the Canadian Centre on Substance Abuse looks at the problem of youth substance abuse from a Canadian perspective. Following extensive reviews of statistical data as well as discussions regarding protective factors, risk factors and attitudes, this document outlines the current approaches to remedy the problem. The most successful outcomes are seen from approaches that reduce early drop-out, namely those which promote trusting bonds between client and therapist. Further, community coordinated involvement, properly matching type of service to need, and focus on increasing protective factors while reducing risk factors are recommended.

Gwekwaadziwin is the creative vision of community members, founded in culture and based upon best practices and local health care needs. Ontario's North East Local Health Integration Network (NE LHIN) acknowledges the importance of creative problem solving which flows from the community, for the good of the community.

Rush, B. R., Kirkby, C., & Furlong, A. (2016). NE LHIN Addiction Services Review. Retrieved from <https://vmcdn.ca/files/sudbury/pdfs-for-web/ne-lhin-addiction-services-review-full-report.pdf>

In response to Ontario's declared focus on mental health and substance use, NE LHIN undertook a literature review and environmental scan of the region to determine best practices in the areas of mental health and substance use treatments, strengths and challenges, and to identify areas for improvement. Findings reveal local trends which frequently mirror the provincial and national picture, but with the context of locality that is useful for service planning. Additionally, attention was given to the necessary movement within the region to obtain health services not available locally. Known best practices were contrasted with reported experiences of service utilization to reveal actual current practices, thereby identifying patterns of use and areas for improvement. One recurrent theme revealed in this work include lack of access to mental health and substance use treatment. For example, one third of people in the region who report a need for mental health support find services inadequate, nonexistent, or inaccessible. Other important findings included a lack of evidence-based practice and evaluation, a lack of culturally relevant care for First Nations groups and others, and a higher-than-average incidence of substance abuse when compared with other parts of the country. These findings have led to recommendations aimed at enhancing planning, treatment and performance: By implementing a

good variety of collaborative and broad systems approaches, developed with the unique cultural, developmental and treatment needs of service users, evidence-based interventions can support the health and recovery of clients throughout the lifespan and across the spectrum of need.

Gwekwaadziwin programming incorporates numerous treatments in its therapeutic environments for both the Four Directions and the Seven Grandfathers groups.

Murrihy, R. C., Kidman, A. D., & Ollendick, T. H. (Eds.). (2010). Clinical Handbook of Assessing and Treating Conduct Problems in Youth. New York: Springer. Retrieved from <http://www.springerlink.com/index/10.1007/978-1-4419-6297-3>

This clinical resource provides a solid theoretical grounding for professionals who treats conduct disorders in a variety of settings. Editors Murrihy, Kidman and Ollendick, internationally respected practitioners and researchers, present a variety of perspectives and authors on topics of contemporary treatment of childhood and youth. Twenty chapters guide the reader through evidence-based clinical practices of both general and specific nature. An introductory chapter instructs the reader through the diagnosis and classification of troubling persistent behavior patterns commonly referred to as conduct disorders—antisocial behaviors such as defiance, aggression, violence and criminality which, if left unaddressed, often lead to worsening lifelong problems. Three more chapters delve deeper into the social impact, etiology and risk factors, and assessment criteria. Several chapters are devoted to treatment topics such as primary and secondary prevention through approaches such as family support, self-regulation training, parenting skills education, and specific teaching methods. Cognitive-behavioral approaches, due to the ability to incorporate interdisciplinary practices and provide concrete direction, figure prominently in this section throughout many treatment programs. A discussion of the effects of negative or unsatisfactory academic and social feedback argues that the most effective treatments focus on increasing prosocial behavior using multiple approaches and involving parents and families, therapists, teachers, peers, and the individual. Residential therapy is found in several studies to provide very good outcomes; longer stays and completed programs provide the best benefit both in terms of long-term outcomes after treatment, and in cost-benefit analyses. The final chapter advocates for collaborative and mixed methods that ultimately involve communities in a public prevention approach, including broad assessment methods, and harm reduction approaches.

Treatment Types

Cognitive behavior therapy, motivational therapy, family therapy, therapeutic environments and residential treatments consistently demonstrate better outcomes when compared with other approaches.

Gwekwaadziwin incorporates these in a multiplicity framework that will attend to youth in its care with the best practices currently available. As trusting relationships are developed and residents and their families develop an affinity for certain approaches, care plans will be adapted to suit their needs in the best possible way.

The authors below have reviewed studies from current best practices in a comparative fashion.

Tanner-Smith, E. E., Jo-Wilson, S., & Lipsey, M. W. (2013). The comparative effectiveness of outpatient treatment for adolescent substance abuse: A meta-analysis. Journal of Substance Abuse Treatment, 44(2), 145–158.

This paper reports the authors' meta-analysis of 45 published and unpublished outpatient adolescent substance abuse treatment studies from the period of 1981 to 2008. Relatively few comprehensive studies exist that address adolescent addictions research, and many that exist have had results combined with results for adults, or provided narrative that could not be effectively compared. This is an important study due to the authors' efforts to retain and analyze multiple disparate outcomes using new meta-analysis techniques. The researchers attempted to overcome the distortion of variables such as demographics and patterns of use on outcomes measures across disparate studies by determining

adjusted effect sizes through the use of meta-regression models. Secondly, pre-post changes were analyzed to control for factors such as personal characteristics that were unrelated to treatment type but which might influence outcomes. Treatment types were compared and analyzed for efficacy. Cognitive behavior therapy (CBT) and motivational enhancement therapy (MET) each performed very well when compared to other approaches. Above all treatments, however, family therapy consistently provided the best outcomes for treating adolescents with substance abuse disorders.

Sussman, S. (2011). Preventing and treating substance abuse among adolescents. Part of a Special Issue on Adolescent Substance Abuse: Prevention, Intervention, and Recovery, 18(2), 3–7.

In this article, Sussman advocates targeted prevention and treatment approaches for adolescents with substance abuse disorders which adjust to an individual's needs. The use of prevention programs is equally important as the development of effective treatment models, and indeed the need for both overlap considerably. Proven methods of prevention such as those that increase decision making skills and inspire motivation are similar to those which promote the best post-treatment outcomes. Family therapy, therapeutic community and cognitive behavior therapy are among the more common treatments with youth, and demonstrate high success rates compared with other treatments. Family involvement in client care yields a 15% improvement toward prevention efforts with 10% gains still measured after one year. Sussman argues that parental involvement appears to be key to successful substance use treatment for youth. Therapeutic communities engage both peers and staff to support clients in their learning. Increasing privileges, and a variety of supportive and educational approaches can be incorporated with this model. Cognitive behavior therapy provides instruction and training aimed at increasing behaviors which make substance use difficult or impossible, while decreasing behaviors which support substance use. Problem solving, improved social engagement, assertiveness training, anger management and similar techniques may be employed. Group therapy, pharmacotherapy, residential care and brief treatment, and residential care are among the lesser-used treatment options. Of those, residential care afforded the greatest success overall, and better outcomes are associated with longer stays. In conclusion, Sussman recommends that multiple approaches should be implemented from prevention through treatment, and they should target all aspects of the individual's functioning including personal abilities, family and social situation, and culture.

Family and Cognitive Behavioral Therapies

Family therapy has emerged as a highly effective way to include loved ones in the support of the recovering youth. At Gwekwaadziwin, it is understood that family can mean immediate relatives and/or extended family, and it can also refer to those with whom the participant feels a close relationship—such as guardians or mentors. Cognitive-behavioral therapy helps families develop skills to create solutions that are relevant for them so they can transfer the tools beyond the program.

Including families in the treatment of the adolescent is central to the Gwekwaadziwin way, and is incorporated into all programming. Each family's unique experience will be enhanced with meaningful engagement through family therapy as well as through shared recreation, telephone or in-person visits, workshops, webinars, and groups. Family preferences and stages will dictate the approach that shall be used, in consult with the Elder and the therapist.

Latimer, W. W., Winters, K. C., D'Zurilla, T., & Nichols, M. (2003). Integrated Family and Cognitive-Behavioral Therapy for adolescent substance abusers: A Stage I efficacy study. Drug and Alcohol Dependence, 71(3), 303–317.

This research compared the Integrated Family and Cognitive-Behavioral Therapy approach to substance abuse with the Drugs Harm Psychoeducation program. Building upon previous studies which have suggested the usefulness of multisystem-, family- and cognitive-based therapies, and informed by ecological-development and neuroscience theories, this therapeutic modality involved participants in four therapeutic modules over a 16 week period while

employing manual based interventions which targeted the development of a specific skill set. The four modules, consisting of problem-focused family therapy, rational emotive therapy, problem solving therapy, and learning strategy training, were presented in group format and individual family sessions. Dimensions of learning text, completing tasks, applying strategies, and applying cognition were used. At the end of treatment and for six months afterward, drug and alcohol use and relapse were significantly reduced when compared with the psychoeducation program group, demonstrating that the family therapy model contributes to successful substance abuse treatment outcomes. Moreover, participants demonstrated improved cognitive-behavioral factors, school learning strategies, rational problem-solving skills, and family protective factors including improved parenting skills at six months after treatment, which in turn may predict increased abstinence at 12-month follow-up.

Rowe, C. L. (2012). Family therapy for drug abuse: review and updates 2003-2010. Journal of Marital & Family Therapy, 38(1), 59–81.

Family factors are considered to be strong contributors to the development of substance abuse. Further, substance abuse impacts family relationships and the family's ability to function in healthy ways. Poor parenting skills, conflict or maladaptive behaviors can create barriers to recovery and increase the potential for relapse. Stemming from multiple theoretical origins, family therapy aims to reduce conflict and improve interfamilial relationships, and to leverage familial influence to help a recovering substance user refrain from using; behavioral, family systems and multiple systems are all well regarded approaches to applying this knowledge. Family therapy can have the added value of reducing intimate partner violence and numbers of arrests and days incarcerated, while providing a cost-effective and respected intervention.

Cultural Care

Traditional Anishnabek teachings have been largely lost through generations of residential schools, the Indian Act, and the Sixties Scoop. Many young Canadian Aboriginal people are not familiar with their traditional practices and ceremonies, and many do not have any relationship with an Elder to counsel them in traditional ways and healing.

Gwekwaadziwin programming will introduce young people to the Anishnabek culture through the use of ceremonies, rituals and experiences on the land. Elders will guide students through spiritual and cultural teachings. Students will learn traditional food preparation and gathering, and traditional crafts. Fireside discussions will allow students to connect in a traditional story-telling way with students and staff, building upon trusting relationships that support a community of recovery as well as facilitate program completion.

The revival of cultural practices for Canadian Aboriginal people, or decolonization, is well recognized as an effective and satisfying way of healing the soul wound that leads to addictions and disordered behavior. The following readings provide further insight into the research and social experiences of positive change vis-à-vis this concept.

Chansonneuve, D. (2007). Addictive Behaviours Among Aboriginal People in Canada. Ottawa: Aboriginal Healing Foundation.

This research report looks at addictions as experienced by Canada's Aboriginal people through a literature review, interviews with key informants working in the addictions field, conversations with people who share their addiction experience, and a review of key documents., Chansonneuve provides a history of the key events of colonization and The Indian Act. The author elucidates how these forces have created unhealed or historical trauma experiences and incalculable losses for many Metis, Inuit and First Nation survivors, translating eventually into addiction and mental health problems. For Aboriginal people suffering addiction, the road back to wellness is not an event. Rather, it is a process which supports individuals, their families and their communities through constructive engagement of all

informal and formal stakeholders. The paper is framed with client stories and illustrated with descriptions of five programs already under way in Aboriginal communities, and it highlights treatment modalities such as prevention, harm reduction, early intervention, community change processes, and holistic healing. Prepared for the Aboriginal Healing Foundation, this report also stresses cultural teaching about the residential school abuses and specific sacred teachings of different Aboriginal groups, with examples of ways to include best practices in a culturally informed approach toward recovery.

Dell, C. A., Seguin, M., Hopkins, C., Tempier, R., Mehl-Madrona, L., Dell, D., Duncan, R., Mosier, K. (2011). From benzos to berries: Treatment offered at an Aboriginal youth solvent abuse treatment centre relays the importance of culture. Canadian Journal of Psychiatry, 56(2), 75-83.

This paper explores the growing concern that western views of health and wellbeing do not sufficiently allow for cultural interpretation of disease or illness, particularly with regard to psychiatric illness. The common diagnostic tool used in North America, Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, permits the consideration of cultural influences upon diagnoses and treatment of substance abuse and mental health problems. However Dell et al. argue that this suggestion is inadequate to rectify the prevailing misconception that DSM diagnoses are universal and culture-free. The authors compared the dominant western biomedical-psychiatric treatment of addictions and mental illness with traditional Aboriginal practices in Canadian, international, and Canadian government publications, and they interviewed staff at a Canadian Aboriginal healing center. The team found disconnection between the two world views, and they have conveyed their findings in this paper using the Aboriginal tradition of storytelling. For Inuit and First Nation peoples, one's connections to self, community, and political context are fundamental to one's health. Recommendations to promote the integration of Aboriginal healing perspectives in health care include using storytelling for knowledge transfer and increasing the amount of culturally relevant research into diagnosing and treating First Nations and Inuit youth who use substances and solvents. Conscientious employment of a health promotion framework considering all determinants of health is critical to the holistic perspective recommended by the World Health Organization, and to the balance needed for traditional healing.

Ross, R. (2014). Indigenous healing: Exploring traditional paths. Toronto ON: Penguin.

Rupert Ross served 26 years as a crown attorney in northern Ontario, and through the course of his work met many First Nations people whose lives were filled with poverty, violence and social injustice. Among his clients, where Ross observed feelings being pushed away to avoid the intractable pain of intergenerational abuse, he found that criminality, substance abuse and violence could thrive. Inspired by the learning he encountered in his previous work *Returning to the Teachings*, he continued his learning journey to delve into the effects of Residential Schools on Canada's Aboriginal people, and sought to identify the healing lessons of Indigenous culture. Ross provides engaging examples to explain traditional cultural concepts that fly in the face of Newtonian, Cartesian and Darwinian views that most European Canadians hold unquestioningly. With childlike curiosity, a mind opened to alternative solutions, and informed with a solid understanding of the failings of Canada's justice system, Ross explores existence of humans in relation to all other existence on earth, and investigates a spirituality where the laws of nature govern life rather than laws of courts. His stories and examples convey the lessons he learns on his own exploratory journey and the new discoveries which fuel his quest. On his journey, Ross meets Elders, leaders and authors, listens to criminals and their families, and reflects upon his own practice and his experience as a non-Aboriginal leader in the justice system. Through numerous examples, Ross demonstrates that decolonization and revival of traditional teachings is the antidote to the widespread problems facing Aboriginal communities today in Canada. The result is a challenge to all Canadians to acknowledge the scar of residential schools and to consider a new way of being in the world that allows for true healing of individuals, families and communities.

Wilderness Stabilization

Traditional lands are central to social systems in Indigenous belief systems. Gwekwaadziwin's maturity-based programming places youth into a supervised wilderness environment for experiential learning and to build or renew connection with the land. The Four Directions program provides a safe wilderness experience for teens to detoxify, away from the environmental and peer substance use triggers. Conducted at the beginning of treatment as it is, the Wilderness Stabilization period establishes relationships while cleansing the body and mind with healthy foods, exercise and skill building activities, and prepares youth for the residential treatment phase. For the young adults in the Seven Grandfathers program, the wilderness experience will imbue the rewards of living with the land, and is the initial treatment prior to moving to residential aftercare.

Big-Canoe, K., & Richmond, C. (2014). Anishnabe Youth Perceptions About Community Health: Toward Environmental Repossession. *Health and Place*, 26, 127–135.

Environmental dispossession has resulted in health, social and economic inequities among First Nations populations the world over. Anishnabe youth in northern Ontario's Pic River First Nation were interviewed by Big-Canoe and Richmond to learn their perspectives on the health of their community. This group, aged 18 to 27 years, revealed concern for their community's health in areas of addiction, diabetes, and cancers. Youth are worried about the land's ability to continue providing sustenance in the face of encroaching and ongoing industrialization. While these young people are worried, they are also very aware of the benefits of community as it comes together in times of crisis, and that burdens of sorrow are lightened when shared with community. They also value community and social relationships for their ability to help keep people from their own harmful tendencies such as addiction. Youth identified environmental repossession and the continued transfer of indigenous knowledge as the most hopeful ways to address these community problems.

The Medicine Wheel

Gwekwaadziwin's Four Directions residential program for youth 13-19 employs the medicine wheel for guidance. Clients will begin with the centre of the medicine wheel, looking inward at one's self and finding the courage to make positive changes. From there, they will progress through to seeing self in relation to the broader community, digging down to find motivation, determining how the future can look, and setting goals. Finally, as clients are planning for home, they will start to practice their new skills and solve new challenges in the safe environment of residence.

Students will learn how the quadrants of the medicine wheel represent physical, mental, emotional and spiritual facets of life, and the paramount importance of balance between these aspects. The medicine wheel's utility will deepen with the client's understanding of its use.

Numerous authors cite the value of the medicine wheel in healing within Aboriginal cultures. Its use in recovery programs is well documented, and medicine wheel teachings can be adapted to use in a variety of ways for programming purposes. Below is a sampling of references which will help the reader to understand this approach.

Gone, J. P. (2011). The Red Road to Wellness: Cultural Reclamation in a Native First Nations Community Treatment Center. *American Journal of Community Psychology*, 47(1), 187–202.

This article provides a history of the medicine wheel in Canada and its contemporary use in healing practices. Gone explains the use of the medicine wheel as it embodies both physical space and direction, as well as the conceptual representations of seasons, animals, and human qualities. Further, the circumference of the circle represents the human lifespan as a "topography of the self" (p. 194). Because of its adaptability and its ability

to denote harmony and connection between all things, the medicine wheel is seen as a tool which encompasses all the universe in its domain, and can be used as a tool by anyone for direction with any type of problem.

McCabe, G. (2008). Mind, body, emotions and spirit: reaching to the ancestors for healing. *Counselling Psychology Quarterly*, 21(2), 143–152.

McCabe offers a discussion of the ways in which traditional knowledge has been pushed underground by western ideologies, despite its value to heal through connecting the mind, emotions, spirit, and body. However, western medicine, beginning with practitioners such as Carl Jung and Carl Rogers, have also found value in seeking balance and harmony, and have found guidance in the natural order of the earth. Traditional teachings offer a link to history, as well as a way forward. Successful healing strategies can incorporate both traditional and western practices; the author considers several ways of traditional healing and relates them to contemporary practices.

Nabigon, H. (2006). *The hollow tree: Fighting addiction with traditional native healing*. Montreal and Kingston: McGill-Queen's University Press.

In this autobiographical text, Nabigon offers reflections upon his personal journey from desperate alcoholism that created deep and lasting losses in his life, to eventually choosing to follow the teachings of the medicine wheel. Through stories of how he healed with the help of the medicine wheel and reconnecting with his community, Nabigon illustrates a first-hand example of traditional medicine at work.

Seven Grandfathers

The Seven Grandfathers teachings serve as a guide for good living in the traditional way; they embrace values of Wisdom, Love, Respect, Bravery, Honesty, Humility and Truth.

Gwekwaadziwin Youth Mental Health and Addiction Treatment program is named in honor of the Seven Grandfathers teaching, Honesty, and in Ojibway it means "living the right way". In addition, the program and its activities are designed to honour all the Seven Grandfathers teachings for self and others.

Wesley-Esquimaux, C. C., & Snowball, A. (2010). Viewing violence, Mental illness and addiction through a wise practices lens. *International Journal of Mental Health and Addiction*, 8(2), 390–407.

Wesley-Esquimaux and Snowball are First Nations researchers who have found that allowing traditional teachings to guide practice for healing in Aboriginal communities is more effective than western best practices alone. They refer to this as wise practice because it honors traditional ways of knowing that draw upon ancient values that still hold true today. The Seven Grandfathers Teachings are instructive rather than punitive and focus on achieving balance within individuals, between individuals, and within entire communities. Community systems that are closed with shame, secrecy and mistrust can be opened with culturally appropriate practices that speak to the identity of community members. With the safety of an explorative and community healing perspective, people who have learned maladaptive behaviors can be helped to acknowledge hurtful ways and make amends in a culturally significant way, permitting devastating problems to be addressed on a community level. In a wise practice approach, those who have hurt others are given opportunities to make amends in a culturally relevant way for their offenses. Focusing on strengths and seeking honesty, wise practice can be applied for any age, any person, any family, and any community.

Residential Aftercare

For clients aged 19-30, Gwekwaadziwin's Seven Grandfathers group will receive residential aftercare in supervised apartment-style living arrangements. Upon the foundation laid during the wilderness experience, young adults will have the opportunity to learn and implement effective life skills, and to incorporate their learning into school, work and volunteer activities to build a more hopeful future.

The Society for Community Research and Action. (2013). The role of recovery residences in promoting long-term addiction recovery. American Journal of Community Psychology, 52(3), 406–411.

Recovery homes are residences where substance users stay once abstinence has been achieved, to continue to practice sobriety in a supportive environment with peers. Such residences vary tremendously in their delivery model depending upon the population served, type of governance and funding, and level or type of supports provided. In general, however, the model always provides peer support at the minimum, but supports may include a range of community and professional health supports. This style of recovery support and has proven very successful with short and long term measures. Severe substance abuse in particular benefits from this type of treatment which provides the critical components of sobriety, functional gains related to all aspects of physical, spiritual and mental health, and reintegration back to community (407).

Community Aftercare

Following residential treatment for addiction, it is imperative that culturally relevant, engaging, accessible and age-appropriate aftercare is implemented and maintained to prolong and reinforce the effects of treatment. Gwekwaadziwin will provide community aftercare to reintegrate back to community living following residential treatment for Four Directions participants, and either directly after Seven Grandfathers treatment, or following Seven Grandfathers residential aftercare. Both of these aftercare programs will include referrals to community services, and support to continue volunteer, work, school and recreational activities. A variety of means will be used to keep participants connected to supports including social media, text messaging, meetings, and telephone contact. Partnering with community stakeholders sets up support systems that continue beyond the active treatment phase and encourage healing for individuals that will ultimately continue to grow healthier communities.

National Native Addictions Partnership Foundation. (2016). Cultural aftercare guidebook. National Native Addictions Partnership Foundation Inc. Retrieved from <http://nnapf.com/nnapf-document-library/>

This guidebook published by the National Native Addictions Partnership Foundation begins with the definition of cultural aftercare: "life-long, holistic support from a range of service providers as well as community and social supports...to help people and their families or other loved ones along their healing journey and to return to positive community life" (p.1). After identifying barriers, methodologies and best practices, the guide offers direction for practitioners to create this support, based on best practices. Cultural aftercare supports people in building skills to recover lost or broken relationships with family. Traditional activities such as naming ceremonies, round dances, feasts, drum making and others provide safe environments to connect with history and with each other. Barriers to aftercare can stem from an array of causes, including such challenges as geographical inaccessibility, clients' negative perceptions, lack of expertise on the part of workers, and cultural incompatibility. Aftercare is therefore most effective when offered through communities in a number of different ways, and by combining traditional and western practices. Ultimately, aftercare should encourage cultural and spiritual wellbeing. As with treatment programs, attention is placed upon maintaining a variety of approaches as well as involving family and community in the healing process. Ultimately, cultural aftercare must be planned from program admission in any treatment modality as a necessary part of the continuum of care.

Residential Treatment

Residential treatment boasts demonstrated success in substance abuse treatment, and is particularly helpful for participants who have multiple problems such as substance use disorder plus one or more mental health problems, or a more severe substance addiction. Often, the youth who come to residential treatment will have been through a number of programs already and require more intensive support.

Residential treatment allows a number of treatment modalities to be used concurrently and the ability to tailor programs to suit individual need. In the Gwekwaadziwin model, residential treatment incorporates both the variety which best practices demand, as well as the therapeutic and social benefits of a cultural environment. Day to day engagement with staff and peers can help to provide continuity and repeated brief, meaningful interactions which contribute to the success of this style of treatment.

Plant, R. W., & Panzarella, P. (2009). Residential treatment of adolescents with substance use disorders: Evidence-based approaches and best practice recommendations. In C. G. Leukefeld, T. P. Gullotta, & M. Staton-Tindall (Eds.), Adolescent substance abuse: Evidence-based approaches to prevention and treatment (pp. 135–154). New York: Springer.

Efficacy of residential treatment for youth with substance abuse disorders is exceedingly difficult to assess due to inconsistent application of the treatment process and the multiple treatments that may be used concurrently. However, in this chapter by Plant & Panzarella, a number of studies have been reviewed and residential treatment for youth with substance abuse disorders has been found to be effective. Characteristics of the youth who enter residential treatment facilities are outlined in this chapter. Plant and Panzarella cite, for example that the incidence of lifetime exposure to trauma is an astonishing 72% for youth in residential treatment, and that cultural minorities are over-represented in residential care treatment programs. This chapter contains a brief overview of numerous modalities such as the Minnesota Model (12-Step), and the Multidisciplinary Professional Model and drug-specific approaches, and their potential for effectiveness. Following a review of the literature, the authors have distilled the treatment options that work with troubled youth, and those options that do not. The chapter makes note of challenges common to residential treatment programs such as separation from family promoting relationship breakdown, and offers suggestions for ameliorating these risks through the application of family models. Treatment recommendations include, but are not limited to, comprehensive intake screening based on outcome measures and reviewed regularly during treatment, developmentally appropriate treatment modalities, trauma informed care, culturally informed care, the use of cognitive behavioral approaches, and comprehensive aftercare which addresses the various unique needs of each individual. Recommendations for organizations include employing multidisciplinary staff, maintaining quality standards and ongoing reviews to allow for iterative improvements, seeking out licensing and accreditation whenever possible, and ensuring fees for service are based on a realistic estimation of expenditures to permit best possible outcomes.

Evaluation

Despite the number of approaches to treating substance abuse, mental health and behavioral problems in use today, research in the field of substance abuse and mental health treatment for youth is still in its infancy when compared with adult treatments. Successful evaluation that is planned from the outset of a program will demonstrate continued value and will improve programming on an ongoing basis. Gwekwaadziwin incorporates this philosophy and its ongoing evaluations will enhance its programming and provide a model for other First Nations communities to begin their own programs that support youth in need.

Pine River Institute is the program upon which Gwekwaadziwin has been modeled. In operation since 2005, Pine River has undertaken evaluation from the beginning and has proven its efficacy from financial, social, health and client/family impact standpoints.

Pine River Institute annual report. (2016). Toronto ON. Retrieved from
<http://pineriverinstitute.com/news/2016/10/11/new-evaluation-report>

Pine River Institute's most recent annual report illustrates the institute's excellence in programming while demonstrating the value of evaluation. Pine River's comprehensive approach to helping adolescent youth who are struggling with addictions and behaviors yields success for clients, contributes to research in the field, and proves excellent cost recovery.

The Gwekwaadziwin program model has achieved the robust combination of western best practices from proven programs such as Pine River Institute and SNAP®, as well as holistic practices which First Nations researchers have sanctioned. It has been designed for accessibility, sustainability, cultural relevance, and evaluation from the outset. Measured against current recommendations, this program has exceptional suitability for the Northern Ontario population. Gwekwaadziwin outcome indicators include a reduction in hospitalizations, police involvement, running away and mental health problems; and increases in academic and life skills achievement, as well as a positive future orientation.

National Native Addictions Partnership Foundation (2013). Guidebook on protocols for Indigenous practitioners specific to substance abuse treatment, cultural interventions, and healing. Retrieved from
<http://nnapf.com/nnapf-document-library/>

This Health Canada report, compiled with the input of First Nations elders, leaders and governments, provides a conceptual framework for First Nations mental wellness, and provides guidelines for cultural-specific services to First Nation communities. To promote sustainability, programming should be community based, community paced, and community led, in collaboration with all levels of government and First Nations. It must be accessible, including not only physical accessibility and proximity, but also cultural accessibility, including language and communication styles. Financial accessibility must consider funding sources and assist clients to access funding for treatment. Wellness must be defined in cultural terms with a clear understanding of factors that must be present for healing to take place. Value must be placed on cultural competence, with investments in training staff to provide a culturally safe environment with supportive, inclusive and caring relationships with individuals, families and communities. This report encourages a comprehensive, strengths-based perspective, and presents tools and suggestions for the development of cultural-specific treatment protocols.

Of the 94 recommendations made by Canada's Truth and Reconciliation Commission, the implementation of Gwekwaadziwin will address 15, constituting a significant contribution toward the restoration of balance to Canada's Aboriginal people.

Gwekwaadziwin has identified outcome measures which focus on improving cultural and environmental connections to improve the overall wellbeing of individuals and increase their future orientation. The sensibility of this comprehensive approach appears to be supported by the recommendations in the Final Report of the Truth and Reconciliation Commission of Canada.

Truth and Reconciliation Commission of Canada. (2015). Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada. Available at www.trc.ca

In 2006 the country's largest class-action lawsuit was won by over 18,000 survivors of Canada's residential school system, resulting in the creation of The Indian Residential Schools Settlement Agreement (IRSSA). The IRSSA directed, in part, the establishment of a Truth and Reconciliation Commission (TRC). The TRC, established in 2008, organized National Events, Regional Events and town halls and invited all citizens to participate. In the end, more than 6,750 stories of survivors were heard.

The commission made 94 recommendations for redress, called Calls to Action, which recommend Canadian governments interact within areas of child welfare, education, language and culture, health, and justice at local, domestic and international levels.

Listed below are Calls to Action which will be improved by Gwekwaadziwin's success:

5. We call upon the federal, provincial, territorial, and Aboriginal governments to develop culturally appropriate parenting programs for Aboriginal families.
- 10.ii. Improving education attainment levels and success rates.
19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess longterm trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.
20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.
21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.
22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.
23. We call upon all levels of government to:
 - i. Increase the number of Aboriginal professionals working in the health-care field.
 - ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
 - iii. Provide cultural competency training for all healthcare professionals.
- 34.i. Providing increased community resources and powers for courts to ensure that FASD is properly diagnosed, and that appropriate community supports are in place for those with FASD.
36. We call upon the federal, provincial, and territorial governments to work with Aboriginal communities to provide culturally relevant services to inmates on issues such as substance abuse, family and domestic violence, and overcoming the experience of having been sexually abused.
- 55.iv. Progress on closing the gaps between Aboriginal and non-Aboriginal communities in a number of health indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.
66. We call upon the federal government to establish multiyear funding for community-based youth organizations to deliver programs on reconciliation, and establish a national network to share information and best practices.

Appendix B

Reviewed Canadian Residential Addiction Treatment Program Applications

Compass Residential Youth Program <i>Youth, residential, non-culturally based</i> https://afm.mb.ca/programs-and-services/for-youth/compass-residential-youth-program/	Box 118 Southport, Manitoba R0H 1N0 Phone 204-428-6600
Behavioral Health Foundation—closed June 2016 due to lack of funding <i>Youth, residential, First Nations culture and non-culturally based</i> http://www.bhf.ca/	35 Avenue de la Digue Winnipeg MB R3V 1L6 Phone (204) 269-3430
Crossroads Centre (one intake form for both pre-treatment and post-treatment services, both residential) <i>Adult, residential, non-culturally based</i> http://www.crossroadscentre.ca/application.html	499 North Lillie Street Thunder Bay, ON, P7C 4Y8 Phone (807) 622-7587
Dave Smith (online application only- permission obtained) <i>Youth, residential, non-culturally based</i> http://www.davesmithcentre.org/apply-refer/application-process/	112 Willowlea Ottawa, ON, KOA 1L0 Phone (613) 594-8333
Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre <i>Youth 16-25, residential, contemporary and traditional First Nation culture</i> http://www.kanachihih.ca/article/referral-forms-130.asp	100 Anemki Drive, Suite 102 Fort William First Nation Thunder Bay, ON P7J 1A5 Phone (807) 623-5577
Pine River Institute (online application only- permission obtained) <i>Youth , residential, developmental model</i> http://pineriverinstitute.com/	180 Dundas Street West, Suite 1410 Toronto, ON M5G 1Z8 Phone (416) 955-1453

<p>Last Door Youth Program</p> <p><i>Youth 14-18, residential, non-culturally based</i></p> <p>https://www.lastdoor.org/litb/wp-content/uploads/2015/06/ReferralPackageYouthProgram-Fillable_v2.pdf</p>	<p>109 Ash Street New Westminster, BC V3M 3M2 Phone (604) 520-3587</p>
<p>Mamisarvik Healing Centre (reopened Jan 23/17 after closing for several months due to funding problems)</p> <p><i>Adult 18+, residential, Inuit culture</i></p> <p>http://tungasuvvingatinuit.ca/programs/</p>	<p>1863 Russell Road Ottawa, ON K1G 0N1 Phone (613)-563-3546</p>
<p>Nelson House Medicine Lodge</p> <p><i>Adult, residential, First Nations culture</i></p> <p>http://www.medicinelodge.ca/treatment/register/</p>	<p>Box 458 Nelson House, Manitoba R0B 1A0 Phone (204) 484-2256</p>
<p>Sunrise Native Addictions Services</p> <p><i>Adult 18+, residential, Aboriginal culture</i></p> <p>http://www.nass.ca/?p=apply.html</p>	<p>1231 - 34 Avenue NE, Calgary, AB T2E 6N4 Phone (403) 261-7921</p>
<p>Centre Walgwan Center</p> <p><i>Youth 12-17, residential, First Nation and Inuit culture</i></p> <p>http://www.walgwan.com/</p>	<p>75 School Street Gessapegiag, Quebec, G0C 1Y1 Phone (418) 759-3006</p>
<p>Wilp Si'Satxw Community Healing Centre</p> <p><i>Youth, residential, Traditional Native values</i></p> <p>http://wilpchc.ca/eligibility/forms/</p>	<p>Box 429 Cedarvale – Kitwanga Road Kitwanga, B.C. V0J 2A0 Phone (250) 849-5211</p>



Gwekwaadziwin Miikan

Application for Residential Treatment

We ask for personal information to help us understand your situation so that we can determine whether Gwekwaadziwin is right for you.

Information you provide on this form is confidential.

Please Print

CLIENT INFORMATION			
Last name:	First:	Middle:	Marital status: Single <input type="checkbox"/> Married <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Partnered/Common Law <input type="checkbox"/>
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Birth date: M / D / Y Age:
Please tell us any other name you like to be called:		I identify my gender as:	
Address:			P.O. Box:
City:		Province:	Postal Code:
Home Phone Number: ()		Cell Phone Number: ()	
Can we leave a message here? <input type="checkbox"/> Yes <input type="checkbox"/> No		Can we leave a message here? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email:			
Provincial Medical Number:		Province of Medical Registration:	
10 Digit Status Number:		Band:	
Languages spoken:		Languages understood:	
Is the applicant completing this form? <input type="checkbox"/> Yes <input type="checkbox"/> No		If No, who is completing this form?	
Do you want us to keep in touch with the person who helps you with this application? <input type="checkbox"/> Yes <input type="checkbox"/> No			
CONTACT INFORMATION			
IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to you:	Home phone: ()	Work phone no.: ()
FAMILY/SUPPORTS THAT YOU CONSIDER FAMILY			
Name:	Relationship to you:	Phone no.: ()	
Name:	Relationship to you:	Phone no.: ()	
Name:	Relationship to you:	Phone no.: ()	
AGENCY CONTACTS			
Agency:	Your contact's name:	Phone no.: ()	
Agency:	Your contact's name:	Phone no.: ()	
Agency:	Your contact's name:	Phone no.: ()	

PROFESSIONAL CARE PROVIDERS

Doctor or Nurse Practitioner:	Address:	Phone no.: ()
Psychiatrist:	Address:	Phone no.: ()
Dentist:	Address:	Phone no.: ()

SOCIAL HISTORY

What is going on in your life that made you choose to apply for treatment at Gwekwaadziwin?

Describe your housing situation:

Who do you live with now?

Do you have a safe place to return to after treatment? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No

How many? _____

Ages _____

If you have children, who do they live with?

Who will look after your family and your finances while you are in treatment?

Who are the main supports in your life?

Do they support this application for treatment? ☐ Yes ☐ No

Are you enrolled in school? ☐ Yes ☐ No ☐ Full time ☐ Part time/casual

Name of your school:

Program or courses you are taking:

What grade are you in now?

What is the highest grade you completed in school?

Are you currently employed? ☐ Yes ☐ No ☐ Full time ☐ Part time/casual

Who is your employer?

What type of work do you do?

Have you ever been involved with a gang? ☐ Yes ☐ No

If Yes, are you still involved? ☐ Yes ☐ No

Have you ever been the victim of abuse? ☐ Yes ☐ No

If Yes, was it reported? ☐ Yes ☐ No

What agencies are you involved with in your community?

SPIRITUAL AND PERSONAL DEVELOPMENT

Do you have relationships with any Elders? ☐ Yes ☐ No
Please tell us about this experience.

Do you practice any traditional teachings? ☐ Yes ☐ No
Please tell us about your practices.

Do you have other religious, ceremonial or spiritual beliefs or practices? ☐ Yes ☐ No
Please tell us about that.

In what ways would you like to learn or develop your spiritual beliefs?

When you think of your emotions and how they affect you, are there some emotions you would like to understand better or manage better? In what ways?

Describe any parts of your day-to-day relationships with others that you would like to handle better.

What physical activities do you enjoy?

In what ways do you want to improve your fitness or learn new physical activities?

How would you describe your strengths and talents?

What other skills you want to learn, or talents would you like to develop?

What interests you most in school or at work?

Is this something you want to learn more about? ☐ Yes ☐ No

Would you like to enroll in any kind of school program? What type?

What are the things you want to get out of treatment?

Use this space to write anything else you'd like to share with us

MEDICAL HISTORY

EYES

☐ Sensitive to light
☐ Low vision
☐ Blurry vision or problems focusing

☐ Double vision
☐ Ghost images or trailing images
☐ Other:

EARS

☐ Reduced hearing
☐ Ringing ears

☐ Other:

MOUTH, NOSE & THROAT

☐ Gum disease or bleeding gums
☐ Tooth grinding
☐ Sores inside mouth, nose or throat

☐ Pain in mouth, nose or throat
☐ Stuffy nose
☐ Other:

SKIN

☐ Infection or abscess
☐ Scabies
☐ Lice
☐ Rashes, scabs

☐ Bruises
☐ Ulcers or sores
☐ Other:

ABDOMEN

☐ Stomach upset, ulcer, or digestive problems
☐ Other _____

RESPIRATORY

☐ Asthma or any respiratory problems
☐ Cough
☐ Wheezing

☐ Pneumonia
☐ Other:

CARDIOVASCULAR

☐ Anemia
☐ Bruise easily, lots of bleeding from cuts
☐ Blood clot anywhere
☐ High blood pressure
☐ Heart rate problems (racing or pounding heart)

☐ Heart pain, especially with exercise (angina)
☐ Congestive heart failure (CHF)
☐ Heart defect or disease
☐ Stroke
☐ Other:

GENITOURINARY

☐ Urinary tract infection (UTI)

☐ Other:

MUSCULOSKELETAL

☐ Bone or joint problems

☐ Other:

BRAIN & NERVOUS SYSTEM

_____ Brain injury
 _____ Confusion
 _____ Forgetfulness

_____ Seizures or convulsions
 _____ Hearing, seeing or feeling things that other people do not
 _____ Feelings of panic

ACCIDENTS

_____ Car accident
 _____ Bike accident
 _____ Falls

_____ Head injury
 _____ Other accident:

INFECTION

_____ Chest
 _____ Throat

_____ Skin
 _____ Sinus
 _____ Other:

OTHER DISEASES AND CONDITIONS

_____ Diabetes
 Type:
 _____ Cancer:

_____ Liver problem:
 _____ Kidney problem:
 _____ Other:

_____ Flashbacks
 _____ Headaches

_____ Fainting
 _____ Other:

COMMUNICABLE DISEASES

_____ Cold or flu
 _____ Chicken pox
 _____ Hepatitis A B C (circle)
 _____ Strep throat

_____ Tuberculosis
 _____ Rheumatic fever
 _____ HIV/AIDS
 _____ Other:

WEIGHT CHANGE

_____ Weight loss

_____ Weight gain

How much _____ in _____ months

SURGERY

_____ Any surgery (please include dates if possible):

Do you have any sexually transmitted infections?

☐ Yes ☐ No

Are you or could you be pregnant?

☐ Yes ☐ No

ALLERGIES: Medicines:		Environmental or other:
List all non-prescription, prescription, and herbal medications you take. Attach a separate sheet if necessary.		
Medication name	Amount and how often each time	Why you take it

If your answer is Yes to any of the questions below, please use the spaces provided to tell us more about your experience.

Do you have any physical health conditions that may prevent you from participating in outdoor or indoor physical activity? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever experienced or been diagnosed with anxiety? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever cut yourself, or hurt yourself in other ways? <input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever experienced or been diagnosed with depression? ☐ Yes ☐ No

Do you have any problems related to eating? ☐ Yes ☐ No

Have you ever thought about suicide? ☐ Yes ☐ No

Have you ever tried to commit suicide? ☐ Yes ☐ No

Do you have problems with anger? ☐ Yes ☐ No

Have you ever been diagnosed with ADD or ADHD? ☐ Yes ☐ No

Do you have any learning disabilities? ☐ Yes ☐ No

Are you worried about any other emotional or mental health problems? ☐ Yes ☐ No

Have you ever received treatment for emotional or mental health issues in the community? ☐ Yes ☐ No
What type of issues were being addressed?

Where did you get the treatment?

Have you ever been hospitalized for any reason? ☐ Yes ☐ No
Why were you hospitalized?

Where?

Use this space to write anything else you'd like to share with us

SUBSTANCE USE HISTORY

Have you ever taken part in community treatment for substance or alcohol use? ☐ Yes ☐ No

What kind of treatment?

Where and when?

Have you ever been hospitalized for substance or alcohol use? ☐ Yes ☐ No

What kind of treatment?

Where and when?

Substance used			Used within the past:			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed	Month	6 months	Up to one year	Longer than one year
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Cocaine	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Glue/inhalants	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Methamphetamines (ecstasy, MDMA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Fentanyl	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Heroin	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Benzodiazepines (e.g. benzos, goofballs, roofies, Valium, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Barbiturates (e.g. barbs, downers, sleepers, reds, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Medicines (e.g. pain reliever, antihistamine, cough syrup)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Other Please name:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				

Which drug(s) do you use most?

LEGAL HISTORY

Do you have a criminal record? ☐ Yes ☐ No
If yes, please provide more information.

Do you have any charges pending? ☐ Yes ☐ No
If Yes, what are the charges?

Do you have upcoming court dates? ☐ Yes ☐ No
If Yes, indicate when:

Have you ever been charged with sexual assault or any sexual offense? ☐ Yes ☐ No

Have you ever been charged with crimes against children? ☐ Yes ☐ No

Have you ever been charged with arson? ☐ Yes ☐ No

Have you ever been charged with assault? ☐ Yes ☐ No

Are you on parole? ☐ Yes ☐ No
Name your parole officer:

Are you on probation? ☐ Yes ☐ No
Name your probation officer:

Lawyer name:

Use this space to write anything else you'd like to share with us

The information contained in this application is true to the best of my knowledge.

Applicant signature

Date

If there is anything else you would like to share with us, feel free to attach a separate piece of paper.