Substance Abuse Treatment for Aboriginal Youth: Should Drug and Alcohol Interventions for First Nations Youth be Subsumed Exclusively Under Harm Reduction Frameworks?

A Critical Policy Review

Abstract

High rates of substance use are prevalent among youth but limited evidence is available regarding the effectiveness of drug prevention and treatment approaches for adolescents with substance abuse problems. Rigorous research in this area is lacking (Leslie, 2008; Poulin, 2006). Harm reduction has, in the meantime, gained increasing prominence and has become the predominant policy stance in addictions treatment, and has influenced other areas of public health (Marlatt & Witkiewitz, 2010; Poulin, 2006; Witkiewitz & Marlatt, 2006). Evolving patchworks of policies currently in place for Aboriginal communities do not adequately define best practices for health services with Aboriginal youth. Self-governance, traditional aboriginal values, and cultural identity are key factors in Aboriginal health policy development. A systematic literature review and critical analysis of evidence-based practice guidelines were conducted for Aboriginal health policy, focusing on addictions programming for aboriginal youth in British Columbia. Drawing upon Indigenous frameworks for policy analysis, the author reviews factors influencing Aboriginal health policies in British Columbia. It is herein emphasized that policies and priorities need to be aligned with the developmental needs of adolescent girls and, when appropriate, should include provision of family support and treatment.

Acknowledgements

Substance Abuse Treatment for Aboriginal Youth:

Should Drug and Alcohol Interventions for First Nations Youth be Subsumed Exclusively Under Harm Reduction Frameworks?

A Critical Policy Review

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Executive Summary

This document is intended to provide current, objective, and empirically-based information to inform this review. In this document, evidence gathered to date which informs addictions treatment for Aboriginal adolescent girls in British Columbia is reviewed. Work that has already been done to address these concerns is acknowledged, and a discussion of the issues and challenges raised by the evidence follows. The review draws on a number of sources, including:

- Ethics guidelines for research with Aboriginal people as a necessary foundation for reviews of evidence for informing practice and policy.
- Research studies and evaluations of harm reduction and abstinence-based addictions treatment.
- An overview of the existing policies and discussion papers regarding addictions treatment.

Stakeholder review is useful for identifying gaps in policy implementation, and for maximizing the use of program resources. This report addresses the challenges and barriers to obtaining government funding for residential treatment agencies that do not fit the criteria set out in current guidelines. Through a systematic review of current policies and relevant literature, this report identifies further opportunities for government representatives to respond to challenges identified by service providers whose services are being cut (i.e., agencies are losing financial resources) due to government cutbacks, even though those services are clearly benefiting the targeted clienteles. With respect to addictions treatment for Aboriginal girls, there are few initiatives in B.C. and this gap needs to be addressed even while further initiatives unfold. Although not available yet, the BC government proposes to put in place provincial

standards and guidelines for publicly funded youth and adult residential substance-dependence programs, including both abstinence and harm reduction-based programs. The intention with this review is to facilitate a collaborative partnership with health officials and policy developers to support this response.

While harm reduction is being promoted within the public health system in Canada and is becoming the mainstream philosophical model for addictions treatment in British Columbia, there still remains a lack of evidence to support its effectiveness for adolescents. Harm reduction constitutes a continuum of treatment including abstinence; however, for youth the options that offer autonomy around the decision to use drugs and alcohol is risky, particularly for Aboriginal youth in residential treatment. This issue and its implications for residential treatment of Aboriginal adolescent girls are reviewed in this report.

This review is focused specifically on the concerns of Aboriginal adolescent girls with dual diagnoses of posttraumatic stress disorder (PTSD) and substance abuse problems. The clinical value for health policy is that this informs best practices for concurrently treating PTSD and Substance Use Disorder (SUD) in this population. Empirical evidence is reviewed regarding the usefulness of harm reduction programming for alleviating both PTSD and SUD symptoms. The review includes recommendations to revisit and inform funding by B.C. government that was refused for abstinence-based residential treatment programs. In response to the call for research by Spirit Bear Center, it is hoped that better funding will be available for treatment centers that deliver interventions using abstinence-based models for addictions and other health related problems of women and girls.

Chapter 1: Community Partnerships in BC Health Care

1.1 As an educational and research community, we (MA Program in Counselling Psychology at Trinity Western University) are pleased to partner with Spirit Bear Center Society in support of their work in providing care to British Columbia Aboriginal at-risk teen girls with addictions and problematic substance use. Together, we acknowledge and applaud the British Columbia government's efforts toward creating a comprehensive response to this very serious issue. Upon reviewing existing policy statements and discussion papers, we are pleased to see that government and health authorities are working toward creating comprehensive and integrated mental health and addictions service systems to guide and support the process of addictions treatment in British Columbia. We encourage continued building of partnerships with communities, including agencies such as Spirit Bear Center, to help them provide compassionate and effective responses to British Columbia youth living with, and recovering from, addictions and problematic substance use. We stand in support of an improved system to compassionately respond to the needs and concerns of front line service providers, such as Spirit Bear Center, which promotes the wellness of Aboriginal young people on a day-to-day basis.

Recognizing the unique needs of Aboriginal people in British Columbia, the B.C. government, the federal government, and the First Nations Leadership Council of B.C. have committed to developing a mental health and substance use plan for B.C.'s Aboriginal people. A recent report stated that by 2011 the B.C. government proposes to have in place provincial standards and guidelines for publicly funded youth and adult residential substance-use programs

based on evidence based treatment options. This will include abstinence-based programs as well as those based on harm reduction.[1]

Since the aforementioned document has not yet been released, treatment facilities are currently being asked to adapt their treatment models to accommodate harm reduction. In so doing, agencies with treatments based on a harm-reduction philosophy have a greater chance of being funded than others. Agencies such as Spirit Bear Center with abstinence-only approaches are being denied funding. In this analysis, the merits and demerits of the BC government harm reduction policy are examined. The effects of this current policy decision on residential treatment for female Aboriginal adolescents are considered.

Health Canada considers culture to be a key determinant of health and over all well-being of Aboriginal people and their communities.[2] A core element of research and evaluation with Aboriginal people involves respect for Aboriginal perspectives.[3] In this report, the authors acknowledge the positive influence of cultural identity, history, and traditional values, on health and healing.

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[1] Ministry of Health Services, Ministry of Children and Family Development. (2010). Healthy *minds, healthy people: A ten year plan to address substance use in British Columbia,* p 34. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

[2] National Aboriginal Health Organization. (2011). Retrieved from http://www.naho.ca/traditional-knowledge/

[3] Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. (2010). *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.* Retrieved from http://www.pre.ethics.gc.ca./eng/policy-politique/initiatives/tcps2-eptc2/Default/

Chapter 2: Culturally Appropriate Health Programming in Addictions

2.1 Maintaining a cultural focus.

Culture has a strong influence on health status of Aboriginal communities and individuals.[4] Maintaining a strong cultural focus is also important when conducting policy reviews that address concerns raised by Aboriginal communities. Research resources also need to emphasize cultural appropriateness during evidence gathering.[5]

For Aboriginal people, health pertains to the whole person, including physical, mental, emotional, and spiritual aspects of each person. Needs must be assessed within the social and physical contexts of the communities in which individuals live. Aboriginal people believe that illness results from imbalances in, and disharmony among, the four elements.[6] [7]

Representatives of federal and provincial governments, First Nations leadership councils, and health authorities agree that improvements in the health of First Nations people is a priority. They also agree that health systems must be adapted to serve the needs of aboriginal communities. Many consultations have been conducted between representatives of national and provincial mental health bodies and First Nations/Aboriginal community members with the

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[4] McIvor, O., Napoleon, A., & Kickie, K. M. (2009). Language and culture as protective factors for at-risk communities. *Journal of Aboriginal Health, 5*(1), 1-117.

[5] Chouinard, J. A., & Cousins, J. B. (2007). Culturally competent evaluation for aboriginal communities: A review of the empirical literature. *Journal of MultiDisciplinary Evaluation, 4*(8), 40-57. Retrieved from http://www.jmde.com

[6] McCormick, R. M. (2000). Aboriginal traditions in the treatment of substance abuse. *Canadian Journal of Counselling*, *34*(1), 25 32.

[7] McIvor, O., Napoleon, A., & Dickie, K. M. (2009). Language and culture as protective factors for at-risk communities. *Journal of Aboriginal Health, 5*(1), 1-117.

intention of developing culturally appropriate program standards. In current policy documents it is recommended that services and programs undergo a reform process. It is stated that "community-based initiatives which provide a broad range of treatment, prevention and health promotion strategies appear to 'work best.'" [8] [9] [10] [11]

There has been a gradual shift toward acceptance of the unique cultural identities of Aboriginal people and the stakeholders in health systems agree that culturally appropriate addictions treatment is a priority need. [12] [13] New initiatives are being introduced to enhance programming; however, the traditions, values, and belief systems of First Nations and other Aboriginal people regarding health are still poorly understood by many providers. Despite these ongoing efforts, many current program delivery models still reflect the values of mainstream western society. Aboriginal knowledge tends to be devalued and marginalized, and the unique health care needs of Aboriginal people are not yet being consistently addressed. While the need

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[8] British Columbia Ministry of Health Services. (2004). *Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction.* Retrieved from http://www.health.gov.bc.ca/library/publications/year/2004/framework_for_substance_use_and_addiction.pdf

[9] Kroes, G. (2008). *Aboriginal youth in Canada: Emerging issues, research priorities, and policy implications. Report on the Round Table on Aboriginal Youth.* Retrieved from http://www.policyresearch.gc.ca/doclib/2009-0005-eng.pdf

[10] Smye, V., & Mussell, B. (2001). *Aboriginal mental health: What works best'.* A discussion paper prepared for the Mental Health Evaluation & Community Consultation Unit. Retrieved from http://www.london.cmha.ca /data/1/rec_docs/1598_Aboriginal%20Mental%20Health%20What%20Works%20Best.pdf

[11] Health Canada. (2006). *Tripartite First Nations health plan memorandum of understanding.* Ottawa: Health Canada. Retrieved from http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/2007-06_tripartite_plan/index-eng.php

[12] Ministry of Health Services, Ministry of Children and Family Development. (2010). Healthy *minds, healthy people: A ten year plan to address substance use in British Columbia,* p 34. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

[13] British Columbia Ministry of Health Services. (2004). *Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction.* Retrieved from http://www.health.gov.bc.ca/library/publications/year/2004/framework_for_substance_use_and_addiction.pdf

for funding is being acknowledged, there remains a void in funding for addiction treatments that reflect the priorities and needs of individual communities (many of which are demonstratively effective long-term interventions). There is a need to strengthen funding for such service providers. Recent documents reflect this problem, stating that "jurisdictional conflicts between federal, provincial and territorial governments have resulted in unequal access to programs for Aboriginal people and a 'confusing and unsatisfactory funding situation" (p. 21).[14] Services must be culturally congruent, consistent with the values, life experiences, and expectations of the surrounding communities. Cultural relevance is best articulated by each community.[15]

Abstinence-based programs are currently being implemented in First Nations communities, and these programs have demonstrated success. Examples include the Nechi Institute and Pound Makers Lodge in Alberta (AA model with goal of abstinence); the Williams Lake program in British Columbia; and the Alkali Lake Reserve, a Shuswap First Nations community in British Columbia. These communities all chose to change their conditions until they were congruent with their own self-defined needs. The Alkali Lake program, the Nechi Institute, and Poundmakers's Lodge in Alberta are considered effective. These programs incorporate traditional healing practices and culturally adapted versions of AA that require abstinence from *any* use of alcohol or drugs during program participation (pp. 14 & 17).[16]

Although these programs are serving community needs, there remains a need for greater infrastructure and more external resources to support the maintenance of sobriety over time. It is

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[14] Ibid

[15] Smye, V., & Mussell, B. (2001). *Aboriginal mental health: What works best.* A Discussion Paper. Retrieved from http://www.london.cmha.ca/data/1/rec_docs/1598_Aboriginal%20Mental%20Health%20What%20Works%20Best.pdf

[16] Ibid

important to note that these programs incorporate a culturally adaptive version of AA, which is neither moralistic nor punitive,[17] and that these programs are currently receiving government support and funding. In the lower mainland of British Columbia, Spirit Bear Center is providing addictions services based on an abstinence-only approach. They blend mainstream interventions with cultural traditions and indigenous knowledge to create an innovative, culturally relevant program. Unfortunately, unlike the three programs mentioned earlier in this chapter, the funding for Spirit Bear Center has been discontinued, and the rationale for cessation of funding is that the program foundation is an abstinence-only model. It can be argued that terminating funding for an abstinence-based program such as Spirit Bear Center is inconsistent with the message conveyed in government documents pertaining to health, mental health, and addictions treatment for Aboriginal people. In a recent report by the BC Ministry of Health Services (Healthy Minds, Healthy People) it states that: "By 2011, provincial standards and guidelines for publicly-funded residential substance dependence treatment facilities will be in place" (p. 34). The action plan states that the government will "provide evidence based treatment options in youth and adult residential substance-use programs, including *abstinence based programs* as well as those based on harm reduction" (p. 34). [18]

2.2 Importance of oral tradition. According to First Nations customs, 'worldview' is the cultural lens through which they view the world and cultural identity is a source of strength. Indigenous peoples are traditionally storytellers. Oral traditions are historical

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[17] Ibid

[18] Ministry of Health Services, Ministry of Children and Family Development. (2010). Healthy *minds, healthy people: A ten year plan to address substance use in British Columbia,* p 34. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

accounts, teachings, lessons, and explanations that have been passed down for centuries, from one generation to the next. Personal stories are important in First Nations cultures, and stories are not 'alive' until they have been told.[19] [20] Therefore, to culturally anchor this report in *lived experiences*, we include excerpts from personal stories that emerge from Spirit Bear Center including an Aboriginal client's story of recovery.

2.2.1 About Spirit Bear Centre Society (SBSC). Spirit Bear Centre is a 10-bed residential treatment centre for young aboriginal women aged 13 to 18 years, located in Abbotsford B.C. Although two Stó:lō members sit on the board of SBCS, Spirit Bear is not situated on the Stó:lō lands and does not fall under the umbrella of the Stó:lō Nation. It is a non-profit society which opened its doors in April 2008. SBCS receives funding from the Ministry of Children and Family Development, the Ministry of Health, and Service Canada; however, the agency is currently experiencing a chronic funding shortage due to cutbacks in funding from the federal government.

Each year, the Spirit Bear Centre Society takes in ten First Nations women from B.C. and across Canada for a year-long program. These young women have addictions, and many have been diagnosed with concurrent mental health disorders and have experienced issues such as sexual exploitation. They are referred by social workers and probation officers, and often enter with established in-care or voluntary care agreements.

Being entrenched in the streets of their communities, they have often broken the law and been involved with the justice system. SBCS has adopted Aboriginal Restorative Justice Practices,

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[19] Sidwell, D., (2007). Telling stories from our lives. *Healing Words* 5(2). A publication of the Aboriginal Healing Foundation. Retrieved from http://iportal.usask.ca/docs/AHF_News/newsletter_2007_fall%5B1%5D.pdf

[20] Chansonneuve, D. (2007). *Addictive behaviours among aboriginal people in Canada.* A report submitted to the Aboriginal Healing Foundation. Retrieved http://www.ahf.ca /publications/research-series

which honour traditional and culturally relevant methods of addressing criminal wrongdoing. Accountability is addressed with a holistic approach, incorporating culturally relevant and sensitive traditions to repair damage.

Spirit Bear Center Society is committed to recovery from substance misuse through an evidence-based, culturally-relevant 16-week program. Much of the program is rooted in traditional teachings, such as the Medicine Wheel, to cultivate renewed interest in traditional practices In accordance with First Nations customs, SBCS addresses overall well-being by exploring healing at all levels: mental, emotional, physical, and spiritual. SBCS counsellors approach recovery by creating a safe and caring environment for their clients in both individual and group sessions. Personal goals and addiction treatment plans are developed with counsellors and their clients using relevant Aboriginal cultural healing practices and traditions such as healing circles, sweat lodges, pow-wows, dancing and a carving program. They also offer cognitive-behavioural therapy and Equine-Facilitated Counselling, to ensure a well- rounded holistic approach to recovery.

2.2.2 Connections with elders in the community. Spirit Bear has a relationship with Stó:lō Elder, Carmen McKay. Carmen provides carving classes for the girls as part of their healing program.

2.3 Program director's personal story.

Lynn Ned, Founder/Director of SBCS, has requested research to support an abstinence-based treatment model for Spirit Bear Centre. Lynn has extensive experience treating substance abuse and all of its related problems, and refuses to adopt Harm Reduction as an underlying model in the Center, for both cultural and practical reasons. Lynn states that she cannot support a harm reduction framework for her population: "I can't justify methadone treatment or a needle exchange program for youth". Fraser Health will not provide funding

unless Lynn is willing to move toward a harm reduction model. Lynn claims, "Abstinence has been working, and I would like to stay with the existing model". Lynn requires financial support from the province of British Columbia to keep the treatment center functioning and serve this clientele.

Lynn Ned worked diligently for five years *prior to* the opening of Spirit Bear Center to get her dream program running and ready for operations. This included volunteers who helped for a full year prior to the center opening. A strong component of the program at Spirit Bear is the way volunteers have participated, and support has been enlisted through people in the Abbotsford community. Although these initiatives have kept Spirit Bear running to date, it is only a matter of time until the lack of formal funding will prevent the center from paying counsellors --- vital elements of the program. "Currently we don't have funding for counsellors. As a result, the center has incurred deficits which has placed it at risk for being shut down". Service Canada has not renewed their funding claiming that Spirit Bear does not meet their criteria. Their argument is that the center is too small, and not situated on the reserve, even though clients come to the program directly off the reserves. Lynn argues for the importance of keeping treatment facilities off (and away from) the First Nations communities (lands or reserves) being served. Two of Spirit Bear's board members from the Stó:lō Nation have volunteered to donate land to the facility; however, Lynn claims that location of the center on the reserve would again expose these young women to high risk, and the same elements that brought them to treatment in the first place (L. Ned, personal communication, March 16, 2011).

2.3.1 Story about Lynn Ned from an outside perspective.

Lynn is not a newcomer to volunteering, as she has spent a lot of time throughout the community and around the world helping to build a better life

for those less fortunate, she has up to this point not received nor asked for a penny in making Spirit Bear Center a reality. The concept of having no source of income is new to her. As a person who has worked since the age of 14, Lynn is accustomed to being a provider for herself and her family. Though you would think that being the brains and heart behind a groundbreaking facility, not to mention the Vice President, Founder and Director of Spirit Bear Center, Lynn should be the first entitled to a pay check; it is for these specific reasons that Lynn is without. As a rule, a person who sits on the Board of a Society is unable to benefit financially from it. Regardless of the hours logged, the injuries collected or the sacrifices made along the way, there is no discussion on this matter. This is a fact that seems to bother others much more than it does Lynn. "Step down from the Board" people often offer, "Get another job" is a frequent suggestion, but these are not suitable alternatives. Were Lynn to step down from the Board, there is a possibility that all her hard work and unique vision could be tampered with, a fate worse than death in her eyes; a possibility that no amount of money is worth. She has in fact created this Center as a safe haven for young girls to grow through their addictions and heal their broken lives; financial benefits are not even a consideration. How can you get another job and split your efforts, when you have self imposed the future and successes of 10 young girls, who have already been through enough, on your own shoulders?

In a way it's a blessing that Lynn doesn't have billable hours because there would essentially be no budget left to speak of. Lynn consistently works

12-15 hour days, often times just running home for dinner and a shower, only to return an hour later. Not only is she there to put out the fires and run the programs, but she is responsible for monthly reports on all 10 girls. She's also the contact for all social workers, and the go to for all our questions. With a schedule like, this it is no surprise that Lynn has to make herself available 24/7. It's a given, that any personal time is subject to the events of the Center. This often causes quick returns from personal outings and sleeps left interrupted. Ironically, these are things that those with even the highest paid salaries are unwilling to do. When such rare occurrences of downtime occur, most of them are devoted to spreading the word and concern throughout the community, and desperately seeking out new funding sources. The work of two full time jobs, crammed into one volunteer position.

Lynn Ned is much needed visionary in today's society. Recognizing a lack of resources and continuing help for young aboriginal women with addiction and trauma issues, she opened the doors to Spirit Bear Center Society. This facility now encourages these young women to take a stand in society, by paving the path of wellness and recovery and becoming leaders for their communities. Now it is time to acknowledge the efforts and sacrifices of its visionary. Lynn Ned is a much deserved figure of respect and recognition....At the end of the day it isn't the sacrifices made in her own life that she thinks about, it is the progress in the lives of 10 young girls that keep her driven (Kimberly Lim, n.d.).

2.4 Client's personal story.

She used to be a child, full of hopes and dreams. No worries, no responsibilities, endless possibilities. She can't recall when she stopped being a child and became the person she is today. "Childhood" is a blur to her now. She clings to what few happy memories she can and tries hard to block out the rest. She learns the meaning of love from her mother, the person she loves most, and learns how to lie, manipulate and apply cover up to conceal the physical side effects. She hasn't learned yet how to deal with the emotional side effects of what she's learned to be love. The people she loves and trust most provide her with coping mechanisms. They provide her with alcohol and teach her how to get high. She now feels a sense of belonging and love, what every child yearns for. Time passes, she meets a boy. He says he loves her. He does, he reminds her of the man her mother loves, and treats her same. She can't find enough drugs to block out the pain now. She can't find the money to buy drugs she needs. She turns to the street. She does what she has to, to get what she needs! This creates more pain, she needs more drugs. She's spinning out of control. She cares nothing of herself now. She forgets to eat. She sleeps wherever she can, only when she's able to.

She wakes up one day, feeling hopeless, wishing she could end her life the way it is. She wants help, reaches out for it, fighting every urge to get high just one more time. She gathers all her strength and courage and makes a phone call. The lady on the other end of the phone tells her that all the treatment centers are full, but would be happy to put her on the lengthy waiting

list. She feels hopeless again. She suddenly remembers hearing of a facility that helps Aboriginal girls. She quickly yells out, “Spirit Bear”. The lady on the phone pauses, “Are you of aboriginal background?” “Yes!” She’s in luck. There is one spot open at the Spirit Bear Center. She feels a small sense of hope once more. She goes through a horrible, indescribable withdrawal process, fighting every urge not to run. Scared, afraid, feeling powerless, she tries hard to prepare herself for the unknown. She has a long hard road ahead of her yet. She has to relearn the real meaning of love and dissociate the feeling of pain that comes with it. She needs to learn how to have people around her that genuinely care of her. This is confusing to her. She can’t remember this feeling, it seems foreign to her. She needs to learn how to be a child again. How to have fun, not worrying where she’s going to sleep, when she will eat again or having to look over her shoulder, wondering if she’ll make it through another day.

Her spirit has taken a beating, but now she’s fighting back, growing stronger every day. She battles demons in her head, one day at a time, but now she’s learning how to do this and making healthier decisions with every passing day. She’s just now learning the true meaning of the words respect, love, and caring. Also discovering what healthy relationships are. She still wants desperately to be a child again but finds it difficult. She finally has hope though. She’s only 15!

Culturally appropriate health programming in addictions embraces holistic frames for needs, strengths, opportunities, and choices in journeys of recovery. Youth well-being is situated

in relational and community contexts as well as strengthened through collaboration. Collaboration and community partnerships are encouraged throughout the literature and government documents to help shape the most effective responses to health concerns and influence policy development. [21] [22] [23]

Chapter 3: Collaboration & Connection

3.1 In October, 2010, a request for research was made by Darryl Klassen of the Aboriginal Neighbours Program MCCBC to Dr. Rick Bradshaw of the Counselling Psychology MA Program at Trinity Western University**.** The intention of the research is to help restore Fraser Health funding to Spirit Bear Center so the treatment center can continue operating under their current abstinence-based treatment paradigm for treatment of aboriginal adolescent girls. Dr. Rick Bradshaw, Dr. Marvin McDonald, and the researcher have since agreed to partner with Lynn Ned of Spirit Bear Center, in a collaborative effort to support the effective work in SBC, advocating for funding to enable the Center to continue operations.

3.2 Researcher's personal story. In line with recommendations of the Social Sciences and Humanities Research Council of Canada (SSHRC), the Natural Sciences and Engineering Research Council (NSERC), and the Canadian Institutes of Health Research (CIHR)

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[21] Chansonneuve, D. (2007). *Addictive behaviours among aboriginal people in Canada.* A report submitted to the Aboriginal Healing Foundation. Retrieved http://www.ahf.ca /publications/research-series

[22] British Columbia Ministry of Health Services. (2004). *Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction*. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2004/framework_for_substance_use_and_addiction.pdf

[23] Ministry of Health Services, Ministry of Children and Family Development. (2010). *Healthy minds, healthy people: A ten year plan to address substance use in British Columbia,* p 34. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

guidelines, it is important for me, as a non-aboriginal researcher and collaborator, to become educated about Aboriginal cultural values and traditions. The *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans,* devoted to research involving aboriginal people in Canada, [24] states that researchers must engage in consultations with the affected First Nation(s). To meet these criteria, the researcher has pursued ongoing consultation with the program director of Spirit Bear Center.

My interests in research with Aboriginal communities developed as a result of my involvement in a proposed research project involving aboriginal women with dual diagnoses (PTSD and addictions). In preparation for that project, I visited Yellow Cedars Learning Center in Chilliwack BC, where I was able to speak to the leaders and meet some of the people who used those services. My experience was enriched, as I gained some important insights regarding the personal stories of both the leaders and the aboriginal clients. I also had the privilege of attending the 2010 annual Canadian Psychology Association conference held in Winnipeg Manitoba. This conference offered an Aboriginal focus, and I was able to attend a number of keynote addresses and symposia by leaders in Aboriginal communities. These included: a symposium by Ed Connors[25]; an address by invited speaker Donald Taylor – Using survey research in Aboriginal communities;[26] keynote address by Ed Connors [27]; a symposium on

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[24] Interagency Advisory Panel on Research Ethics. (2009). Research involving aboriginal peoples in Canada (chapter 9). In author draft 2nd edition of the tri-council policy statement: Ethical conduct for research involving humans (TCPS). Retrieved from www.pre.ethics.gc.ca Available from the author at 350 Albert Street, Ottawa, ON K1A 1H5

[25] Connors, E. A. (2010, June). Indigenous *community success stories: Suicide prevention from the inside.* Symposium conducted at the annual meeting of the Canadian Psychological Association, Winnipeg, MB.

[26] Taylor, D., (2010, June). Making a river flow back up a mountain: Survey research as a vehicle for constructive change in disadvantaged cultural communities. Symposium conducted at the annual meeting of the Canadian Psychological Association, Winnipeg, MB.

national Aboriginal peoples studies, which included a report on the Urban Aboriginal People Study[28]; and a presentation by Edward A. Connors, Okwatenrosohna Health Planner – Understanding health and wellness among Indigenous communities – A strengths based approach[29]. In his speech, Dr. Connors emphasized the importance of being familiar with traditional cultural practices when working with First Nations communities. "It is important to collect success stories from First Nations communities about health and wellness. Inquiry must come from a strength based (rather than a deficit based) approach that builds hope within communities".

To become more familiar with research protocols among Aboriginal people, I viewed on-line videos (Pathways to Health and Healing) from the NEARBC (Network Environments for Aboriginal Research BC) and the Centre for Aboriginal Health Research 2–day conference which took place at the University of Victoria in 2009.[30] The conference included presentations from the Aboriginal Health Authorities and a panel of Aboriginal health researchers. The conference centered on discussion of the recent Provincial Health Officer's Report on the Health and Well-being of Aboriginal People in BC, and future directions in Aboriginal health research.

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[27] Connors, E. A. (2010, June). *First Nations "Psychology" Is alive and well.* Symposium conducted at the annual meeting of the Canadian Psychological Association, Winnipeg, MB.

[28] Nova, D., Adams, M., Kunkel., S., Janz, T. (2010, June) *National Aboriginal People Studies.* Symposium conducted at the annual meeting of the Canadian Psychological Association, Winnipeg, MB.

[29] Connors, E. (2010, June). Understanding Health and Wellness among Indigenous Communities – A Strength Based Approach. Symposium conducted at the annual meeting of the Canadian Psychological Association, Winnipeg, MB.

[30] Network Environments for Aboriginal Research BC. (2009, Sept 24-25). *(NEARBC) Video: Pathways to Health & Healing* [Audio podcast]. Retrieved from http://www.cahr.uvic.ca/nearbc/videos.html

NEARBC is an environment for researchers and communities to collaborate, and develop research relevant to Aboriginal peoples.[31]

My initial curiosity about this project evolved out of my interest in trauma and addiction affecting women. After learning about Spirit Bear Center and being introduced to the needs and challenges of the community, it became clear that I needed to get involved in this project. A face-to-face meeting took place at Spirit Bear Center Society in March 2011. It involved a traditional gift exchange, a tour of the facility, meeting some of the staff members, and an in-depth discussion of issues most important to Lynn. Her passion and care for helping adolescent girls from her community was evident. Over the past several months, my conversations with Lynn have shed light on the challenges she faces at Spirit Bear Centre Society. My visit to the center provided even clearer insight regarding the importance of this work for adolescent girls. My concern for Lynn's predicament has grown, and I consider it a privilege to conduct this research in support of the needs in this community.

[31] Network Environments for Aboriginal Research BC, (2008). Retrieved from http://www.cahr.uvic.ca/nearbc/UBC/NEARBC-AboutUs-NearBCNodes-UBC.html

Chapter 4: Residential Treatment Strategy for Aboriginal Youth

4.1 In the Canadian Center on Substance Abuse (2003) report, based on an extensive literature review regarding residential programs for youth with substance abuse problems, several arguments were presented in favour of residential treatment: (1) detoxification in a protective, drug-free environment; (2) respite for family; (3) opportunity to focus on recovery issues, free from distractions and temptations by family members and peers; (4) intense exposure to positive role models (staff and other youth in recovery); (5) an efficient way of serving clients with special needs; (6) provision of intensive services; (8) social milieu therapy benefits that facilitate enforcement of attitudes and behaviours conducive to recovery. A safe and secure treatment environment that incorporates traditional spiritual beliefs and practices was identified as an important factor for client retention in treatment.[32]

Alcohol and drugs have been destructive influences in the lives of many people in Aboriginal communities. The forced loss of language, culture, land, traditions, and identity has resulted in mental health and addiction problems for many.[33] Is "harm reduction" the only solution to this very serious concern? Many Aboriginal communities continue to prefer abstinence-based approaches for recovery from substance use problems. Leaders in some First Nations communities state that harm reduction practices go against their customs, beliefs, and traditions. They argue that abuse of alcohol and drugs causes people to live "out of balance".[34] It

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[32] Canadian Centre on Substance Abuse. (2003). *Youth residential solvent treatment program design: An examination of the role of program length and length of client stay.* A report submitted to the Youth Solvent Abuse Committee c/o Nechi Training, Research, and Health Promotions Institute. Retrieved from http://members.shaw.ca/ysac /publications/Images%20and%20Files/Youth%20Residential %20Solvent% 20Treatment%20Program.pdf

[33] McIvor, O., Napoleon, A., & Dickie, K. M. (2009). Language and culture as protective factors for at-risk communities. *Journal of Aboriginal Health, 5*(1), 1-117.

[34] Ibid

is in the best interest of governments to respect the traditional views of members and leaders in each First Nations community, and recognize their needs to identify practices or strategies that fit best with their philosophies and values.[35] Historically, most Aboriginal communities have supported abstinence-based approaches because of the devastating impact addictions have had on their communities. Respecting Aboriginal people and their cultures will enhance social and economic well-being. It is up to each community to decide, based on local experiences and needs, what treatment models are most appropriate, and it is the responsibility of governments to respect and fund those choices.[36]

4.2 Aboriginal youth in Canada. The prevalence of substance abuse in First Nations communities is higher than in non-aboriginal communities, putting Aboriginal children and youth at greater risk of developing substance abuse problems. Aboriginal youth are also at higher risk of mortality as a result of illicit drug use and related health issues than their non-aboriginal peers.[37] [38] Aboriginal children and youth have been impacted by intergenerational traumas, and the impact of residential schools. They are overrepresented in incarceration facilities, psychiatric hospitals, and suicide statistics. Their lives are also associated with significant higher rates of poverty, teenage pregnancy, and parental mental illness, which all

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[35] Ibid

[36] Dell, C. A., (2008). Harm reduction and abstinence – more alike than different. *Visions: BC's Mental Health and Addictions Journal, 5*(1), p. 21-22.

[37] Ministry of Health Services, Ministry of Children and Family Development. (2010). *Healthy minds, healthy people: A ten year plan to address substance use in British Columbia,* p 34. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

[38] Wardman, D., & Quantz. (2006). Harm reduction services for British Columbia's First Nation population: a qualitative inquiry into opportunities and barriers for injection drug users. *Harm Reduction Journal, 3*(30) doi:10.1186/1477-7517-3-30 Retrieved from http://www.harmreductionjournal.com/content/2/1/30

contribute to family stress. This has resulted in children and youth being removed from their birth families and taken into care, and higher rates of emotional and behavioural problems due to neglect, abuse, and other traumatic experiences.[39] [40]

The abuse of substances is often linked to experiences of trauma, violence, and abuse among aboriginal girls. It is also important to acknowledge the health consequences of substance abuse among youth. Adolescence is a time when the brain and hormones go through rapid maturation. The abuse of alcohol and drugs can seriously compromise bone health, sexual/reproductive health, and brain functioning. Excessive ingestion of such chemicals also increases risk, during pregnancy, of having children affected by fetal alcohol syndrome disorder (FASD).[41]

Many Aboriginal communities have succeeded in preventing or reducing substance use problems among their people via community-wide, culturally-based solutions; however, the issue of prevention and treatment continues to present considerable challenge in most communities. There is significant diversity, for example, in British Columbia's First Nation communities. Each having its own distinct cultural and traditional health practices.[42]

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[39] Ministry of Health Services, Ministry of Children and Family Development. (2010). *Healthy minds, healthy people: A ten year plan to address substance use in British Columbia,* p 34. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

[40] British Columbia Ministry of Health Services. (2004). *Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction*. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2004/framework_for_substance_use_and_addiction.pdf

[41] British Columbia Centre of Excellence for Women's Health. (2010). *Coalescing on women and substance use: Linking research, practice and policy. Girls Centered approaches to prevention, harm reduction and treatment.* A discussion guide submitted to the National Framework for Action to Reduce Harms Associated with Substance Use. Retrieved from www.coalescing-vc.org

[42] Wardman, D., & Quantz. (2006). Harm reduction services for British Columbia's First Nation population: a qualitative inquiry into opportunities and barriers for injection drug users. *Harm Reduction Journal, 3*(30) doi:10.1186/1477-7517-3-30 Retrieved from http://www.harmreductionjournal.com/content/2/1/30

4.2.1 Abstinence-based approach is a good fit for aboriginal youth.

Many aboriginal communities follow abstinence-based philosophies (p. 22) [43] and are uncomfortable with harm reduction as an underlying model due to its incompatibility with cultural values.[44]

Improvements in response to girls and women are of particular importance. Programs need to be accessible, relevant, and safe for women, particularly when trauma and mental health issues are linked to substance use problems.[45] Prevention and health promotion programming must address differing needs for support based on cultural and social contextual factors.[46] Furthermore, criteria for entry into intensive treatment must be different for males and females, recognizing the differential impact of substance use on the physical bodies of girls vs. boys.[47]

Abstinence has, in the past, often been associated with the "moral model" which holds people individually responsible for their behavioural choices (whether good or bad). Those with bad *habits* are labelled bad *people*, deserving of punishment. Under this model, people with

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[43] BC Harm Reduction Strategies and Services. (2010). *Harm reduction training manual: A manual for frontline staff involved with harm reduction strategies and services.* Retrieved from http://www.bccdc.ca /NR /rdonlyres /C882975 0-9DEC-4AE9-8D00-84DCD0DF0716/0/CompleteHRTRAININGMANUAL January 282011.pdf

[44] Dell, C.A., & Lyons, T. (2007). *Harm reduction policies and programs for persons of Aboriginal descent*. Harm Reduction for Special Populations in Canada, Canadian Center on Substance Abuse, 1020. Retrieved from http://www.ccsa.ca/2007%20CCSA%20Documents/ccsa-011515-2007.pdf

[45] Chansonneuve, D. (2007). *Addictive behaviours among aboriginal people in Canada.* A report submitted to the Aboriginal Healing Foundation. Retrieved http://www.ahf.ca /publications/research-series

[46] Poole, N., & Dell, C. A. (2005). *Girls, women and substance Use.* Ottawa, ON: Canadian Centre on Substance Abuse.

[47] British Columbia Ministry of Health Services. (2004). *Every door is the right door: A British Columbia planning framework to address problematic substance and addiction.* Retrieved from http://www.health.gov.bc.ca/library/publications/year/2004/framework_for_substance_use_and_addiction.pdf

addictions are often stigmatized and demoralized by feelings of self-blame, shame, and guilt.[48] Another view holds that addiction is a *disease* caused by genetic and biological factors that are beyond the individual's control; thereby, releasing the individual from being morally responsible for their bad behaviours. The US, and national Institute of Drug Abuse has officially designated addiction as a disease of the brain. This model is endorsed by the AA 12-step recovery movement.[49] A third approach recognizes a complex set of determinants that impact addictive behaviour. This is the harm Reduction model.[50] This model accepts and works with individual differences in client characteristics and offers individuals the choice in self-management, treatment and recovery. The goal is to reduce the problem consequences associated with using substances.

Although the harm reduction model is being implemented in some settings (i.e. Insite - supervised injection site in Vancouver's Downtown Eastside; programs aimed at reducing the spread of HIV and HCV), in practicality, abstinence based treatment is a better fit for Aboriginal youth in residential treatment. According to the literature, 'harm reduction' and 'abstinence' models share a common goal of helping people ultimately achieve abstinence from the use of harmful substances. However, within the 'harm reduction' framework, there is no recognition of any benefits to a standalone abstinence-only based model. The argument is that 'abstinence' models illicit moralistic judgmental attitudes, guilt and shame, implying that harm reduction does

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[48] Brickman, P., Rabinowitz, V. C., Karuza, J., Jr., Coates, D., Cohn, E. & Kidder, L. (1982). Models of helping and coping. *American Psychologist, 37*(4), 368-384.

[49] Cook, C. C. H. (1988). The Minnesota model in the management of drug and alcohol dependency. *British Journal of Addiction, 83,* 735-748.

[50] Marlatt, G. A., & Witkiewitz, K. (2010). Update on harm reduction policy and intervention research. *Annual Review of Clinical Psychology, 6,* 591-606. Retrieved from www.anualreview.org doi:10.1146/annurev.clinpsy.121208.131438

not. [51] This appraisal is unfortunate, and confusing because it can lead to the false assumption that judgemental attitudes are elicited all of the time under an abstinence-only model, yet harm reduction includes abstinence as a choice option. On this basis, abstinence can be recognized as helpful and effective without assuming that it will illicit shame and guilt all of the time. It can also be argued that addictions treatment can be appropriately offered in a supportive, non-judgmental environment under an explicitly abstinence-based model for youth given their social, emotional and intellectual, and life stage development. Furthermore, when specifically implemented with a traditionally grounded Aboriginal health setting, respect is fundamental, counteracting potential dangers of moralistic, punitive attitudes.

"In order to provide effective counselling, to work through the issues, youth need to remain clean from harmful substances so that psychotherapy can do its work. Aboriginal youth need to feel their feelings and work through the difficult emotions that they have been hiding through self medicating. Continuing to provide other harm reduction options defeats this purpose" (L. Ned, personal communication, March 16, 2010).

4.3 Efficacy of psychotherapy. A meta-analysis conducted by Miller, Wampold, & Varhely (2008)[52] comparing differences in efficacy among treatment approaches applied to youth showed no evidence of any differences among treatment approaches when controlling for researcher allegiance. Allegiance explained all systematic differences among treatments. The researchers proposed that therapists trained by the originator of a particular treatment have greater belief in the efficacy of that treatment, are better trained, and receive more

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[51] Ibid

[52] Miller, S., Wampol d., B., & Varhely, K. (2008). Direct comparisons of treatment modalities for youth Disorders: A meta-analysis. *Psychotherapy Research, 18*(1) 5-14. doi:10.1080/1050330070147231

attention, suggesting that it is inappropriate to conclude that some treatments are superior to others. They suggested that considerable care needed to be exercised to ensure evenly-balanced allegiances between treatment approaches. Caution was recommended for professional organizations, payers, and regulators before specific approaches were deemed better than others. The implication of these results for research policy and practice are that abstinence based approaches are best understood as having equal merits to harm reduction approaches for the treatment of substance abuse disorders among youth, given available evidence.

The priority of cultural fit, comparable status in evidence-based considerations, and record of success in aboriginal treatment programs provide a strong basis for maintaining programs like Spirit Bear Center. Governments and health care leadership encourage discussion and partnerships with community and care providers [53] to help identify needs and priorities to inform policy planning. Policy review provides a means to assess the adequacy of policy and to identify gaps.

In the next chapter, Ulrich offers an analytical framework that allows us to recognize and make sense of the full range of factors that affect the ability to access effective support for policies and their implementation, a key priority for policy makers and for stakeholders responsible for monitoring implementation. The following analytical framework is used to identify deficiencies in existing policy and implementation and to determine which factors for addressing mental health and problematic substance use could be improved. We hope this review

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[53] Ministry of Health Services, Ministry of Children and Family Development. (2010). *Healthy minds, healthy people: A ten year plan to address substance use in British Columbia,* p. 34. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

will stimulate discussion and identify alternatives that could better fulfill the mandate of government to ensure sustainability of supports.

Chapter 5: Strategy for Policy Review.

5.1. Introduction: Policy Priorities in BC.

Currently in British Columbia there is no provincial policy framework to guide the process of mental health and addiction treatment. This review, therefore, consists of an analysis of existing available key literature, discussion papers, and existing policies to provide guidance and recommendations regarding provision of government funding and resources for treatment programs.

The provincial policy on harm reduction, best practices, and supply distribution is guided by the BC Harm Reduction Strategies and Services (HRSS) committee. Under the "BC Harm Reduction Strategy", the BC government has established what is called the "Four Pillar Drug Approach", a substance abuse treatment strategy that requires the cooperative efforts of five BC regional health authorities, along with the BC Centre for Disease Control, the BC Ministry of Healthy Living and Sport, and First Nations and Inuit Health. The "four pillars drug approach" includes:

(1) prevention,

(2) treatment,

(3) harm reduction, and

(4) enforcement.[54]

HRSS policy states that each health authority and its community partners must work together to provide a full range of harm reduction services within their respective jurisdictions,

[54] BC Centre for Disease Control. *Harm reduction strategies and services policy and guidelines.* (2009). Retrieved from http://www.bccdc.ca/prevention/HarmReduction/default.htm (accessed 31 March 2011)

including access to supplies and referrals to health care, mental health, addictions, and other relevant community services. The BC government policy states that harm reduction supplies should be made available to whoever needs them, regardless of the person's age, drug-using status, drug of choice, or residence. This policy guides services to diverse and often marginalized populations. In line with this policy, Fraser Mental Health and Addiction Services promotes a harm reduction framework within its regional boundaries (which include Spirit Bear Center).

Some of the most significant and relevant recommendations in the existing documents for this review include the following:

- Solutions are best achieved through the collaborative engagement of all levels of public and private health services providers, working together with community partners such as agencies and client groups at the community level.[55]
- The BC government will work in collaboration with current service delivery systems.[56]
- First Nations community members must be involved in partnerships for the design, delivery, and evaluation of service systems. Community-level coordination and planning is critical so that services address diverse client needs and community priorities, since these needs and priorities are unique to each community.[57]

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[55] Ministry of Health Services, Ministry of Children and Family Development. (2010). *Healthy minds, healthy people: A ten year plan to address substance use in British Columbia,* p 34. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

[56] Ibid

[57] Health Canada. (2006). *Tripartite First Nations health plan memorandum of understanding.* Ottawa: Health Canada. Retrieved from http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/2007-06_tripartite_plan/index-eng.php

- Health services will reflect the diversity, interests, and visions of First Nations for the delivery of health and other community services and lead to improved health status for individuals, families, and communities.[58]
- The success of treatment programs should be assessed at the community level, based on the experiences of clients. Consultation with people with lived experiences must be enhanced and protected.
- A goal of BC mental health and addiction services is that people will have access to the best mental health and addiction services in their communities.
- Components of a formal addictions treatment system should include withdrawal management, pharmacotherapy, individual counselling, family therapy, residential treatment, and case management.[59]
- Aboriginal people experience higher mortality rates and represent a higher population of injection drug users.[60]
- High rates of substance use occurs during adolescence, resulting in violence and increase vulnerability to becoming exposed to violence such as sexual assault, particularly for girls. Adolescence represents a critical period for early intervention and treatment initiatives.[61]

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[58] Ibid

[59] British Columbia Ministry of Health Services. (2004). *Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction.* Retrieved from http://www.health.gov.bc.ca/library/publications/year/2004/framework_for_substance_use_and_addiction.pdf

[60] Ibid

[61] Ibid

- The importance of understanding sex differences and gender influences on women's substance use is highlighted in Canada and the U.S., and the need for tailoring female-centered treatment is highly recommended. Girls progress more quickly into problematic substance use than boys, even when using the same amounts of substances.[62]
- Risk factors for Aboriginal girls with substance dependence include high rates of sexual abuse; exploitation, violence, and sexual assault; being forced into the sex trade; and concurrent disorders; resulting in high mortality rates.[63]
- The Ministry of Child and Family Development (MCFD) believes that all Aboriginal children, youth, and families, whether on or off reserve, should have access to a full range of equivalent, effective services that reflect and support Aboriginal cultures and traditions. The BC government has committed to support the development of policy and practice interventions in a flexible manner which respond to conditions which differ among Aboriginal communities, along with Aboriginal delivery of services to their own children. "We will see Aboriginal children and youth receiving services through an Aboriginal service system that strongly connects children and youth to their culture and tradition".[64]
- The following opportunities for action have been suggested in the documents:
    - Recognize the role that culture plays in determining health;

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[62] Ibid

[63] Ibid

[64] Ministry of Children and Family Development. (2010). *Strong Safe and Supported: A commitment to B.C.'s children and youth*, p. 25 – 28.

- Focus on implementing ecological, innovative interventions with cultural traditions and indigenous knowledge;
- Develop high quality culturally sensitive training;
- Provide mentoring and support;
- Foster links within and between communities;
- Support ongoing capacity building [65]

5.2 Critical Systems Heuristics. Critical Systems Heuristics (CSH) is a framework rooted in systems thinking, designed by Werner Ulrich.[66] These guidelines provide an analytical focus and lens for examining the existing policy decision by the BC government to not fund abstinence-only treatment at Spirit Bear Center. The director of Spirit Bear Center feels that her concerns have not been adequately addressed, and is seeking an opportunity to challenge the assumptions upon which this decision is based. For the purposes of this analysis, CSH helps to identify relevant problem aspects, questions, and solution strategies. A close examination of this specific funding decision in relation to policy priorities and stakeholder perspectives clarifies implications beyond this one program. As a result of an analysis of this funding decision as an implementation of current government priorities, changes can be proposed to improve existing policies and their implementation in addictions treatment for Aboriginal female youth in British Columbia.

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[65] British Columbia Ministry of Health Services. (2004). *Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction.* Retrieved from http://www.health.gov.bc.ca/library/publications/year/2004/framework_for_substance_use_and_addiction.pdf

[66] Ulrich. W. (1994). *Critical heuristics of social planning: A new approach to practical philosophy.* Chichester, UK & New York: Wiley & Sons (Original work published 1983)

Harm reduction is the dominant philosophical paradigm for addressing treatment of addictions in BC. Based on considerations like those noted earlier [in section 4.2.1], however, criticisms have arisen because Government authorities have refused to fund treatment facilities and programs that employ alternative models, such as abstinence-only approaches.

In response to the government's (Fraser Health/Youth Mental Health & Addictions; Health Canada/Mental Health & Addictions) refusal to fund Spirit Bear Center, the director of the program has initiated a review of current policies for addiction treatment in British Columbia. This review is conducted with the intent of renegotiating funding arrangements for the distinctive programming offered through Spirit Bear Center. Policy review enables decision makers to systematically assess the effectiveness and impact of policy decisions and implementation.[67] The course of action under review is the refusal to fund abstinence-only programming for residential addictions treatment of female Aboriginal adolescents. The following questions provide a map for identifying solution strategies:

1. Sources of Motivation:
    a. Who is the policy's client, and whose interests are being served?'
        - The *stakeholders* involved include several groups. The clients served are First Nations adolescent girls who receive the services. The aboriginal community is involved through Spirit Bear Center, the Program Director of Spirit Bear Center *(Lynn Ned);* all support staff, and therapists (*nursing staff, counsellors, teaching staff*); and the funders.
    b. What is the policy's purpose? What are the potential consequences?

[67] Ulrich, W., & Reynolds, M. (2010). Critical systems heuristics. In M. Reynolds & S. Holwell (Eds). *Systems approaches to managing change: A practical guide* (pp. 243-292). London: Springer.

The principle concern is whether the policy supports Aboriginal service priorities. The community within which it functions (The Aboriginal Community).

- According to the Tripartite First Nations Health Plan (2006)[68], all parties (First nations Leadership Council, the government of Canada, and the government of British Columbia) agreed to a comprehensive health plan that involves working partnerships with governments and health services providers. All agreed that delivery of services must effectively meet the needs, priorities, and interests of First Nations communities and individuals, while recognizing the fundamental importance of community solutions and approaches. The Tripartite First Nations Health Plan stresses the importance of establishing mutual respect and fiduciary relationships, and responsibility for removing obstacles in the design and delivery of health programs and services to First Nations communities. First Nations and existing governments acknowledge that participation of all parties is required to improve First Nations' health outcomes. According to the First Nations Health Plan Memorandum of Understanding outlined in 2006[69], the parties have agreed to collaborate and increase the involvement of First Nations in decision making concerning the best services for First nations, so that services are aligned with the needs of communities. It is expected that the parties will work together to improve health outcomes by providing equitable access to health services that meet the needs of the surrounding communities and ensure that services are culturally

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[68] Health Canada. (2006). *Tripartite First Nations health plan memorandum of understanding.* Ottawa: Health Canada. Retrieved from http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/2007-06_tripartite_plan/index-eng.php

[69] Ibid

sensitive, and that First Nations are fully involved in decision-making regarding the health of their people (Tripartite First Nations Health Plan). It is further stipulated that health services delivered by First Nations be coordinated with provincially-funded services, such as those provided by regional health authorities. Hence, the most effective addictions intervention programming for Aboriginal people is grounded in the wisdom of traditional cultural knowledge that involves a holistic approach to health and healing. Aboriginal belief systems have much to teach about recovery and the restoration of balance. Although the government's initiatives stimulate movement toward addressing the concerns expressed by marginalized groups, there are still criticisms that the needs and concerns of some groups (i.e., First Nations) are being overlooked. One criticism is that the current policy is not sufficiently inclusive of First Nations groups, whose values and world views are consistent with an abstinence-based treatment approach. As stated earlier [in section 4.1], MCFD is committed to support the developments of policies and practices in a flexible manner that is responsive to conditions in Aboriginal communities (including Aboriginal delivery of services to their own children).

c. What is the policy's measure of improvement? Who decides what constitutes an improvement, and how is it decided? Is the program working toward improving health status?

   - The current stand on addictions recovery via harm reduction is being enforced by Fraser Health to all service providers, limiting the range or choice of alternative healing options (i.e., abstinence-based models) through restrictive

funding. Residential addiction intervention programs are being inappropriately and unnecessarily limited in scope. Increasing evidence shows that when governments and local Aboriginal communities work together, to establish more collaborative practices and policies that reflect the values of specific communities, success stories of recovery are more likely. This occurs because programs are more relevant for Aboriginal people within these communities.[70]

2. Sources of Control

The 'decision-maker' role:

a. What is the basis of power and sources of control? Who is the decision-maker, and who is in the position to change the policy's measure of improvement?

- Those who hold the power to make decisions regarding funding distribution and policy decisions include: Government departments, and funding agencies. As reviewed above, community leaders in Aboriginal communities are in good position to inform and improve the policy's measure of improvement.

b. The principle concern/problem of the decision-maker is resources. What resources and other conditions of success are controlled by the decision-maker?

- Government Health Authorities (Fraser Health; Health Canada), stakeholders and community service providers are partners in the delivery of funding

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[70] Kroes, G. (2008). *Aboriginal youth in Canada: Emerging issues, research priorities, and policy implications.* Report on the Round Table on Aboriginal Youth. Retrieved from http://www.policyresearch.gc.ca/doclib/2009-0005-eng.pdf

resources. Spirit Bear Center should be a partner in the decision-making process. Their role is to balance societal and individual interests, and to be accountable for their decisions. It is in the best interests of Government to consult with service providers. Governments should be aware of the full range of service options, and consult with addiction service providers through collaborative processes.

3. Sources of Knowledge

The Expert Role

a. What is the source of knowledge for the policy? Who is involved as planner or expert? Who is considered competent to participate in the development of the policy?

b. On what expertise does the policy rely?

- This would include the research base on harm reduction and the voices of those considered experts in the field. Expertise regarding the well-being of aboriginal youth draws upon traditional knowledge available in aboriginal communities and their leaders [as well as the broader health and human services system]. This includes selection of resources from mainstream health systems as well as traditional practices.
- Through enforcing their existing position, whereby funding will only be granted to those agencies who provide harm reduction services, the BC government is essentially saying that harm reduction is always better than abstinence, for every group.

c. What is the guarantee that the policy will be implemented and be effective?

- There is no guarantee that the policy will work. It will be up to those who oversee the implementation of the policy to monitor its effectiveness.

4. Sources of Legitimation:
    a. The 'affected' role or 'witnesses' role (those who can bear witness to the concerns of those who don't have a voice): Who is witness to the interests of those affected but not directly involved? Who is affected by decisions, and on whom might the policy impose undesirable risks, costs, and consequences? These questions are intended to uncover the policy's ethical assumptions and deficiencies with respect to those affected by it (see section titled "Ethical Issues in Adapting Harm Reduction to Youth").
        - Urban Native Youth Association (UNYA) is a registered not-for-profit society with the Province of BC and a federally registered charitable organization. UNYA was formed in 1988 to address Native youth issues, when growing numbers of young people began leaving reserves for the city. Young Bears' Lodge is a co-ed residential program offered through UNYA to Aboriginal youth aged 13 – 18 years. This is a culturally based empowerment program with an alcohol and drug focus.
        - A program evaluation is currently underway by professionals affiliated with the University of the Fraser Valley.
    b. The principle concern for the witness to the affected role is, "To what extent are those affected given the chance of emancipation from the premises and promises of those involved?"

- British Columbia policy recommends consulting with community partners to monitor implementation and adjust courses of action as needed. "If there are changes in the community or larger policy, funding, or service delivery context, course corrections may be needed to ensure the strategy remains relevant and responsive to local concerns" (p. 17) .[71] This statement provides support for this inquiry, and offers some indication that the BC government is amenable to making corrections in response to concerns raised by agencies such as Spirit Bear Center.

Chapter 6: Substance Abuse Treatment Approaches

6.1 Introduction. Illicit drug use is complex and difficult, contributing greatly to human suffering while at the same time carrying a large cost to society. A great deal of effort has been employed in deriving effective intervention models to reduce the impact. According to the literature, harm reduction has gained increasing presence in the addictions field, and has become the predominant philosophy for addictions treatment (and many other areas of public health) [72] [73] [74]. Harm reduction is rooted in the principles of pragmatism and humanism.

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[71] BC Harm Reduction Strategies and Services. (2010). *Harm reduction training manual: A manual for frontline staff involved with harm reduction strategies and services* (p. 17*).* Retrieved from http://www.bccdc.ca /NR /rdonlyres /C882975 0-9DEC-4AE9-8D00-84DCD0DF0716/0/CompleteHRTRAININGMANUAL January 282011.pdf

[72] Marlatt, G. A., & Witkiewitz, K. (2010). Update on harm reduction policy and intervention research. *Annual Review of Clinical Psychology, 6,* 591-606. Retrieved from www.anualreview.org doi:10.1146/annurev.clinpsy.121208.131438

[73] Witkiewitz, K. & Marlatt, G. A. (2006). Overview of harm reduction treatment for alcohol problems. *International Journal of Drug Policy, 17,* 285-294. doi:10.1016/j.drugpo.2006.03.005

[74] Poulin, C. (2006). Harm reduction policies and programs for youth. Harm reduction for special populations in Canada. *Canadian Center on Substance Abuse*. 1-16. Retrieved from http://www.ccsa.ca/ 2006%20CCSA%20 Documents/ccsa-11340-2006.pdf

It is a non-moralistic, non-judgemental response, in which the dignity and rights of users are respected (no guilt or shame are implied). Harm reduction offers users a choice of how they minimize harms to themselves. Individuals are encouraged to participate and negotiate their own treatment options, which may or may not include abstinence. Harm Reduction emerged as a significant paradigm in the early 1980's and has since been adopted by the World Health Organization, the Joint United Nations (U.N.), the Red Cross, and the World Bank. [75] [76]

According to Ministry of Health Services[77], harm reduction delivers superior treatment outcomes over policies of zero tolerance and abstinence; however, gaps the research still exist and it is not clear that such a definitive statement should apply to all populations and settings.

6.2 Relevant definitions. Harm reduction is difficult to define and lends itself to competing descriptions, because it refers to both a philosophical approach and specific types of programs and interventions.[78] Several terms have emerged in the literature: (see Appendix A for glossary of terms).

6.3 Harm reduction strategies. Harm reduction strategies involve needle/syringe exchange programs, safe injection facilities, drug substitution programs such as methadone treatment for opiate users, and advertising campaigns.[79] According to Lennings,

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[75] Ritter, A & Cameron, J. (2006). A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs. *Drug and Alcohol Review, 25,* 611-624.

[76] Wodak, A. (2009). Harm reduction is now the mainstream global drug policy. *Addiction, 104,* 340-346.

[77] Ministry of Health Services, Ministry of Children and Family Development. (2010). *Healthy minds, healthy people: A ten year plan to address substance use in British Columbia,* p 34. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

[78] Ritter, A., & Cameron, J. (2006). A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs. *Drug and Alcohol Review, 25,* 611-624.

[79] Lennings, C. J. (2000). Harm minimization or abstinence: An evaluation of current policies and

methadone treatment for heroin users has stimulated the use of other opiates and drugs such as crack cocaine, indicating that free methadone treatment releases funds to buy other drugs. *In Aboriginal communities* harm reduction includes supply management (i.e., limiting supply; control of hours of sale, product, and volume regulated consumption; managing alcohol consumption (consumption in managed doses); safer spaces (places where consumption can take place with reduced risk (supervised injection facilities); and Injection Drug Use-Related Services (IDU) (i.e., for HIV transmission, needle exchange programs, supervised injection facilities, methadone maintenance, and anonymous HIV/AIDS testing).[80]

6.4 Dilemmas/gaps/implementation barriers in adopting policies. *Supply control, demand reduction,* and *harm reduction* result in both harms and benefits. For example, *supply control* is intended to reduce the availability of illicit drugs for the purpose of eradicating the cultivation of plants used to produce supply for drug trafficking. Harm reducing potential includes: limiting the scale of availability, price, and overdose. *Demand reduction* involves early prevention and intervention strategies, treatment and rehabilitation programs, and reduction of health consequences. The dilemma is in the efficiency and cost effectiveness of such strategies.

6.5 Harm reduction as it is applied to youth. High rates of substance use exist among the youth.[81] According to the Ministry of Health Services, and Ministry of Children

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practices in the treatment and control of intravenous drug use groups in Australia. *Journal of Disability and Rehabilitation, 22*(1/2), 57-64.

[80] Dell, C.A., & Lyons, T. (2007). Harm reduction policies and programs for persons of Aboriginal descent. Harm reduction for special populations in Canada, Canadian Center on Substance Abuse, 1020. Retrieved from http://www.ccsa.ca/2007%20CCSA%20Documents/ccsa-011515-2007.pdf

[81] Poulin, C. (2006). Harm reduction policies and programs for youth. Harm reduction for special populations in Canada. *Canadian Center on Substance Abuse*.1-16. Retrieved from http://www.ccsa.ca/ 2006%20CCSA%20 Documents/ccsa-11340-2006.pdf

and Family Development (2010)[82], adolescents and young adults are at higher risk due to greater experimentation, which can lead to problems related to substance use and mental health issues. The prevalence and risk associated with substance use among adolescents increases with each school grade. By grade 12, about 80% of adolescent students had consumed alcohol, and more than 40% had consumed cannabis during the course of the year (as cited in Poulin, 2006)[83]. Furthermore, there is limited evidence for the effectiveness of drug prevention and treatment approaches for adolescents with substance abuse problems, and rigorous research in this area is lacking.[84] [85]

Harm reduction is defined similarly when applied to adults and youth. [86]. This poses ethical concerns. Poulin points out three main issues related to youth: (1) Canada's laws concern those who are under the legal age whereby the autonomy and ability of youth to make wise decisions and generate alternatives concerning substance is decided for them. Youth over a certain age are considered qualified to make informed decisions; however, youth under a certain age are not. Under this law, one could argue that offering harm reduction to a youth population

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[82] Ministry of Health Services, Ministry of Children and Family Development. (2010). *Healthy minds, healthy people: A ten year plan to address substance use in British Columbia,* p 34. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

[83] Poulin, C. (2006). Harm reduction policies and programs for youth. Harm reduction for special populations in Canada. *Canadian Center on Substance Abuse*.1-16. Retrieved from http://www.ccsa.ca/ 2006%20CCSA%20 Documents/ccsa-11340-2006.pdf

[84] Leslie, K. (2008). Youth substance use and abuse: Challenges and strategies for identification and intervention. *Canadian Medical Association Journal, 178*(2), 145-148. doi:10.1503/cmaj.071410

[85] Poulin, C. (2006). Harm reduction policies and programs for youth. Harm reduction for special populations in Canada. *Canadian Center on Substance Abuse*.1-16. Retrieved from http://www.ccsa.ca/ 2006%20CCSA%20 Documents/ccsa-11340-2006.pdf

[86] Ibid

as a whole presents controversial ethical concerns regarding underage youth and their decision-making capacities; (2) Youth may not acknowledge risks and harms associated with youth substance use as problematic in the same way that adults do; (3) Research has not shown that harms experienced by youth populations have been reduced as a result of harm reduction policies and programs. According to Poulin, there is little evidence regarding the benefits of harm reduction or application of universal harm reduction policies across contexts targeting under-aged youth. Poulin further states that after reviewing the literature, there remains a gap in evidence needed to support a shift toward universal harm reduction policies targeting youth. Although there are established harm reduction programs available to Aboriginal people, research and evaluation demonstrating methodological soundness, culturally appropriateness, and effectiveness are still needed.[87]

Some of the questions raised about the effectiveness of harm reduction include: How does one measure qualitatively different types of harm? If harm is reduced toward users, how do we know that it has also been reduced toward everyone else? What kinds of trade-offs are involved? [88] These questions have attracted little scholarly attention.[89] According to Marlatt and Witkiewitz [90] harm reduction strategies are best individualized according to the needs and wants

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[87] Dell, C.A., & Lyons, T. (2007). Harm reduction policies and programs for persons of Aboriginal descent. Harm Reduction for Special Populations in Canada, Canadian Center on Substance Abuse, 1020. Retrieved from http://www.ccsa.ca/2007%20CCSA%20Documents/ccsa-011515-2007.pdf

[88] Leschner, A. I. (2008). By now, "harm reduction" harms both science and public health. *Clinical Pharmacology and Therapeutics, 83*(4), 213-214.

[89] Weatherburn, D. (2008). Dilemmas in harm minimization. *Addiction, 104,* 335-339. doi:10.111/j.1360-0443.2008.02336.x

[90] Marlatt, G. A., & Witkiewitz, K. (2010). Update on harm reduction policy and intervention research. *Annual Review of Clinical Psychology, 6,* 591-606. Retrieved from www.anualreview.org doi:10.1146/annurev.clinpsy.121208.131438

of individuals or communities. They suggest that a universal harm reduction program will not be suitable for all. Furthermore, appropriate goals can be tailored to meet the needs of individuals, whether they are oriented toward abstinence or not. [91]

Programs that adopt the *harm reduction* model must provide sufficient evidence for its effectiveness for reducing harm, to both substance abusers and the general public. Unfortunately, there are no practical means of measuring many of the harms associated with substance abuse. [92]

Harm reduction for youth is controversial. The situation regarding under-aged youth poses a difficult challenge to those who have the duty to care for them. For example, the decision about the appropriateness of harm reduction as a basis for policies and programs targeting youth may hinge on the strength of evidence about the effectiveness of that approach. Evidence for the effectiveness of harm reduction interventions is essential, to arrive at an evidence-informed decision. Furthermore, evidence for harm reduction with youth must include sufficiently large effect sizes to indicate that the benefit of harm reduction outweighs abstinence, without compromising the safety of youth. Reviews of empirical literature and Internet Web sites of addictions agencies in Canada reveal little information about the ability of harm reduction interventions to actually reduce substance-related harm, or the risk of other related harms to youth. [93]

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[91] Poulin, C. (2006). Harm reduction policies and programs for youth. Harm reduction for special populations in Canada. *Canadian Center on Substance Abuse*, 1-16. Retrieved from http://www.ccsa.ca/2006%20CCSA%20documents/ccsa-11340-2006.pdf

[92] Weatherburn, D. (2008). Dilemmas in harm minimization. *Addiction, 104,* 335-339. doi:10.111/j.1360-0443.2008.02336.x

[93] Poulin, C. (2006). Harm reduction policies and programs for youth. Harm reduction for special populations in

The Criminal Code of Canada identifies young people as a vulnerable population sub-group. The law supports abstinence as a correct stance regarding alcohol and other drug use for youth. In fact, it is a criminal offence to possess, produce, or sell cannabis in Canada regardless of age, and various provincial laws prohibit public intoxication, possession of alcohol by a minor, and sale of alcohol to a minor (age 19 in the province of BC). Furthermore, the United Nations Convention on the Rights of the Child, ratified by Canada in 1990, stresses the notion that a child's rights be in accordance with age, maturity, and evolving capacity, within the context of parental responsibility, community involvement, local customs, and legal constraints. [94] Is it reasonable, then, to consider that youth with addictions possess the emotional and intellectual maturity to be engaged in self-management, and capable of making well-reasoned, viable, and informed harm reduction choices? Do we assume that adolescents are capable of making informed choices about what they need, and should we let them make such decisions?

Drug prevention education aimed at youth has been repeatedly shown to be minimally effective.[95] A barrier to harm reduction in schools is that administrators have a duty of care toward students and accountability to parents. Formal school board policies support abstinence as a goal. Harm reduction as a universal intervention, targeting under-aged youth should be informed by the legal and policy constraints placed on schools and school boards. [96] Would these

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Canada. *Canadian Center on Substance Abuse*. 1-16. Retrieved from http://www.ccsa.ca/ 2006%20CCSA%20 Documents/ccsa-11340-2006.pdf

[94] Ibid

[95] Ibid

[96] Ibid

same principles not apply to treatment center administrators and staff members who provide services to under-aged youth?

6.6 Harm reduction as it is applied to aboriginal youth. Currently, there is no evidence to support harm reduction for treatment of Aboriginal youth in residential treatment. Harm reduction approaches are not accepted in many aboriginal communities due to conflicting values, customs and traditions with harm reduction philosophy. [97] [98] Historically, most Aboriginal communities have supported abstinence-based approaches. Respecting Aboriginal people's choice is the responsibility of governments.[99]

Given that Aboriginal children and youth are at greater risk of developing substance abuse problems than non aboriginal youth, programs need to be relevant, particularly when trauma and mental health issues are linked to substance use problems. Prevention and health promotion programming must address differing needs for support based on cultural and social contextual factors.[100] Aboriginal youth desire to experience a sense of belonging with their identity and culture.[101] [102] Although the harm reduction model is being implemented in some

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[97] BC Harm Reduction Strategies and Services. (2010). *Harm reduction training manual: A manual for frontline staff involved with harm reduction strategies and services.* Retrieved from http://www.bccdc.ca /NR /rdonlyres /C882975 0-9DEC-4AE9-8D00-84DCD0DF0716/0/CompleteHRTRAININGMANUAL January 282011.pdf

[98] Dell, C.A., & Lyons, T. (2007). *Harm reduction policies and programs for persons of Aboriginal descent*. Harm Reduction for Special Populations in Canada, Canadian Center on Substance Abuse, 1020. Retrieved from http://www.ccsa.ca/2007%20CCSA%20Documents/ccsa-011515-2007.pdf

[99] Dell, C. A. (2008). Harm reduction and abstinence – more alike than different. *Visions: BC's Mental Health and Addictions Journal, 5*(1), p. 21-22.

[100] Poole, N., & Dell, C. A. (2005). *Girls, women and substance Use.* Ottawa, ON: Canadian Centre on Substance Abuse.

[101] Ball, J. (2006). *Early childhood care and development programs as hook and hub: Promising practices in First Nations communities.* University of Victoria. School of Child and Youth Care. Early Childhood Development Intercultural Partnerships Programs Report. Victoria, British Columbia, Canada.

settings (i.e., in reducing HIV and AIDS), [103] abstinence based treatment is more practical for Aboriginal youth in residential treatment. For treatment to be effective, youth need to remain clean from harmful substances.

Chapter 7: Recommendations for Policy

7.1 Cooperation between governments and service providers to improve access to funding for mental health and addictions can only strengthen outcomes. Funding must be dependent on the experience of clients, and its most successful defenders and beneficiaries must be local clients and service providers. Based on the above information drawn from the literature and current policy documents, we propose the following recommendations/opportunities:

- Fraser Health should exercise flexibility in providing funding to support service providers where cases can be made that treatment has improved client care and outcomes.
- Accessing resources improves the ability of service providers to meet the needs of their clients in a coordinated, cost-effective, and accessible manner.
- There is no single answer regarding how this should occur. It is about building a continuum that is needs-based and strengths-based. Collaboration, alliances, partnerships, and other mechanisms have been used effectively in both public and private sectors. Moreover, consumers should have a say in the planning, coordination, implementation, and evaluation of these choices. Clients would have better continuity of care and be less likely to fall through the cracks.

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[102] Aboriginal Healing Foundation. (2006). *Final report of the aboriginal healing foundation. A healing journey: Reclaiming wellness.* Ottawa: Aboriginal Healing Foundation.

[103] Canadian Aboriginal Aids Network. (2010). *National Aboriginal youth strategy on HIV & AIDS in Canada: For First Nations, Inuit, and Métis youth from 2010 to 2015.* Retrieved from http://library.catie.ca/pdf/ATI-20000s/26358.pdf

- Many people with mental illnesses and addictions will require a range of services, so it is unlikely that one system of care or service could ever encompass all their needs.
- Choice initiatives should be encouraged to address the needs and strengths of these clients including recognition of available community resources. Abstinence-based treatment initiatives should be granted the same status and resources as other care models, including, harm reduction programs.
- Currently, the treatment of mental illness and addiction is relegated to distinct systems of care, particularly to those who adopt harm reduction frameworks. Yet neglecting to fund addiction services that adopt abstinence-based frameworks for Aboriginal youth works against the interest of building a strong system of care. More importantly, this works against the interests of service providers who have demonstrated the capacity to help Aboriginal youth in recovery (such as Spirit Bear Center).
- Collaboration can facilitate delivery of the 'right services' by the 'right people' at the 'right time', reducing the risks and impacts of addictions and mental illnesses.
- An abstinence-based approach that is culturally adapted can draw on the strengths of Aboriginal communities and existing social supports. These help to stabilize vulnerable youth.

Summary Statement

To date, no research related to harm reduction has been conducted with Aboriginal adolescent girls in residential treatment. This makes it difficult to ascertain whether currently identified harm reduction programs are, in fact, 'best practice' models for this at-risk group. Although interventions using harm reduction strategies have limited effectiveness for reducing risks and harms in some populations, it is unknown to what degree this approach might be useful

with Aboriginal youth. It is important to acknowledge that reasons for drinking and using drugs may differ for First Nations youth relative to mainstream Caucasian youth[104] so novel interventions and approaches may be required.

The program developed and run by Spirit Bear Center Society (treatment of problems related to substance abuse in First Nations at-risk teen girls) is unique to this province. This novel program constitutes an innovative attempt to nurture health and promote indigenous healing practices for adolescent girls. Unfortunately, the program is not recognized as fitting within the scope of the current system of care. Systems issues often present barriers due to philosophical incongruence between the cultures of decision making organizations and community service providers. Spirit Bear Center representatives have been told that they lack many of the preconditions necessary to qualify for funding; however, this does not mean that their program is ineffective. It merely means that research has not yet been done, and that the evidence base has not yet been fully established. It is important to keep in mind that initiatives considered "evidence-based" are not the only *effective* programs. Some programs may be no better than other options that are available, simply more researched. Furthermore, there are differences in ways of knowing among cultures. What counts as "evidence" is defined differently from group to group. If given a chance, the program offered at Spirit Bear Center can teach researchers and community partners about effective practices. Research is currently underway and will soon be completed. It is commonly understood that some programs are ineffective, yet public funding is available for such programs year after year. Currently, public

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[104] Comeau, M. N., Stewart, S. H., Mushquash, C., Wojcik, D., Bartlett, C., Marshall, M.,...Stevens, D. (2005). Community collaboration in developing a culturally relevant alcohol abuse earl intervention program for First Nation youth. *Ontario Association of Children's Aid Societies (OACAS) Journal,* 49(1), 39-46.

funds are being used to support *in*effective programs instead of programs that have at least *some* evidence to support their effectiveness.

Spirit Bear Center has been operating beyond the reach of evidence-based practice research, but has effectively adapted to cultural ways of knowing, and community needs. There is a gap between evidence-based practice and policy, and traditional ways of knowing in aboriginal communities. We don't yet have in-depth research adapted to Aboriginal practices and contemporary health systems. Since that research bridge is not yet available, we must draw upon policy resources to make those connections. Current policy clearly guides us to adapt health services priorities to Aboriginal communities, programs, and systems that are well-grounded culturally. Relational legitimacy emerges in this document by way of partnership and shared commitments to the well-being of female aboriginal youth in this community.

On this basis, we hereby appeal to decision makers and policy developers to remove any policy or funding barriers so that Spirit Bear Center can continue its operations. We ask that decision makers be open to a broader conceptual understanding of what Spirit Bear Center has to offer. Supporting this initiative can pave the way to strong partnerships among First Nation community stakeholders serving youth. To this end, policy developers, community leaders, funders, service system directors, referral agents, and other key players can become resources for one another, moving forward with new perspectives toward mutual gains. Everyone can benefit from the expertise, experiences, and wisdom of service providers from special communities such as Spirit Bear Center Society. Continued financial support of Spirit Bear Center will lead to opportunities for other agencies and communities to learn from experiences involving application of culturally-relevant, abstinence-based strategies.

Based on these strengths and needs, financing resources must be allocated to assure availability of effective and appropriate services to meet the needs of this high-risk group of Aboriginal adolescents. Planning and program development efforts in the Nechi Institute and Pound Makers Lodge in Alberta, Williams Lake program in British Columbia, and Alkali Lake Reserve, serve as models for aligning funding streams to support programs through Spirit Bear Center. Sensitive evaluations and positive responses by government funding sources can lead to effective addictions services for adolescent Aboriginal girls in British Columbia. The outstanding program model offered in Spirit Bear Center can be shared across the country.

Appendix A

Glossary of Terms

Harm reducing. Any approach intended to reduce the harms related to drug use, including reduction in the use of drugs and alcohol.[105]

Harm minimization. An approach intended to minimize drug-related harmful consequences via supply reduction, demand reduction, and harm reduction.[106]

Harm reduction. An approach intended to reduce the risks and consequences (health and social harms) associated with substance abuse, without requiring reductions in drug & alcohol use. This approach is offered as an alternative to abstinence for individuals who are unwilling or unable to completely stop using substances. A collaborative approach is proposed, based on principles of willingness of treatment providers to collaborate with clients (under their terms) for reducing the harmful consequences of drug and alcohol use. Abstinence is viewed as one option among many, to reduce the health and social harms associated with alcohol and drug use. [107] [108] [109] [110] [111] [112]

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[105] Weatherburn, D. (2008). Dilemmas in harm minimization. *Addiction, 104,* 335-339. doi:10.111/j.1360-0443.2008.02336.x

[106] Ibid

[107] BC Harm Reduction Strategies and Services. (2010). *Harm reduction training manual: A manual for frontline staff involved with harm reduction strategies and services* (p. 17*).* Retrieved from http://www.bccdc.ca /NR /rdonlyres /C882975 0-9DEC-4AE9-8D00-84DCD0DF0716/0/CompleteHRTRAININGMANUAL January 282011.pdf

[108] Dell, C. A., & Lyons, T. (2007). Harm reduction policies and programs for persons of Aboriginal descent. Harm reduction for special populations in Canada, Canadian Center on Substance Abuse, 1020. Retrieved from http://www.ccsa.ca/2007%20CCSA%20Documents/ccsa-011515-2007.pdf

[109] Marlatt, G. A., & Witkiewitz, K. (2010). Update on harm reduction policy and intervention research. *Annual Review of Clinical Psychology, 6,* 591-606. Retrieved from www.anualreview.org doi:10.1146/annurev.clinpsy.121208.131438

Abstinence. Refraining from drug use or (particularly) from drinking alcoholic beverages, whether as a matter of principle or for other reasons. Those who practise abstinence from alcohol are termed "abstainers", "total abstainers", or-in a more old-fashioned formulation- "teetotallers". The term "current abstainer", often used in population surveys, and is usually defined as "a person who has not drunk an alcoholic beverage in the preceding 12 months; this definition does not necessarily coincide with a respondent's self-description as an abstainer"[113] For some people, abstinence is the best and only way to reduce harms.[114] As stated within the document[115] harm reduction does not exclude abstinence as an ultimate goal (p. 15).

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[110] Poulin, C. (2006). Harm reduction policies and programs for youth. Harm reduction for special populations in Canada. *Canadian Center on Substance Abuse*.1-16. Retrieved from http://www.ccsa.ca/ 2006%20CCSA%20 Documents/ccsa-11340-2006.pdf

[111] Ritter, A., & Cameron, J. (2006). A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs. *Drug and Alcohol Review, 25,* 611-624.

[112] Weatherburn, D. (2008). Dilemmas in harm minimization. *Addiction, 104,* 335-339. doi:10.111/j.1360-0443.2008.02336.x

[113] World Health Organization. (n.d.). Lexicon of alcohol and drug terms published by the World Health Organization. Geneva: World Health Organization. http://www.who.int/substance_abuse /terminology /who_lexicon/en/

[114] BC Harm Reduction Strategies and Services. (2010). *Harm reduction training manual: A manual for frontline staff involved with harm reduction strategies and services* (p. 17*).* Retrieved from http://www.bccdc.ca /NR /rdonlyres /C882975 0-9DEC-4AE9-8D00-84DCD0DF0716/0/CompleteHRTRAININGMANUAL January 282011.pdf

[115] Ministry of Health Services, Ministry of Children and Family Development. (2010). *Healthy minds, healthy people: A ten year plan to address substance use in British Columbia,* p 34. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

Appendix B

Literature Review

Overview

The primary focus of this section is to provide an overview of the relevant literature to support the rationales for this policy review. It contains a critical review of the existing practice and policy guidelines for addictions programming *in British Columbia* with a focus on female aboriginal youth.

This review pertains primarily to residential addictions treatment for female Aboriginal adolescents with the dual diagnoses of Posttraumatic Stress Disorder (PTSD) and Substance Use Disorder (SUD). This section begins with an overview of the literature related to persons of Aboriginal descent, highlighting the importance of cultural practices. This includes the significance of storytelling, which bring to life Aboriginal peoples' experiences and is an important way of sharing knowledge in Aboriginal culture. Subsequently, a review of the literature regarding prevalence rates for PTSD and SUD is provided, followed by the diagnostic criteria for PTSD and SUD according to the DSM-IV-TR (APA, 2000). Next, a discussion regarding gender differences highlights the importance of research related specifically to women. Factors associated with the development of PTSD, with an emphasis on variables most relevant for the aboriginal population in British Columbia is provided. An overview of relevant explanatory theories for the treatment of substance abuse is included. Theoretical underpinnings of treatment models are discussed, concentrating on harm reduction and abstinence based models, with implications for residential treatment of Aboriginal youth. An overview of the analytical process concludes the literature review.

Contribution

The clinical value of this policy analysis and literature review is that it includes valuable information regarding best practices for treating the dual diagnoses of PTSD and SUD in aboriginal adolescent girls. Both qualitative and quantitative empirical evidence is reviewed regarding the usefulness of harm reduction programming for alleviating both PTSD and SUD symptoms. In response to the call for research by Spirit Bear Center, to address treatment choice for concurrent PTSD and SUD symptoms, it is hoped that better funding will be available for treatment centers that deliver abstinence-only treatment of problems associated with this dual (comorbid) diagnosis. This review focuses specifically on the concerns of Aboriginal adolescent girls with PTSD and substance abuse problems, adding to the literature regarding best treatments for this population, and aiding advancements toward better health for women and girls. There is a clear need for innovative and diverse approaches (Dell, 2005).

Vulnerable (First Nations) population

In Canada collaboration between the Social Sciences and Humanities Research Council of Canada (SSHRC), the Natural Sciences and Engineering Research Council (NSERC), and the Canadian Institutes of Health Research (CIHR) has been formed to guide ethical policy development (the Interagency Secretariat on Research Ethics). There is an entire chapter in the second edition of the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans* devoted to research involving aboriginal people in Canada (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2010). In Chapter 9 of the second draft of that document, several principles are presented. First, the researcher should consider the extent to which any findings from a proposed study will affect (or reflect upon) broader First

Nations communities. To the extent that this is likely to occur, the researcher must engage in consultations with the affected First Nation(s). That includes, but is not limited to: (a) notification of (and consultation with) band leaders and elders about the proposed research project, (b) incorporation of suggested changes in methods, measures, or variables as suggested by the elders, and (c) inclusion of First Nations representatives on the REB that evaluates the ethics of the proposed research project. In the case of this project, the policy analysis will not lead to broad sweeping statements about First Nations people in general. In spite of this, consultation with, and authorization by, Spirit Bear leaders has been pursued. Additionally, the researcher has been consulting with Lynn Ned of Spirit Bear Center Society from the Abbotsford area.

The need to maintain a strong cultural focus is an important criterion when doing research in Aboriginal communities (McCormick, 2000; Mussel, Cardiff, and White, 2004). Culturally competent research requires establishing relationships between members of the relevant Aboriginal community and the evaluator, and ensuring that the evaluator is firmly grounded within the cultural, historical, and social context of the community (Chouinard & Cousins, 2007). This will include engaging stakeholders and participants in reflective dialogue about the issues that matter to these individuals, and reflect the communities they serve.

Lynn Ned, Founder/Director, has requested research to support an abstinence-based treatment model for Spirit Bear Centre. Lynn has extensive experience in substance abuse and all of its related problems, and refuses to adopt Harm Reduction for both cultural and practical reasons. Lynn states that she cannot support a harm reduction framework for her population; “I can’t justify methadone treatment or a needle exchange program for youth”. Fraser Health will not provide funding unless Lynn is willing to move toward a harm reduction model. Lynn

claims, “Abstinence has been working and I would like to continue to stay with the existing model”. Lynn requires restored financial support from the province of British in order to keep the Spirit Bear Center functioning and support her ability to serve this clientele.

Using cultural oral traditions. According to First Nations, “worldview” is the cultural lens through which they evaluate the world, and cultural identity is a source of strength. Indigenous peoples are traditionally storytellers. Story telling is a way of transmitting knowledge. Oral traditions are historical accounts, teachings, lessons and explanations that have been passed down for centuries, from one generation to the next. Personal stories are important in First Nations culture; “stories are not alive until they have been told” (Sidwell, 2007). To culturally anchor this evaluation, we include the following *stories* of individuals and groups that are relevant to this review:

About Spirit Bear Centre Society (SBSC). Spirit Bear Centre is a 10-bed residential treatment centre for aboriginal girls aged 13 to 18, located in Abbotsford B.C. Although two Stó:lō Nation residents sit on the board of SBSC, Spirit Bear is not situated within the Stó:lō lands and does not fall under the umbrella of the Stó:lō Nation. It is a non-profit society which opened its doors in April 2008. SBSC receives funding from the Ministry of Children and Family Development, the Ministry of Health and Service Canada, however, the agency is currently experiencing a chronic funding shortage due to cut backs in funding from the federal government.

Each year, the Spirit Bear Centre Society takes in ten First Nations girls from around B.C. and Canada for a year-long program. The young women have addictions and many have been diagnosed with concurrent mental health disorders and have experienced issues such as

sexual exploitation. The girls are referred by social workers and probation officers, coming with already established in-care or voluntary care agreements.

Being entrenched in the streets of their communities, most often results in breaking the law and involvement with the justice system. SBCS adopts Aboriginal Restorative Justice Practices which honour a traditional and culturally relevant method of addressing criminal wrong doing, thereby addressing accountability from a holistic approach, incorporating culturally relevant and sensitive traditions to help repair any damage.

Spirit Bear Center Society is committed to the overall recovery from substance misuse through an evidence based, culturally relevant 16 week program. Much of the program is rooted in traditional teachings, such as the Medicine Wheel, to cultivate a renewed interest in traditional practices.

In accordance with First Nations customs, SBCS addresses overall well-being by exploring healing at all levels: mental, emotional, physical, and spiritual. SBCS counsellors approach recovery by creating a safe and caring environment for their clients in both Individual and Group sessions. Personal goals and treatment plans for addiction treatment are developed with counsellors and their clients using relevant Aboriginal cultural healing practices and traditions such as healing circles, sweat lodges, pow-wows and dance. They also offer a carving program that is taught by their Elder, Carmen McKay, of the Stó:lō Nation. They offer cognitive behavioural therapy and Equine Facilitated Counselling to ensure a rounded holistic approach to recovery.

Prevalence and Comorbidity of Posttraumatic Stress and Substance Use Disorder

Trauma and Posttraumatic Stress Disorder

Through years of research, 17 PTSD symptoms have been identified. These symptoms are listed in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-IV-TR; APA, 2000). These 17 symptoms are divided into three separate clusters:

1. Re-Experiencing Symptoms: frequent upsetting thoughts or memories; strong feelings of distress when reminded of the traumatic event, recurrent nightmares, "flashbacks" (acting or feeling as though the traumatic event is happening again), and physically responding to reminders of the traumatic event (e.g., surges in heart rate, sweating);
2. Avoidance Symptoms: avoidance of trauma-related stimuli (e.g. avoidance of people, places, or thoughts and feelings that remind the individual of the trauma; avoidance of conversations about the traumatic event); restricted range of affect (emotional numbing and/or inability to experience positive emotions such as happiness or love), having a difficult time remembering important parts of the traumatic event; loss of interest in important, once positive, activities; feeling as though one's life may be cut short; and
3. Hyperarousal Symptoms: hypervigilance, exaggerated startle response, difficulty concentrating, having a difficult time falling or staying asleep, feeling more irritable or having outbursts of anger, having difficulty concentrating, feeling constantly "on guard" or like danger is lurking around every corner, being "jumpy" or easily startled (Fournier, 2002; Kubany et al., 2004).

PTSD symptoms must have lasted for longer than one month for a diagnosis of PTSD; and the disturbance must cause significant clinical distress or impairment in social and occupational functioning.

Fournier (2002) defines trauma as "a natural human response to the physical, psychological, social, and spiritual manifestations of stress in a person's life" (p. 116). People often develop posttraumatic stress disorder following traumatic events (Payne, Liebling-Kalifani, & Joseph, 2007) and, according to Adshead (2000), PTSD occurs in 20-30% of the people who are exposed to traumatic stressors. Trauma can result from situations that involve domestic violence, rape, sexual abuse, criminal assault, serious accidents, natural disasters, and combat (Najavits, 2004). Empirical research supports the perspective that early traumatic experiences such as childhood sexual abuse are associated with long-term disruption of affect regulation, a central feature of complex PTSD (Herman, 1992; van der Kolk et al., 1996). Affect dysregulation is a disorder of extreme emotional distress (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005) whereby survivors of childhood sexual abuse will often have difficulty managing or tolerating intense emotional feelings in the present. Posttraumatic disorders do not typically exist in isolation. The most common comorbid disorders involve depression and substance abuse (Adshead, 2000).

Findings from a study conducted by Sochting, Corrado, Cohen, Ley, and Brasfield (2007), suggest that it may be useful to adapt a complex posttraumatic stress disorder framework when assessing mental health problems in Canadian Aboriginal people. Many mental health problems associated with complex trauma were identified, including risk factors for complex PTSD. A complex PTSD formulation takes into account the possibility of layers of trauma and the many potential associated long-term consequences. The authors suggest that including this

diagnosis may have positive implications for treatment recommendations and identification of gaps in health care resources for Aboriginal people.

Substance Use Disorder (SUD)

The core feature of alcohol dependence is a pattern of excessive use of alcohol, usually with a narrowing of one's behavioural repertoire, despite adverse consequences. Tolerance and withdrawal are often present according to the *DSM-IV-TR* (APA 2000). Two or more standard drinks per day are considered heavy alcohol consumption for women. The negative effect of alcohol and other drug dependence on women is devastating. Up to 2.7 million American women reportedly abuse alcohol. Alcohol misuse is particularly on the rise among young women (Holdcraft & Iacono, 2002). And one-quarter to one-third of injection drug users in Canada are women, a major risk factor for developing HIV (Wiebe & Reimer, 2000). Aboriginal women are over-represented in the IDU population (Craib, Spittal, Wood et al, 2002). The province of British Columbia spent over $1.3 billion in direct costs to address mental health and substance use issues in 2008/09, which does not include indirect costs which are estimated at $6.6 billion each year with lost productivity at $1.1 billion (BC Ministry of Health Services, 2010).

Gender Differences

A consistent finding across epidemiologic studies shows higher prevalence rates of PTSD in women compared with men who have been exposed to traumatic events (Breslau, 2009). Extensive research exists on domestic violence involving women, including physical and psychological abuse and its association with substance abuse (Ford & Russo, 2006). Research indicates that women are more likely to experience interpersonal violence than men.

Women tend to report greater exposure to physically-and sexually-related traumas (Breslau, 2009; Najavits & Lester 2008).

Exposure to traumatic events is particularly common among individuals with SUD (Najavits, Weiss, & Shaw, 1997, 1999). Individuals with SUD tend to present with symptoms of chronic affect dysregulation (Chilcoat & Breslau, 1998) and loss of ability to self-regulate (see Felitti et al. 1998; Putnam 1999, and van der Kolk et al. 1991 – from van der Kolk, 2002, p. 134). The findings from a study on gender differences, with a sample of outpatient treatment-seeking individuals suffering from comorbid PTSD and alcohol dependence, suggest that the link between PTSD and SUD may be particularly salient for women (Sonne, et. al., 2003). Studies show that women in substance abuse treatment programs report higher rates of PTSD than men in treatment programs. Information gathered from a National Comorbidity Study (NCS; Kessler et al., 1995) showed that women (26%) were more than twice more likely to have PTSD at some point in their lives than men (10%). The study also reported that women (10.4%) were more than twice as likely overall as men (5%) to have lifetime histories of PTSD, while 35% of men and 18% of women met criteria for SUD. More specifically, more than half (52%) of men and 28% of women with PTSD met criteria for lifetime alcohol abuse or dependence while 34.5% of men and 27 % of women met criteria for drug abuse or dependence. In a study comparing cocaine-dependent men and women, Najavits and Lester (2008) found that women had greater family/socioeconomic problems, three times the rate of PTSD, and twice the rate of any anxiety disorder, compared to men; whereas, in earlier studies (Najavits, Gastfriend et al., 1998) it was found that women with cocaine-dependence had two times the rate of PTSD. This comparative increase may indicate that PTSD symptoms are now being recognized and diagnosed more accurately.

Studies also show a high prevalence of PTSD in individuals who seek treatment for SUD; however, PTSD symptoms failed to remit in somewhat more than one third of persons with or without treatment (Kessler et al., 1995). Interestingly, PTSD is more common in women who seek treatment for SUDs than in men. Najavits, Weiss, and Shaw (1997) report that 33 to 59% of women and 12 to 34% of men registered in substance abuse treatment programs have current PTSD. According to Dahlgren and Willander (1989) treatment provided for men is not as effective for women; therefore, establishing effective assessment and treatment strategies for women is critical. Najavits & Lester (2008) also found that women were more positively engaged with treatment than men, and had more positive attitudes and greater expectations for treatment success (a major finding, considering that treatment outcome is so linked with perceived credibility of treatment). Recent studies that addressed gender-specific needs showed more positive outcomes than traditional treatment (Morissey et al., 2005; Gatz et al, 2007).

Risk factors for women and girls. Epidemiological evidence shows a high historical prevalence of trauma among women in substance abuse treatment (Clark & Power, 2005). Traumatic events reported among individuals with PTSD and SUD are typically interpersonal and are generally violent in nature. Childhood abuse has been recognized as an important predictor of adult dysfunctional behaviour, including substance abuse (Najavits, Weiss, & Shaw, 1997, 1999; Najavits, Weiss, Shaw, & Muenz, 1998; Sacks, McKendrick, & Banks, 2008). Patients in treatment for PTSD and SUD report histories of childhood abuse that include emotional and physical neglect or abuse, rape or other sexual assault, robbery, witnessing domestic violence, death of a loved one due to homicide, and unhealthy environments (Najavits, Weiss, & Shaw, 1997) . Overall, physical, emotional and/or sexual abuse are reported to be the most common forms of trauma in the life histories of women who enter substance abuse

treatment (Clark & Power, 2005; McHugo et al., 2005; Brady et al., 2004). Specific personality profiles (i.e., Anxiety Sensitivity (AS); Hopelessness ((H) and Sensation Seeking (SS)) have been identified as behavioural-trait risk markers for development of substance misuse for women (Conrad, Pihl, Steward, & Dongier, 2000a; Comeau et al., 2005; Mushquash, Comeau, McLeod, & Stewart, 2010)

Characteristics of women and girls with dual diagnosis. The abuse of substances is often linked to experiences of trauma, violence, and abuse among aboriginal girls. It is also important to acknowledge the health consequences of substance abuse among youth. Adolescence is a time when the brain and hormones go through a maturation process (Poole & Dell, 1005). Adolescent girls have higher rates of depression than adolescent boys. The abuse of alcohol and drugs can seriously compromise bone health, sexual/reproductive health, brain functioning, and pregnancy, i.e., risk of having a child affected by Fetal Alcohol Spectrum Disorder (FASD; British Columbia Center of Excellence for Women's Health, 2010; British Columbia Ministry of Health Services, 2004).

Research results indicate that women with dual diagnoses represent a more impaired population, with clinical profiles that are greater in severity and have worse treatment prognoses than women with PTSD alone, or SUD alone (Back, et. al., 2003; Brady, et. al., 1994; Najavits, Weiss, & Shaw, et al., 1997, 1999; Ouimette, Brown, & Najavits, 1998). Over their lifetimes, women often report experiencing multiple traumatic events (Brady et al., 2004). The more severe the trauma, the greater the likelihood of developing a substance abuse disorder (Najavits, Weiss, & Shaw, 1999). Those who suffer from PTSD are thought to experience greater levels of negative emotional intensity and more emotional dysregulation (Najavitis, Weiss, & Liese, 1996); therefore, substances may be used as a way to relieve the pain associated with the

negative emotions, which can lead to greater social impairment. Results of studies also indicate that interpersonal violence disproportionately affects women (Clark & Power, 2005). In addition, according to Browne and Bassuk (1997), Brier and Eliott (2003), and Scher, Forde, McQuaid, and Stein (2004), homeless women experience much higher incidence of sexual, physical, or emotional abuse than women in the general population. Unfortunately, homeless addicted women are less likely to respond to existing residential substance abuse treatment programs.

Gender Sensitive Treatment for Women. Increased attention is being brought to specialized treatment for substance abuse by women and girls and the associated consequences. The gender gap in substance use is closing as young women are engaging in using alcohol, illicit drugs and cigarette smoking equalling or surpassing rates of young men; however, the consequences for such behaviour are more serious for young women. Girls experience higher rates of depression and trauma, body image distortions, and increased risk for pregnancy (Poole & Dell, 2005).

Support is a key factor in recovery for young women; particularly connecting with other girls and caring adults (British Columbia Centre of Excellence for Women's Health, 2010). Adolescence represents a critical period for intervention due to high rates of substance use and risk of developing long-term substance use problems. Early intervention and treatment initiatives for those with high-risk factors are critical (British Columbia Ministry of Health Services, 2004). Moreover, the need for specialized women- centered treatment has been highlighted in national initiatives in the U.S. and Canada and responses need to be tailored to address the specific needs of women (National Centre on Addiction and Substance Use at Columbia University; 2003).

Persons of Aboriginal Descent

The term *First Nations* refers to aboriginal people who identify themselves as descendants of the first inhabitants of Canada (Callighan, Cull, Vettese, & Taylor, 2006) and report being members of Indian Bands or First Nations of Canada (Statistics Canada, 2001). The term *Métis* refers to Aboriginal persons with mixed First Nations and European ancestry (Callighan et al., DATE?).

According to data from the 2001 Census (Statistics Canada), the percentage of Aboriginal people in Canada is on the rise, with just over 1.3 million people reported as having at least some Aboriginal ancestry, representing 4.4 % of the total population. Within British Columbia, the population reporting Aboriginal identity in the 2001 report consisted of 170,025 (17.4% of the total aboriginal population in Canada), which is the second highest Aboriginal population for a Canadian province. Of the 170,025 Aboriginal people in British Columbia, 86,805 were women.

Health status of Aboriginal women is of particular concern. Within their communities, these women experience high rates of sexual and physical violence, both as precursors to, and consequences of, alcohol and drug involvement (Redgrave, Swatz, & Romanoski, 2003). Aboriginal and First Nations peoples in BC are overrepresented in mortality and morbidity rates connected to problematic substance use involving both alcohol and illegal drug use (BC Provincial Health Officer, 2002). Trauma and addiction have been linked to experiences of colonization from which many are self-medicating. Many aboriginal women are exposed to increased rates of violence and associated trauma. Aboriginal women are disproportionately affected by family violence, sexual harassment, inequality, discrimination, single parenting and poverty (Dell & Lyons, 2007). Women whose childhood histories include sexual assault are significantly more likely than women without these histories to report substance misuse, as well

as depression, anxiety, and other mental health problems. Research has shown that there is a high correlation between trauma, PSTD, and substance use and misuse (Redgrave, Swatz, & Romanoski, 2003).

Aboriginal youth. The prevalence of substance abuse (used as a coping mechanism) in First Nations communities is higher than in non-aboriginal communities. Aboriginal youth are at higher risk of mortality as a result of illicit drug use and related health issues than their non-aboriginal peers (Ministry of Health Services, Ministry of Children and Family Development, 2010, Wardman & Quantz, 2006). Many Aboriginal communities have succeeded in preventing or reducing substance use problems among their people by way of community-wide, culturally-based solutions; however, the issue of prevention and treatment continues to present a considerable challenge in most communities. For example, there is significant diversity in British Columbia's First Nation communities; each having their own distinct cultural and traditional health practices (Wardman & Quantz). Many aboriginal communities follow an abstinence-based approach (BC Harm Reduction Strategies and Services, 2010), and are uncomfortable with a harm reduction model due to its incompatibility with cultural values (Dell & Lyons, 2007).

Residential Treatment

The Canadian Center on Substance Abuse (2003) released a report based on an extensive/in-depth literature review pertaining to residential programs for youth with substance abuse problems. The report is based on a review of literature, interviews, and other material from both non-empirical and empirical evaluations (anecdotal or uncontrolled studies). They identified several arguments in favour of residential treatment: (1) detoxification in a protective, drug-free environment; (2) respite for family; (3) opportunity to focus of recovery issues free

from distractions and temptations from family members and peers; (4) intense exposure to positive role models (staff and other youth in recovery); (5) an efficient way of serving clients with special needs; (6) provision of intensive services; (8) social milieu therapy benefits that can enforce attitudes and behaviours conducive to recovery. A safe and secure treatment environment that incorporates traditional spiritual beliefs and practices is identified as an important factor for treatment retention.

Substance Abuse Treatment Approaches

Abstinence has, in the past, often been associated with the "moral model" which holds people individually responsible for their behavioural choices, whether good or bad. Those with bad habits are labelled "bad persons who should be punished". Under this model, people with addictions are often stigmatized and demoralized by feelings of self-blame, shame, and guilt (Brickman, et al., 1982). Another view holds that addiction is a disease caused by genetic and biological factors that are beyond the individual's control; thereby, releasing individuals from morally responsibility for their bad behaviours. The US National Institute of Drug Abuse has officially designated addiction as "a disease of the brain". This model is endorsed by the AA 12-step recovery movement (Cook, 1988). A third approach recognizes a complex set of determinants that impact addictive behaviour. This is the harm reduction model (Marlatt & Witkiewitz, 2010). The authors of this model accept and work with individual differences in client characteristics, and offer individuals choices in self-management, treatment, and recovery. The goal is to reduce problem consequences associated with use of substances.

Illicit drug use is complex and difficult, contributing greatly to human suffering while at the same time carrying a large cost to society. A great deal of effort has been employed in developing an effective intervention model to lessen the impact. According to the literature,

harm reduction has gained an increasing presence in the addictions field and has become the predominant philosophy in addictions treatment, and in other areas of public health (Marlatt & Witkiewitz, 2010; Witkiewitz & Marlatt, 2006; Poulin, 2006). Harm reduction is rooted in the principles of pragmatism and humanism. It is a non-moralistic, non-judgemental response in which the dignity and rights of users are respected (i.e., no guilt or shame). Harm reduction offers users choices regarding how they will minimize harms to themselves. Individuals are encouraged to participate and negotiate their own treatment options, which may or may not include abstinence. Harm reduction emerged as a significant paradigm in the early 1980's, and has since been adopted by the World Health Organization, the Joint United Nations (U.N.), the Red Cross, and the World Bank (Ritter & Cameron, 2006; Wodak, 2009).

According to BC Health Services, Ministry of Children and Family Development (2010), harm reduction delivers superior treatment outcomes to policies of zero tolerance and abstinence. The British Columbia Government has recently proposed adoption of a harm reduction model whereby treatments that incorporate harm-reduction will be more likely to receive funding than other programs. In this paper, the author examines the merits and demerits of the BC government's thrust toward adopting a blanket harm reduction policy. The concern is that this policy may be forcefully applied to *all* treatment communities, limiting the range or choice of alternative treatment options (i.e., abstinence-based models). Will restrictive rules be placed on the types of treatment options provided by treatment providers, including residential treatment centers? If so, is that practice justified based on research literature and First Nations policies?

Relevant Definitions

Harm reduction is difficult to define and lends itself to competing descriptions as it refers to both a philosophical approach and specific types of programmes or interventions (Ritter & Cameron, 2006). Several terms have emerged in the literature:

Harm reducing. Any approach intended to reduce the harms related to drug use, including reduction in the use of drugs and alcohol.

Harm minimization. An approach intended to minimize drug-related harmful consequences via supply reduction, demand reduction, and harm reduction.

Harm reduction. An approach intended to reduce the risks and consequences (health and social harms) associated with substance abuse, without requiring reductions in drug & alcohol use. This approach is offered as an alternative to abstinence for individuals who are unwilling or unable to completely stop using substances. A collaborative approach is proposed, based on principles of willingness of treatment providers to collaborate with clients (under their terms) for reducing the harmful consequences of drug and alcohol use. Abstinence is viewed as one option among many, to reduce the health and social harms associated with alcohol and drug use.

Abstinence. Refraining from drug use or (particularly) from drinking alcoholic beverages, whether as a matter of principle or for other reasons. Those who practise abstinence from alcohol are termed "abstainers", "total abstainers", or-in a more old-fashioned formulation- "teetotallers". The term "current abstainer", often used in population surveys, and is usually defined as “a person who has not drunk an alcoholic beverage in the preceding 12 months; this definition does not necessarily coincide with a respondent's self-description as an abstainer”. For some people, abstinence is the best and only way to reduce harms. As stated within the document harm reduction does not exclude abstinence as an ultimate goal (p. 15).

Harm Reduction Strategies

Harm reduction strategies involve needle/syringe exchange programs, safe injection facilities, drug substitution programs such as methadone treatment for opiate users, advertising campaigns (Lennings, 2000). According to Lennings, heroin users on methadone treatment has stimulated the use of other opiates and drugs such as crack cocaine, indicating that free methadone treatment releases funds to buy other drugs. Harm reduction services in Aboriginal communities includes supply management (i.e. limiting supply; control of hours of sale, product and (volume), regulated consumption; managing alcohol consumption (consume in managed doses); safer spaces (places where consumption can take place with reduced risk (supervised injection facilities); Injection Drug Use-Related Services (IDU) (i.e. for HIV transmission, needle exchange programs, supervised injection facilities, methadone maintenance and anonymous HIV/AIDS testing) (Dell & Lyons, 2007).

Dilemmas in Adopting Policies

Supply control, demand reduction, and *harm reduction* result in both harms and benefits. For example, *supply control* is intended to reduce the availability of illicit drugs for the purpose of eradicating the cultivation of plants used to produce supply for drug trafficking. Harm reducing potential includes: limiting the scale of availability, price, and overdose. *Demand reduction* involves early prevention and intervention strategies, treatment and rehabilitation programs and reduction of health consequences. The dilemma is in the efficiency and cost effectiveness of such strategies (Weatherburn, 2008).

Alcohol and drugs have been a destructive influence in the lives of many Aboriginal communities. The forced loss of language, culture, land, tradition and identity has resulted in mental health and addiction problems for many. Restoration of balance to the four aspects of

humanity (mental, emotional, physical, and spiritual) is integral for aboriginal healing (Mussel, Cardiff, & White, 2004). Should harm reduction be the only solution to this very serious concern? Some First Nations communities state that harm reductions practices go against their customs, beliefs and traditions, arguing that the use of alcohol and drugs causes people to live "out of balance". Both harm reduction and abstinence have a common goal of helping people ultimately achieve abstinence from the use of harmful substances. It is in the best interest of governments to respect the traditional views of each community, and their need to identify what practice or strategy best fits their philosophy and values. Historically most Aboriginal communities supported abstinence-based approaches because of the devastating impact addiction had on their communities. Respecting Aboriginal people and their culture can enhance their social and economic well-being. It is up to each community to decide based on their experience and needs and the government to accept their choice (Dell, 2008).

Harm Reduction As It Is Applied to Youth

High rates of substance use exist among the youth population (Poulin, 2006). According to Ministry of Health Services, Ministry of Children and Family Development (2010) adolescents and young adults are at higher risk because of greater experimentation which can lead to problems related to substance use and mental health issues. The prevalence and risk associated with substance use among adolescents' increases with increasing grade. By grade 12, about 80% of adolescent students had consumed alcohol and more than 40% had consumed cannabis during the course of the year (Poulin, 2006). Furthermore, there is limited evidence for the effectiveness of drug prevention and treatment approaches for adolescents with substance abuse problems and rigorous research in this area is lacking (Leslie, 2008; Poulin, 2006).

By 2011, the BC government proposes to have, in place, provincial standards and guidelines for publicly funded youth and adult residential substance-use programs based on evidence based treatment options. This will include abstinence based programs as well as those based on harm reduction (Ministry of Health Services, Ministry of Children and Family Development, 2010, pg 33 & 34).

Ethical issues in adapting harm reduction to youth. Harm Reduction is defined the same when applied to both adults and youth populations (Poulin, 2006). This poses some possible ethical concerns. Poulin points out three main issues related to youth: (1) Canada's laws concerning those who are under the legal age whereby the autonomy and ability of youth to make wise decisions and generate alternatives concerning substance is decided for them. Youth over a certain age are considered qualified to make informed decisions however, youth under a certain age are not. Under this law, one could argue that offering harm reduction to a youth population as a whole presents controversial ethical concerns regarding underage youth and their decision making capacity; (2) Youth may not acknowledge some risks and harms associated with youth substance use to be problematic in the same way that adults do; 3) To what extent has research shown that harms experienced by youth populations have actually been reduced as a result of harm reduction policies and programs? According to Poulin, there is little evidence about the benefits of harm reduction or a universal harm reduction policy in all contexts targeting under-aged youth. Poulin further states that after reviewing the literature, there remains a gap in evidence needed to support a shift toward a universal harm reduction policy targeting youth. Some of the questions raised about the effectiveness of harm reduction include: how does one measure qualitatively different types of harm? If harm is reduced toward users, how do we know that it has also been reduced to everyone else? What kinds of trade-offs are involved (Leshner,

2008). These questions have attracted little scholarly attention (Weatherburn 2008). According to Marlatt & Witkiewitz (2010), harm reduction strategies are best individualized according to the needs and wants of the individual or community, suggesting that a universal harm reduction program would not be possible or suitable for all. Furthermore, appropriate goals can be tailored to meet the needs of individuals, whether they are oriented toward abstinence or not (Poulin, 2006). Although there are existing, established harm reduction programs available to Aboriginal people, research and evaluation demonstrating methodological-sound and culturally appropriate effectiveness is still needed (Dell & Lyons, 2007).

Questions of concern. How does one measure qualitatively different types of harm? If harm is reduced toward users, how do we know that it has also been reduced to everyone else? What kinds of trade-offs are involved (Leshner, 2008). These questions have attracted little scholarly attention (Weatherburn 2008). According to Marlatt & Witkiewitz (2010), harm reduction strategies are best individualized according to the needs and wants of the individual or community, suggesting that a universal or one size fits all harm reduction program would not be possible or suitable for all. Furthermore, appropriate goals can be tailored to meet the needs of individuals, whether they are oriented toward abstinence or not (Poulin, 2006).

Programs that adopt the *harm reduction* model must provide sufficient evidence for its effectiveness for reducing harm to both the substance abuser as well as the general public. Unfortunately, there are no practical means of measuring many of the harms associated with substance abuse (Weatherburn, 2008).

Harm reduction for youth is controversial. The situation regarding under-aged youth poses a difficult challenge to those who have a duty to care for them. For example, the decision about the appropriateness of harm reduction as a basis of policies and programs targeting youth

may hinge on the strength of the evidence about the effectiveness of the approach. Evidence of the effectiveness of harm reduction interventions is essential in order to arrive at an evidence-informed decision. Furthermore, evidence for harm reduction in a youth population must confirm a sufficiently large enough effect size that the benefit of the harm reduction approach outweighs an abstinence approach without compromising the safety of youth. Empirical literature and a scan of the internet websites of addictions agencies in Canada reveal little information about the ability of harm reduction interventions to actually reduce substance related harm or the risk of harm to youth (Poulin, 2006).

The Criminal Code of Canada identifies young persons as a vulnerable sub-group of the population, whereby the law embeds abstinence as a correct stance toward alcohol and other drug use. In fact, it is a criminal offence to possess, produce or sell cannabis in Canada regardless of age, and various provincial laws prohibit public intoxication, possession of alcohol by a minor, and sale of alcohol to a minor (age 19 in the province of BC). Furthermore, the United Nations Convention on the Rights of the Child, ratified by Canada in 1990, stresses the notion that a child's rights be in accordance with age, maturity and evolving capacity within the context of parental responsibility, community involvement, local customs, and legal constraints (Poulin, 2006). Therefore, is it reasonable to consider that youth with addictions possess the emotional and intellectual maturity to be engaged in self management, and capable of making well-reasoned, viable and informed harm reduction choices? Do we assume that adolescents are capable of making informed choices about what they need, and that we should let them make such decisions?

The effectiveness of drug prevention education aimed toward youth has been repeatedly shown to be minimal (Poulin, 2006). A barrier to harm reduction in schools is that

administrators (may result in legal challenges) have a duty of care toward the student body and accountability to parents. Formal school board policies support abstinence as a goal. Harm reduction as a universal intervention targeting under-aged youth should be informed by the legal and policy constrains placed on schools and school boards (Poulin, 2006). Would this not be the same for treatment centers who provide services to under aged youth?

Vancouver Four Pillar Drug Strategy. The BC government's provincial policy on harm reduction best practices and supply distribution are guided by the BC Harm Reduction Strategies and Services (HRSS) committee. Under the "BC Harm Reduction Strategy", the BC government has established what is called the "Four Pillar Drug Approach", a substance abuse treatment strategy that involves the cooperative efforts of five BC regional health authorities, BC Centre for Disease Control, BC Ministry of Healthy Living and Sport, and First Nations and Inuit Health. The four pillars drug approach includes: (1) prevention, (2) treatment, (3) harm reduction and (4) enforcement. HRSS policy states that, each health authority and its community partners must work together to provide a full range of harm reduction services within their respective jurisdictions, including access to supplies and referrals to health care, mental health, addictions, and other relevant community services. The BC government asks that all community partners work together to provide a full range of harm reduction services within their respective jurisdictions whereby harm reduction supplies should be available to whoever needs them, regardless of the person's age, drug-using status, drug of choice, or residence (Harm Reduction Strategies and Services Policy and Guidelines, 2009). This policy serves diverse and often marginalized populations. In line with the BC government's policy, the Fraser Mental Health and Addiction Services promotes a harm reduction framework within its region.

British Columbia policy recommends consulting with community partners in order to monitor implementation and adjust course of action if needed. "If there are changes in the community or larger policy, funding or service delivery context, course corrections may be needed to ensure the strategy remains relevant and responsive to local concerns" (BC Centre for Disease Control, Harm Reduction Strategies and Services Policy and Guidelines, 2009, p. 17).

Analytical Process

Critical systems heuristics. Critical Systems Heuristics (CSH) is a philosophical framework rooted in systems thinking, designed by Werner Ulrich that supports a systemic process of boundary critique (Ulrich, 1983; 1987; 1996; 2005). It can be used to connect reflective practice, critical thinking and rational argument to the process of policy evaluation as a means to provide options and improvements that arise between opposing viewpoints. Systems boundaries provide a conceptual framework for dealing with facts and values that underlie a decision particularly around who should benefit and what should count as relevant sources of expertise. To this end, CSH offers a framework of boundary categories with a checklist of twelve boundary questions as guidelines for identifying solution strategies to problems that arise offering those involved or affected (various stakeholders, including those excluded or marginalized), those who feel their concerns have not been adequately addressed an opportunity to challenge the assumptions and voice their concerns (emancipatory boundary critique). For example, which groups of people and types of information have been considered relevant to the decision and which have been considered irrelevant and thus excluded or marginalized.

For the purposes of this analysis, its procedures will serve to identify and explore relevant problem aspects, questions, or solution strategies (what kind of change might represent an

improvement) to existing policies involving addictions treatment for Aboriginal youth in British Columbia.

Policy decisions surrounding the use of harm reduction as a philosophy for addressing treatment of addictions appears to be the dominant paradigm for addictions treatment in British Columbia. Criticisms have arisen that Government authorities refuse to fund treatment facilities that adhere to an abstinence-only based approach. In response to Fraser Health's refusal to fund Spirit Bear Center, the director has initiated a review of the current policies for addiction treatment in British Columbia.

Although the Government's initiatives go some way towards addressing the concerns that have been expressed by various groups, there are still criticisms that they are overlooking the needs and concerns of certain cultural groups. One criticism is that the current policy is not sufficiently inclusive of groups whose values and world view fit an alternative treatment approach.

The guidelines provided by this model provide an analytical focus and practical tool for examining the existing policy decision by the BC government pertaining to their choice to not fund Spirit Bear's abstinence only based treatment facility. The director of Spirit Bear feels that her concerns have not been adequately addressed and is seeking an opportunity to challenge the assumptions around this decision and an opportunity to voice her concerns. For the purposes of this analysis, its procedures serve to identify and explore relevant problem aspects, questions, and solution strategies to propose changes that might represent an improvement to existing policies involving addictions treatment for Aboriginal female youth in British Columbia.

Policy decisions surrounding the use of harm reduction as a philosophy for addressing treatment of addictions appears to be the dominant philosophical paradigm. However, based on

considerations like those noted earlier [in section 4.1], criticisms have arisen because Government authorities refused to fund treatment facilities/programming that employ alternative models such as abstinence only based approaches.

In response to the government's (Fraser Health / Youth Mental Health & Addictions; Health Canada / Per Diem Rates for Mental Health & Addictions) refusal to fund Spirit Bear Center, the director has initiated a review of the current policies for addiction treatment in British Columbia. This review is conducted with the intent of renegotiating funding arrangements for the distinctive programming offered through Spirit Bear Center. Policy review enables decision makers to systematically assess effectiveness and impact of policy and implantation decisions. The course of action being reviewed is the refusal to fund abstinence based only programming for residential addictions treatment for female Aboriginal adolescents. The following questions provide a map for identifying solution strategies:

Critical Systems Heuristic (Lucket, 2006; Ulrich, & Reynolds, 2010)

Four social roles:

A. The 'stakeholder/client' role

Sources of Motivation:

1. Who is the policy's client, and whose interests are being served?'

- With respect to this policy review, the stakeholder is: *Lynn Ned, Director of Spirit Bear Center,* Those whose interests are being served (clients): female adolescent aboriginal girls who receive the services; residential treatment; the aboriginal community is involved through Spirit Bear Center; the Program Director of Spirit Bear Center *(Lynn Ned);* all support staff, and therapists (*nursing staff, counsellors, teaching staff*); and the funders.

2. Principle concern: to establish the policy's purpose and its potential consequences.

   What is the policy's purpose? What are the potential consequences?

   The principle concern is whether the policy supports the Aboriginal services priorities. The community within which it functions (The Aboriginal Community).

   - According to the Tripartite First Nations Health Plan (2006), all parties (First nations Leadership Council, the Government of Canada and Government of British Columbia); agreed to a comprehensive health plan that involves working partnerships with governments and health services providers. All agreed that delivery of services must effectively meet the needs, priorities and interests of First Nations communities and individuals, while recognizes the fundamental importance of community solutions and approaches. The Tripartite First Nations Health Plan stresses the importance of establishing mutual respect and fiduciary relationships and responsibility to remove obstacles in the design and delivery of health programs and services to First Nations communities. First Nations and existing governments acknowledge that participation of all parties is required in order to improve First Nations' health outcomes. According to the First Nations Health Plan Memorandum of Understanding outlined in 2006, the parties have agreed to collaborate and increase the involvement of First Nations in decision making concerning the best services for First nations so that services are best aligned with the needs of the community. That the parties will work together to improve health outcomes by providing equitable access to health services that meet the needs of the community and to ensure the services are culturally sensitive, that First Nations are fully involved in decision-making regarding the

health of their people (Tripartite First Nations Health Plan). That Health services delivered by First Nations be coordinated with provincially-funded services, such as those provided by the regional health authorities. Thus, the most effective addictions intervention programming for Aboriginal people is grounded in the wisdom of traditional cultural knowledge that involves a holistic approach to health and healing. Aboriginal belief systems have much to teach about recovery and the restoration of balance. Although the Government's initiatives go some way towards addressing the concerns that have been expressed by various groups, there are still criticisms that they are overlooking the needs and concerns of certain groups. One criticism is that the current policy is not sufficiently inclusive of First Nations groups whose values and world view fit an abstinence based treatment approach. As stated in [section 4.1] MCFD is committed to support the developments of policy and practice interventions in a flexible manner that responds to different conditions, among Aboriginal communities along with Aboriginal delivery of services to their own children.

3. The key problem: What is the policy's measure of improvement? How is what constitutes an improvement decided and by whom? Is the program working towards improving health status?
    - The current stand on addictions recovery via harm reduction is being enforced by Fraser Health to all service providers, limiting the range or choice of alternative healing options (i.e. abstinence-based models) for funding requirements. When applying for government health funds toward residential addiction intervention programs, restrictive rules are being placed on the type of intervention options

provided by service providers. Increasing evidence shows that when governments and local Aboriginal communities work together to establish more collaborative practices and policies that reflect the values of specific communities, success stories of recovery are more likely. This occurs because programs are more relevant for Aboriginal people within these communities.

B. The 'decision-maker' role

Sources of Power:

1. What is basis of power and sources of control (i.e. who is the decision-maker, and who is in a position to change the policy's measure of improvement)? (I don't have an answer for this yet).

a. What is the basis of power and sources of control? Who is the decision-maker, and who is in the position to change the policy's measure of improvement?

- Those who hold the power to make decisions regarding funding distribution and policy decisions include: Government departments, and funding agencies. As reviewed above, community leaders in Aboriginal communities are in good position to inform and improve the policy's measure of improvement.

2. The principle concern/problem of the decision-maker is resources (what resources and other conditions of success are controlled by the decision-maker.

- Government Health Authorities (Fraser Health; Health Canada), stakeholders and community service providers are partners in the delivery of funding resources. Spirit Bear center can serve as a joint partner in the decision making process. Their role is to balance societal and individual interests and to be accountable for

their decisions. It is in the best interest of Government to consult with service providers. Governments should be aware of the full range of dimensions of concern; therefore, consulting with Addiction service Providers as a collaborative process.

C. The Expert Role

Sources of Knowledge:

1. What is the policies basis and source of knowledge? (Who is involved as planner or expert; who is considered competent to participate in the drawing up of the policy?)
2. On what expertise does the policy rely?
    - This would include the research base on harm reduction and the voices of those considered experts in the field. Expertise in the well-being of aboriginal youth draws upon traditional knowledge available in aboriginal communities and their leadership [as well as the broader health and human services system]. This includes selection of resources from mainstream health systems as well as drawing upon traditional practices.
    - Through enforcing their existing position, whereby funding will only be granted to those agencies who provide harm reduction services, the BC Government is essentially saying that harm reduction is better than abstinence all the time, for every group.
3. What is the guarantee that the policy will be implemented and will work?
    - There is no guarantee that the policy will work.

D. The ‘affected’ role or ‘witnesses’ role (those who can bear witness to the concerns of those who don’t have a voice).

The Sources of Legitimation:

1. Answers the question: Who is witness to the interests of those affected but not directly involved? Who is affected by it and on whom might the policy impose undesirable risks, costs and consequences? These questions are intended to uncover the policy's ethical assumptions and deficiencies with respect to who is affected by it (see section entitled "Ethical Issues in Adapting Harm Reduction to Youth"). Legitimation - resources with partnerships of communities that are respected and policy reflecting 'Best Practices" that allow complementary approaches in this domain – emancipator principles of guidance (Ulrich, 2010, p. 279)
    - Urban Native Youth Association (UNYA) is a registered not-for-profit society with the Province of BC and a federally registered charitable organization. UNYA was formed in 1988 to address Native youth issues when growing numbers of young people began leaving reserves for the city. Young Bears' Lodge is a co-ed residential program offered through UNYA to Aboriginal youth aged 13 - 18 by providing a culturally based empowerment program with an alcohol and drug focus.
    - A program evaluation is currently underway by University of the Fraser Valley.
2. The principle concern for the witness to the affected role is, 'to what extent are those affected given the chance of emancipation from the premises and promises of those involved?
    - British Columbia policy recommends consulting with community partners in order to monitor implementation and adjust course of action if needed. "If

there are changes in the community or larger policy, funding or service delivery context, course corrections may be needed to ensure the strategy remains relevant and responsive to local concerns" (p. 17). This statement provides some indication that the BC Government is amenable to making corrections to in response to concerns raised by agencies such as Spirit Bear Center.

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