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National Native Addictions Partnership Foundation Inc.

FNI-CERP

(First Nations and Inuit Community Emergency Response Program)

A Program Model to Address Child & Youth Substance Abuse Crises

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Revised, Working Draft: Prepared For Discussion Purposes Only

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Table of Contents

List of Figures

1.0 INTRODUCTION

This report describes a plausible model for a multi-level crisis intervention program to address those group substance abuse patterns that severely threaten the health, safety and even lives of children and youth in First Nations and Inuit communities. Through a partnership with their families, communities, areas and regions, the program would work remedially with the children and youth to facilitate positive change and healthy lifestyles. Managed and delivered by First Nations' and Inuit representatives, the model proposed would be referred to as the *First Nations and Inuit Community Emergency Response Program* or *FNI-CERP*.

The model would combine specific, new program elements with existing resources. Those resources are available through the National Youth Solvent Abuse Program (NYSAP) and its Youth Solvent Abuse Centres (the "YSAC Network") and the National Native Alcohol and Drug Abuse Program (NNADAP) through its community programs and treatment centres.

The model would establish a national program resource reporting to the National Native Addictions Partnership Foundation. The national program component would directly link four spheres of input: a centralized program resource; the resources of regional partners; a sub-regional or area support and organizational capacity; and a local crisis prevention, monitoring and emergency response capacity.

The nationally centralized component of the partnership-based program would be referred to colloquially as "CERP." Its basic functions would be to provide a highly skilled, mobile intervention and skill transfer capacity, and a small special needs support program.

The secondary but no less significant function of the initiative is to draw upon and further develop the capacity of the existing, dedicated First Nations and Inuit addictions and community health service network. It is fundamental to the basic program concept that FNI-CERP would have direct regional participation on its intervention team, and would facilitate the development of a fully capable regional crisis management capacity within ten years of program start-up. In short, through its own efforts at capacity-building in the regions, FNI-CERP would work itself out of a job, with regional, area and local NNADAP and YSAC services undertaking all direct crisis delivery services focussed on children and youth.

Through this working relationship, local capacities to monitor, prevent and overcome high risk substance abuse activities would be enhanced. Rather than establishing another, long-term dependence on external expertise, the emphasis in the proposed program model is on building sustainable, local, problem-solving capacities and community self-reliance.

Mobile Intervention Would Be at the Core of the Program

The proposed program centres on a *mobile intervention capacity* that would potentially provide service coverage to any First Nation in Canada. The program would be designed to address protective, immediate responses to emergency situations in communities lacking the

local resources to adequately respond to such crises. Initially work is undertaken with local advisors and front-line workers to ensure that the health and safety needs of the children and youth involved are met. Subsequently critical incident debriefing is undertaken and a stabilization process is engaged. The next stage of the process involves intensive intervention (the "Intermediate Phase"). Following the period of intensive healing, a long-term prevention and relapse prevention process can be facilitated.

During the Intensive Intervention Stage, the Resiliency of Children, Families and Communities Would be the Primary Focus

All too often, the "helping professions" have discussed and treated First Nations and Inuit people as being characterized, as a group, by "social problems" or, individually, as having "disordered personalities" or being "diseased" by addiction. Yet there is a growing literature that is making it clear that the solutions of people and groups with significant disadvantages lies in drawing upon family, community and personal strengths. The CERP approach is consistent with that recent literature, which essentially encourages an adaptation of effective, traditional practices to the realities of today. It does so by emphasizing and utilizing the positive, no matter how difficult that may sometimes be, and by re-establishing the fundamental, traditional principles of personal development and healing from the past.

CERP would Also be Guided by the Belief that Effective Solutions Should Not Focus exclusively on the Child or Youth; Instead, the Family as a Whole Should be the Primary Focus of Healing Processes

The program would be based on the belief that, while both the difficulties and the problem-solving abilities of individual children and youth are distinctive, much of their thinking and behaviour is intrinsically bound up with the needs and strengths of their families. For this reason, not only would the CERP interventions focus on the child or youth but they would work with and engage the strengths and assets of the families, even if the parents in those families may at times have needs as profound as the child or youth involved in high-risk substance abuse activities.

Change in the Mutual Relations Between the Child And the Family and the Formal and Informal Networks in the Community Must Also Often Be Facilitated

While it is true that some families are quite isolated and that very isolation can pose problems for overcoming the difficulties experienced by their dependent children, the family never lives in a complete vacuum: It is connected to informal social networks, including distant relatives, friends and acquaintances, as well as being connected, in various ways, to the education system and various people-serving agencies within or near the community of residence. Further, even if the family is isolated, the child or youth involved in a group substance abuse crisis is, by definition, profoundly implicated in influential peer relations.

As with the individual child or youth and his/her family, these social networks have weaknesses and may be contributing to the crisis; they also have within them the potential for supporting the recovery of children, youth and families from substance abuse and its effects, and for actively promoting healthy lifestyles. Consequently, CERP would also attempt to work directly with the formal and informal networks in the community to jointly facilitate and support positive change.

1.1 OVERVIEW OF REPORT

This document describes a formal Emergency Response Program that could be established as a means of filling present gaps in current responses to child and youth substance abuse crises in First Nations and Inuit communities. The program would be developed as a partnership between the National Native Addictions Partnership Foundation Inc., its regional, area, local and institutional partners (i.e., treatment centres), and the Federal and, in some cases, Provincial and Territorial Governments.

The proposed program would primarily respond to situations in which either (a) a unique set of circumstances or (b) an influential group are frequently placing children or youth at unacceptably high health risk levels as a result of abusing one or a number of mood- and behaviour-modifying substances.

The most fundamental goal of the First Nations and Inuit Community Emergency Response Program (referred to as "FNI-CERP" or, for convenience sake, simply "CERP") would be to assist First Nations and Inuit communities with their efforts to prevent and overcome group-influenced substance abuse crises among children and youth. As indicated above, that assistance focuses on not only emergency, protective intervention, but also on the building of personal, family and community capacities through an intensive, highly disciplined skill-development transfer process.

With its central, national functions organized, managed and operated by the National Native Addictions Partnership Foundation, Inc., the program would directly provide assessment, protection planning, therapeutic intervention, training, and community organization planning assistance to communities. When specific criteria are met, the program would also provide indirect support in the form of financial assistance for a community to secure long-term technical assistance or moveable capital assets.

1.2 PURPOSE OF THE DOCUMENT

The purpose of this document is for NNAPF Inc. to provide Health Canada, First Nations and Inuit communities and health organizations, and other interested partners with a description of how FNI-CERP would operate.

It should be emphasized that this document does not provide comprehensive detail about program operations. It can be anticipated that the demands created by local circumstances

would tend to vary significantly, thus defying attempts to craft any program with too much in the way of standardization and detail: Flexibility is essential, if the *real*, often distinctive needs of situations confronted by communities, families and children and youth facing substance abuse crises are to be adequately met.

There is another reason for not providing too much detail. The model described in this document was developed in recognition that, for a new intervention strategy to work, those who must implement the strategy "on the ground" must learn its details in great depth, become comfortable with it, take possession of its philosophy and principles and acquire and continually develop and improve the skills and techniques that make the program effective. In short, the team members must *become* the program. It is our belief that, for that type of commitment to occur, those who provide the service must invest their own ideas in and be involved in designing the details of the model. This possibility would be afforded through a program development training institute/support group and through a final, detailed manual containing policies, procedures and an intervention protocol.

2.0 BACKGROUND

In this section, we describe the experience that has encouraged the development of the present program proposal.

2.1 EXTREME CASES AS INSPIRATION

The growth in recent years of public awareness regarding widespread and frequent substance abuse among children and youth in First Nations and Inuit communities has been spurred on by several solvent abuse crises in remote communities. In each of these circumstances, behaviours were exhibited that posed extreme, persistent threats to the health and safety of the participants. Understandably, these situations have drawn national media attention; they are, obviously, the "sensational" stories that attracts the press and electronic media.

Unfortunately, there are no sensational, "quick fix"solutions readily available to solve the agonizing problems of this nature. The factors contributing to the problem of groups of children and adolescents tempting the fates by ingesting potentially lethal doses of mood-modifying substances are numerous. The social, economic, cultural and personal factors that may be implicated are not sufficiently concentrated on a single or limited cluster of causes to yield to the accurate aim of any single "magic bullet."

2.2 THE EXPERIENCE OF THE NATIONAL YOUTH SOLVENT ABUSE TREATMENT CENTRES AS A STRATEGIC INFLUENCE

The National Youth Solvent Abuse Program (YSAC) was established and developed from 1993 to the mid-1990s. Through the operation of ten centres, the program has primarily provided residential treatment for adolescents who have been referred as a result of recognized solvent abuse behaviours. The management and staff of the Youth Solvent Abuse Centre (YSAC) network have been directly involved in receiving and providing treatment services to many of the children and adolescents who have been at the centre of solvent abuse crises in many Aboriginal communities.

After active reflection on their own work and the outcomes of the residential treatment model, the YSAC service providers have drawn a number of conclusions that are seminal to the crafting of an effective, consistent approach to preventing and ameliorating youth substance abuse crises in First Nations and Inuit communities. It should be noted that the therapeutic thinking embedded in YSAC operators' thoughts are consistent with the most widely accepted, relevant research and clinical theory in the addictions and applied social and behavioural science fields.

The YSAC perspective was summed up in a communication to NNAPF in early 2001 that listed the following statements:

1. Research strongly suggests that treatment services *must* include family oriented treatment

and community development approaches.

2. History has demonstrated that "institutional care" of First Nations and Inuit youth does not promote healing when it is offered without reflection of First Nations culture and identity.
3. Research also indicates that the treatment environment itself is critical to the engagement of the client in the healing process and, further, that long term institutional care is not an environment that would promote optimal healing opportunities.
4. Psycho-social characteristics of inhalant abusers indicate that small group processes are necessary for the prevention and management of impulsive and explosive behaviours.
5. Human resources that are comprised of skills and knowledge specific to inhalant issues and First Nations and Inuit cultures are critical for effective intervention.
6. When parents are involved in the process of healing, there is greater success and engagement in the healing process.
7. If the treatment process would have any long term effects on the youth, then the parents must have support to realize their inherent strengths as parents. Without support to parents, they are left to their own to address feelings of inadequacy, shame and abandonment.
8. Treatment must not only include parents, but affirm the value of parents.
9. It is recognized that a period of stabilization may be necessary in the continuum of planning for longer term strategies. The YSAC experience is that during this stabilization period, youth in residential or carefully supervised care must be grouped according to their distinctive needs.
10. Stabilization, which may last up to 6 weeks, is appropriate for initial detoxification purposes. If behaviours of clients do not allow home-based treatment and care, clients must be transported to a treatment program which includes family and community connections, a secure environment, medical assessment, one-to-one supervision, suicide watch, and provision of basic client needs.
11. Stabilization is effective when the environment is as non-institutionalized as possible and small groups are part of the intervention process.
12. The continuum of treatment made available must include non-medical detoxification.

While the YSAC network statement focusses specifically on solvent abuse, substance abuse crises may involve the use of various other drugs, including alcohol. Both as reflected in the above statement and as voiced at the workshop in emergency response program development hosted by NNAPF in Saskatoon on January 28 and 29, of 2001, the YSAC perspective has been a vital reference point for the crafting of this proposed program model.

2.3 EVOLUTION OF THE *FNI-CERP* PROPOSAL

This proposal grew out of a request by First Nations and Inuit Health Branch (FNIHB) of Health Canada to the National Native Addictions Partnership Foundation (NNAPF Inc.) to develop and, if appropriate, to manage and deliver a formal program response to recurring substance abuse crises in which children and youth were placed at extreme risk. The NNAPF Board agreed to the request and subsequently initiated a consultation process with representatives of its regional partners.

A workshop involving representatives from all First Nation and Inuit health regions was held in Saskatoon, Saskatchewan on January 28 and 29, 2001, designed to elicit input into the selection of the principles and practices that would comprise a culturally appropriate and effective program. The workshop was hosted and facilitated by Karen Pine Chee Choo, who was contracted by NNAPF to facilitate consultations and input. On the basis of a review of available evaluation literature on effective intervention and crisis intervention models used with youth and the general direction suggested by the recommendations at the Saskatoon workshop, a program model was drafted by *Socio-Tech Consulting Services*, and then reviewed and revised through a continuing consultation process. This document is a final, working draft of the program proposal.

Part One:

FNI-CERP : A PROGRAM OVERVIEW

3.0 IDENTIFYING, MOBILIZING AND ENHANCING INDIVIDUAL, FAMILY AND COMMUNITY RESILIENCY

Typically the outcome of various contributing factors, solutions to group substance abuse crises often require changes in the personal, interpersonal, and organizational habitat in which the participating children live.

Strategies which coordinate interventions and changes in the various sectors of the living environments of these children and youth are typically very difficult to achieve—and are often abandoned, leaving the intervention process to be undertaken in a "piecemeal' fashion, with the agendas of different helping services to work in ways that are odds with each other. The powerful impact of a single healing and relapse prevention plan, supported by several partners, is thus a rare occurrence, despite is potential effectiveness.

A reading of the available literature, relevant to solvent abuse among children and youth, is clear about one thing: There is no panacea! Overwhelmingly successful program templates are not simply waiting on the sidelines in a state of readiness to remedy the circumstances that encourage youth to engage in potentially lethal substance abuse practices. However, there are some programs that have a better track record than others, and it is far better to utilize programs that have been relatively successful than programs with unknown outcomes.

Programs utilizing the coordinated efforts of helping agencies and informal social networks and based on demonstrably sound program principles are rare. Yet governmental and community responses to substance abuse crises among children and youth have tended to be narrow in scope rather than comprehensive; they have also been reactive and *ad hoc* rather than proactive and systematic.

Response strategies have lacked a coordinated problem-identification system operated by community health workers capable of identifying the risk factors. The have also lacked a standardized notification system with relevant authorities who could activate appropriate, early interventions. As a result, crises of this kind tend to come to the attention of key decision-makers only if and when the situation becomes wholly unmanageable at the local level. This reactive, "crisis and rescue" approach has not been backed up by an effective preventive and early intervention system that is wholly integrated into the existing substance abuse and addictions service infrastructure dedicated to First Nations and Inuit communities.

3.1 FAMILY AND FAMILY NETWORKS: THE FABRIC OF COMMUNITY LIFE FOR FIRST NATIONS AND INUIT COMMUNITIES

Families and relations between families are the fabric of First Nation and Inuit communities. Inherent to the identity of the families and communities of indigenous peoples are the core values of kindness, caring, sharing, respect and strength. These core values have persisted, despite negative coping behaviours that have evolved as an adaptation to a history of oppression. The very fact that Aboriginal peoples remain distinct as peoples serves to

highlight their resiliency.

These core values are inherent to the cultures of First Nations and Inuit peoples and they are intertwined in the relations between families and between families and communities—no matter how torn and tattered the condition of the community fabric has sometimes become. These same core values of kindness, caring, sharing, respect and strength, must also inform and direct any formal response to a crisis.

3.2 BUILDING FROM STRENGTHS OF THE INDIVIDUAL, THE FAMILY AND THE COMMUNITY

The process of discovering the sources of individual, family and community resilience is the core of a distinctive, culturally appropriate approach to crisis intervention in First Nations and Inuit communities. Underlying such an approach is a recognition that our distinctiveness as peoples must be considered as our greatest strength when we collectively, as communities and as groups of nations, begin a healing journey with the necessary resolve to assure success. The practical challenge is to re-establish traditional, culturally-based informal and formal social support networks. Once active, these networks would themselves have the capacity to not only overcome substance abuse and other crises but also to prevent their emergence.

If long-term strategies are to be authentically aimed at capacity-building, then the premise for their foundation must be one of existing strengths and inherent values.

Like the many causal factors at play, a community's solutions to the problems of their troubled youth, acting out their despair by participating in death-defying episodes of substance abuse, must also be multi-dimensional.

To have an impact, solutions must often cut across parent/child relations, sibling and peer relations, a variety of governmental jurisdictions, human service agencies and occupations, and both informal and formal dimensions of community leadership.

Another difficulty with past interventions has been the skewed emphasis on the individual adolescents who have been at risk in substance abuse crises. This emphasis violates the principles behind traditional Aboriginal healing philosophies. Those principles emphasize transforming processes that balance emotional, rational, physical and spiritual aspects of individuality and the building of health-promoting interactions between troubled youth and their family, community and physical environment.

The predominant emphasis placed on the individual in various substance abuse interventions also contradicts the thrust of much of the most compelling ideas in contemporary mental health and addictions fields. Undergirding these current approaches is the central idea that intervention should not be limited to the "Identified Patient" (the "I-P") but must instead be broadened to examine and work with that person's family system, the primary social network, and the community services with which the adolescent must turn to for services.

3.3 'CERP' AS AN EXPANDING PARTNERSHIP

The FNI-CERP program model described below is not only oriented to building the health-promoting, sobriety-maintaining capacities of individuals, their families and the informal social networks which they inhabit. The program is also aimed at assisting with the renewal and enhancement of the capacities of local helping systems which have often been damaged or displaced by externally imposed social, economic, political and technical changes. Conceptually and practically FNI-CERP is grounded in a community development approach; it is about the renewal of traditional strengths and approaches and their adaptation to contemporary needs.

While immediate child protection and harm reduction is a vital program element, the larger purpose of the program is to assist communities, shared service areas and regions, in their efforts to establish effective systems to prevent substance abuse crises, monitor the emergence of those crises that do arise, and to pro-actively and effectively intervene when health and safety risks have risen to intolerable levels.

It is intended that this capacity-building process would be assisted by the following activities and arrangements initiated by FNI-CERP:

1. *Regional Partnerships*

With the assistance of the FNI-CERP Community Emergency Response Team (CERT), appropriate Regional coordinating bodies would establish a Regional crisis management response system. While the details of Regional approaches would differ, the following fundamental elements would be in place:

- Each Region would designate an *Emergency Response Assessor* to serve on CERT and to provide initial assessments and first CERP contacts with communities-in-crisis seeking external interventions. The Emergency Response Assessor (ERA) would be selected according to criteria developed by NNAPF.
- Each Region would provide training to front-line workers in First Nations and Inuit communities in team development and in the procedures to be enacted in an *Emergency Response Protocol* prepared by NNAPF. The training would focus on the sequence and techniques of providing crisis management and emergency response services.
- The ERAs would be trained along with the core members of CERT and would participate in its "refresher school" workshops. It is hoped that the Regions would assign the ERAs to assume training responsibilities for emergency response team-building in each of their respective Regions.

The *Regional CERP Partners*, whether simply NNAPF Working Groups or Regional Substance Abuse and Addictions Coordinating Councils, would be responsible for:

a. *Regional Crisis Management Training and System Development*

b. *Initial CERT Crisis Assessments*

c. *Program Evaluation*

2. *NYSAP as Partner*

The National Youth Solvent Abuse Program Directors, in concert with their Boards and with the support of their staff, have identified a need to diversify their services beyond the current emphasis on in-patient services to individual youth. Their voice has been vocal, articulate, and well-directed in calling attention to the need for a more systematized, multi-dimensional response to crisis prevention and intervention to address youth substance abuse issues. It is expected that YSAC Centres would play a pro-active role in developing local and area capacities to prevent, monitor, intervene in and manage youth substance abuse crises. It is also expected that,

- the management and staff of the YSACs would be an important referral and recruitment base for establishing CERT;
- in many Regions, the Emergency Response Assessor (ERA) would be an employee of a YSAC, seconded when necessary to undertake an assessment and participate in a CERT intervention

It is envisioned that the YSACs would also be used, when appropriate,

- to provide protective containment services

and to provide:

- long-term residential therapy.

Depending on the Regional needs and the plans of YSACs, the solvent abuse centres may also provide various extension services to supplement inpatient programming, including:

- outpatient programming; and
- other forms of outreach programming, such as mobile intervention teams linking centres to community strategies as part of a long-term, comprehensive plan.

3. *NNADAP Intervention Service Partners*

Like the YSAC Network, existing Regional NNADAP service providers would not only participate as representatives at one or all levels of the FNI-CERP decision-making and information-sharing network, they would also provide practical services through their treatment programs. Such services include:

- depending on the availability of bed spaces in other facilities, NNADAP treatment centres might be called upon to provide supervised residential stays and supervised detoxification
- long-term residential therapy

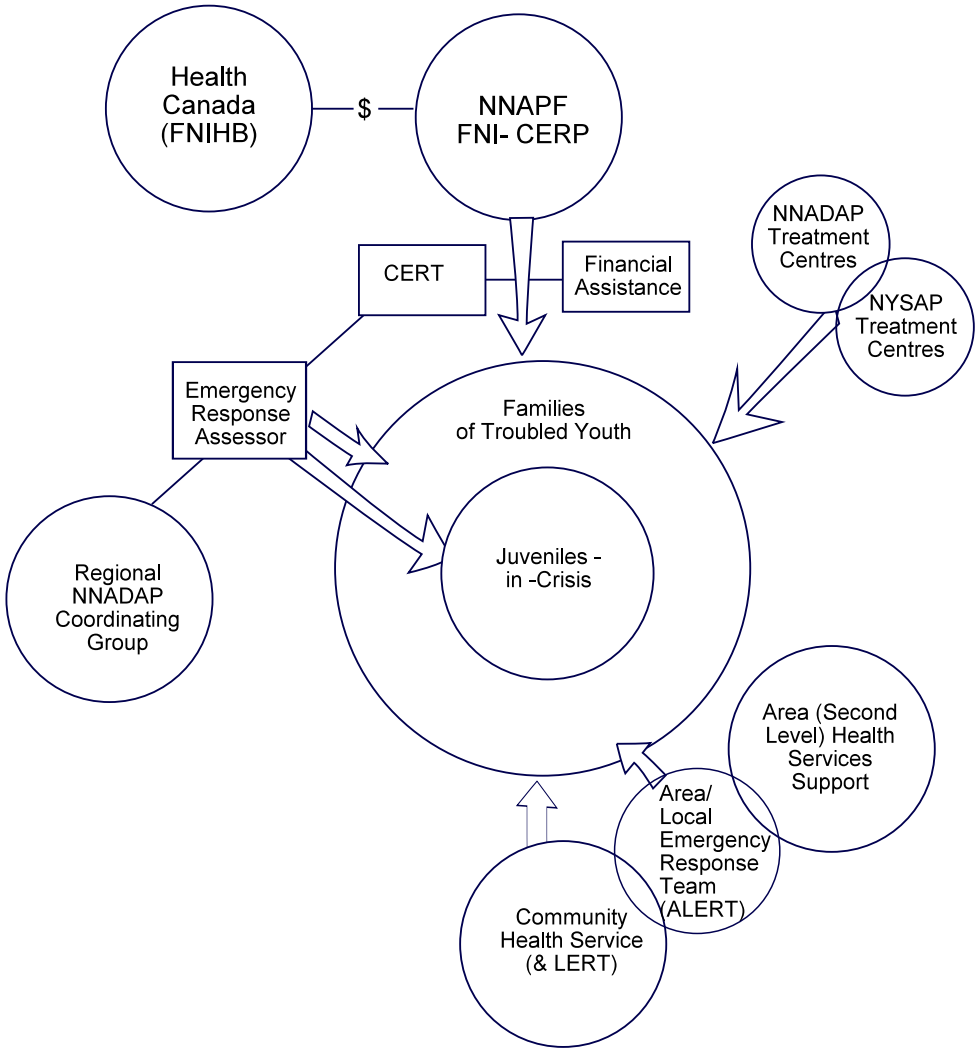
- outpatient programming
- outreach programming - participation in local and area emergency response teams (LERT and ALERT)

4. *Area/District and Community CERP Partners—and ALERT AND LERT Teams*

The Area or District CERP Partners functioning through shared service structures, such as Tribal Councils or First Nation and Inuit Health Districts, in an advisory or support capacity for front-line, community workers, would be responsible for developing and supervising ***Area and Local Crisis Intervention Teams*** **(ALERT Teams)**. These teams would join together a Coordinator, such as an Addictions Consultant, and a Mental Health Counsellor, with front-line workers from the Red Alert community, who comprise a ***Local Emergency Response Team*** **(LERT)**.

The LERT team would comprise front-line workers, typically including the NNADAP Worker, the Community Health Nurse, the Mental Health Counsellor, and an appropriate representative of the school(s) comprising the largest enrollment of children/youth from the community.

Figure 1 A View of the FNI-CERP Response System as a Whole



4.0 EXPECTED OUTCOMES

It is expected that the program would generate the following positive outcomes:

1. A culturally sensitive, comprehensive, emergency response system would be in place with a capacity for accurate surveillance, and effective prevention, early intervention, and protective and therapeutic intervention into substance abuse crises involving children and youth. The improved capacity would significantly reduce the risks of group-influenced substance abuse crises in First Nations and Inuit communities, thereby promoting the health and safety of children and youth.

2. By reformulating their overall service strategies, the YSAC Network, operated by the National Youth Solvent Abuse Program (NYSAP), would be diversifying their services in response to needs identified in the course of past service provision. Those services would not only be compatible with but would be a part of the broader FNI-CERP initiative. It would include a greater emphasis on family intervention and support, outreach and mobile assistance to communities, as well as other responses, formulated in response to changing and newly emerging needs.

3. A mobile, expert emergency response team (CERT) would be added to the full complement of the First Nations and Inuit community health services system operating throughout Canada, thus enabling the relief of and assistance to health workers in communities which do not have this expertise within or near to their own settlements. This is not anticipated to be a permanent addition but, instead, an interim measure designed as a spur to capacity building for the future. It is intended that CERT would be dissolved once all Regions have their own local, area and regional youth substance abuse emergency response capacities.

4. All First Nation and Inuit communities in Canada would have a professional risk assessment capacity accessible to them through their Regional NNADAP program.

5. Within five years of the start-up of FNI-CERP, all First Nations and Inuit communities in Canada would have the capacity locally or within convenient geographic proximity to identify emerging substance abuse crises among children and youth, to intervene in them prior to the onset of an emergency, and to self-assess their own need for the securing of outside expertise to assist them with their intervention.

6. Within ten years of the start-up of FNI-CERP, all First Nations and Inuit communities in Canada would have accredited primary and secondary prevention programs to effectively divert, respectively, the general child and youth population and their at-risk sub-groups from substance abuse crises.

7. When substance abuse crises do occur among First Nations and Inuit youth, internal communications and the flow of information to the press and media from the community and emergency respondents would be coordinated and managed through a formal communications strategy.

5.0 KEY PROGRAM PRINCIPLES

The following specific principles have been identified as a set of parameters for the creation and operation of the program:

Programming Operated by First Nations and Inuit People

1. The program would be overseen and operated by the National Native Addictions Partnership Foundation Inc., which would work in partnership with Regional First Nation and Inuit Addictions Working Groups or Regional Coordinating Bodies, and, when appropriate, Territorial and Provincial authorities with commitments to intervene remedially in such crises. In turn, the responsible Regional partners would work with area and community workers to develop comprehensive system embedded in a multi-level network.

Working Partnerships with Local Authorities and Service Personnel

2. In undertaking an intervention "on the ground," CERP program staff would work as a partner with community leaders, local health and social development workers, and other responsible health agencies, community organizations and levels of government.

Interventions According to Standardized Criteria

3. The program would only be available to communities that meet specific, pre-determined eligibility criteria. One such criteria would be that intervention would be conditional upon demonstrated support by a local, representative group. In most instances that group would be the community's formally elected leadership or an advisory body appointed by that leadership. However, under extenuating circumstances, the key local partner might be a locally supported, organized group of concerned members. What would constitute "demonstrated support" would include a readiness to advise the intervention team, to assign local liaison persons and public employees to assist, and a willingness to cooperate with program staff and to publicly and privately support them in their undertakings, so long as local customs are not inadvisably violated.

Culturally Sensitive Service Provision

4. Program interventions would be executed in a way that is sensitive to the cultural diversity of the many First Nations and Inuit peoples of Canada.

Children's Health and Safety First

5. The most immediate responsibility of the program is to ensure that children and youth affected by these problems would be protected from harm's way.

Program Resource Expenditures would Vary with Community Needs

6. It is recognized that some communities may be unable to adequately or appropriately mobilize resources to respond to either the short term crises or to activate sufficient intermediate or long-term change to overcome the context within which the crisis has arisen. In this instance, long-term crisis management arrangements may have to be made

with the assistance of one or more third party organizations.

Interventions would be Holistic and Recognize the Need to Mobilize Family and Community Assets

7. The program perspective would be holistic, with families, peers, neighbours, schools, police, health and social development workers and Elders all being viewed as potential interveners and natural healers in individual and community recovery processes. The solutions selected would reflect this perspective, with counselling and personal development, family systems enhancement and community development being the fundamental strategies.

Successful Programming would Enhance Local Capacities and Reduce Dependency

8. It is paramount that the program work to assist the community with its own efforts to solve its own problems, and to make every effort to avoid the creation of further dependencies. It is also recognized that, in some instances, communities in transition do not have sufficient resources to effectively manage local substance abuse crises until further, fundamental community development occurs. In these rare cases, it would be the stance of FNI-CERP to not only enhance local resources but to advise and assist the community's efforts to undertake broadly-based, fundamental development work. Only through such efforts can severely underdeveloped communities ultimately establish the foundation for building their own informal and formal capacity to prevent serious child and youth substance abuse and to intervene when crises do occur.

6.0 PROGRAM DEFINITION

The program can best be defined by describing it through a series of statements moving from the general to the specific, from statements of purpose through goals to program definitions.

6.1 VISION

As determined by the NNAPF Partnership at a workshop in Saskatoon held on January 28 and 29 of 2001, the vision of FNI-CERP can be stated as follows:

> *The empowering assistance of the partnership comprising FNI-CERP would result in the restoration of health and balanced lifestyles for First Nations and Inuit children and youth who are experiencing a substance abuse crisis, for their families and for their communities.*

6.2 MISSION

The mission of the program can be summarized as follows:

> *FNI-CERP would provide human expertise and financial resources to assist First Nations and Inuit families and communities with their remedial and capacity-building efforts intended to prevent, intervene on an emergency basis, protect and permanently divert their children and youth from abusing mood- and behaviour-modifying substances, and from creating and actively participating in peer group formations that actively engage in substance abuse.*

6.3 GOALS

The goals of the program are as follows:

1. To work with Regional partners to establish an accurate monitoring, risk assessment and notification system to ensure that communities and emergency responders can intervene to remove children and youth in any First Nation and Inuit community in Canada from the immanent danger of high-risk substance abuse behaviour patterns systemically promoted by adverse environmental circumstances or influential peers or adults.
2. To assist individuals, families and communities in crisis in realizing their own assets and strengths and to utilize those resources in restoring individual, family and community wellness and balanced lifestyles.
3. To establish and utilize a risk assessment process that begins with a notification system at the community and regional level and includes various decision and planning points involving interactions between professional program personnel and community leaders and health workers.

4. To provide an emergency response intervention process to ensure that the children and youth who are actively engaging in high-risk substance abuse behaviours are protected from the immediate health risks of excessive substance abuse.

5. Through facilitating effective communication strategies and by providing critical incident debriefing and grief and trauma counselling, to bring calm to crises and to stabilize crisis situations so that they can be effectively managed and overcome in a satisfactory way.

6. To provide high quality, effective, mobile, emergency intervention services in communities interested in receiving external assistance in order to remedy a substance abuse crisis among children and youth.

7. To assist communities in crisis with their planning for long-term strategies aimed at stabilizing crisis situations involving substance abuse behaviours of children and youth, sustaining healing and recovery processes, and preventing the recurrence of such crises.

8. To provide support for community leaders and front-line addictions and other community health workers and agencies and to assist them with their efforts to build their own team, organization and community capacities..

9. Through consultations, training, planning assistance, local strengths and assets identification, and, in some instances, minor capital resource allocations, to assist in the development of individual, family, school, and community capacities for deterring children and youth from high-risk substance use.

10. To assist communities in establishing linkages and developing partnerships that can contribute to effective long-term prevention and intervention strategies in the community, in shared service and cultural areas, and in regions.

6.4 KEY PROGRAM DEFINITIONS

For the purposes of this program, a ***Substance Abuse Problem*** would be defined as follows:

> *An individual is experiencing a behavioural problem related to the use of mood- and behaviour-modifying substances (including alcohol, prescription drugs, organic "street" drugs, designer drugs, prescription drugs, and solvents) if its frequent use is affecting his or her physical, emotional, social, intellectual, educational or occupational functioning. Among the psychoactive substances associated with abuse are alcohol (including solvents), sedative hypnotics, opioids, amphetamines, cannabis, and cocaine, as well as the manufactured 'designer' equivalents of some of these drugs, and health-damaging, addictive foods and tobacco.*
>
> *Substance abuse is associated with the following self-destructive behaviour patterns:*
>
> ! *recurrent substance use resulting in a failure to fulfill major role*

obligations associated with one's central life actvity, such as parenting, work or schooling;

- *a risk of suicide;*
- *recurrent substance use in situations in which it is physically hazardous;*
- *recurrent substance-related legal problems;*
- *continued substance use despite having recurrent social, interpersonal or physical health problems associated with substance use episodes.*

In the FNI-CERP operational glossary, a ***Child or Youth Experiencing a Substance Abuse Crisis*** would be defined as:

> *. . . any First Nations or Inuit person under the age of 20 years old who is identified according to a common set of standards to be abusing a mood- or behaviour-modifying substance in a way that places him or her or those with whom s/he is in contact below acceptable levels of health and safety.*

A ***Child or Youth Group-in-Crisis*** is defined, for FNI-CERP purposes, by the following statement:

> *A 'Child or Youth Group-in-Crisis' can be described as any group of children or youth with three or more members who are known to engage in substance-abusing behaviour in a fashion that poses extreme health and safety risks to the members of the group and other members of the community.*

A ***Family-in-Crisis*** is described in the program as follows:

> *A `Family in Crisis' can be described as any unit of socially bonded, adult care-givers and their dependent children and youth in which the adults are currently unwilling or unable to provide sufficient motivational, supervisory or disciplinary care to protect the child from the risks of substance abuse. As a general rule, a family-in-crisis is viewed as a family in need of assistance with the basics of child care and general family functioning and also as the primary support in efforts to modify their child's substance-abuse; except in the rarest of circumstances, the family is* not *seen as an obstacle to be separated from a troubled child's healing process.*

A ***Community-in-Crisis*** would be defined as follows:

> *A `community-in-crisis' is any community in which the dangerous use of mood- or behaviour-modifying substances is believed to be a sufficiently frequent and growing practice among children and adolescents that community leaders and/or mandated community health service providers believe a concerted intervention initiative of top priority in the community is required.*

For program purposes, a ***Pre-emergency Community*** would be defined as follows:

> *A 'pre-emergency community' is any First Nation or Inuit community in Canada that is in a state of crisis but does not qualify for FNI-CERP assistance because program consultants have determined that local, area or regional resources are available to respond adequately to the crisis,*

An ***(Emergency) Red Alert Community*** would be defined as follows:

> *For program purposes, 'red alert community' is any community that is eligible for FNI-CERP assistance because of the high risk levels facing children and youth in the community, formally qualifies for that assistance, and is agreeable to the terms of intervention under which NNAPF Inc. is willing and able to provide such assistance.*

A ***(Mobile) Community Emergency Response Team*** would be formed at the request of community leaders. It would:

> *. . . provide specialized, emergency interventions in substance abuse crises involving children and youth. The team would consist of a Coordinator/Supervisor, a Crisis Management Assessor (selected by a regionally-appropriate YSAC Centre Board operating within or closest to an FNIHB Health Region), three mental health facilitators, a community organizer, and a Traditional Healer who would facilitate a respectful and appropriate entry by the team into a community inviting assistance.*

A ***Long-term Family Support Circle*** would be defined as:

> *. . . an arrangement by which a formal group consisting of visiting professional therapists with caseloads of no more than 5 families, front-line NNADAP workers, a Regional Intervention Advisor from FNI-CERP, and an Elder or other respected advisors selected by the community, are called upon to support a child or youth and his/her family through a period of 3 months to 5 years beyond an initial crisis intervention period lasting up to*

3 months. Such a circle would be arranged in a community in which local human resources are unable or unwilling to adequately respond to the needs of children and youth at risk.

6.5 CORE VALUES OF THE SYSTEM OF CARE

The following are the core values upon which the organization and implementation of the program would be based:

1. The system of care would be child/youth- and family-centred, with the distinctive needs of both dictating the types and mix of services provided.
2. Children and youth belong with families and they need enduring relationships with adults.
3. Children and youth with substance abuse and other behavioural and emotional problems have unique needs that require individualized services.
4. If peer group formations are central to substance abuse activities in a community, then substantial efforts should be made to find alternative, pro-social, healthy socializing outlets for the members of these groups.
5. It takes an entire community to raise a child and, consequently, the community, its leadership, and those community service workers dedicated to health, education and public security should play an active role in crafting and implementing crisis intervention services.
6. Beyond the community level, district, regional, territorial and even provincial partnerships would often be required to assist many communities in the development and ongoing implementation of intervention, relapse prevention and fundamental, primary prevention strategies. Working with such partnerships is wholly in keeping with the realities and needs of communities and the current direction being taken in the development of First Nations and Inuit governance and public service provision structures.

6.6 PRINCIPLES GUIDING INTERVENTIONS

The FNI-CERP intervention process would be guided by the following principles:

1. Early identification and intervention for children with high risk, substance abuse problems should be promoted by the system of care to enhance the likelihood of positive outcomes.
2. Troubled children regularly or occasionally engaging in substance abuse behaviour that places them at high health risk should have access to a full range of services that address physical needs, emotional needs, social needs, educational needs and cultural needs.

3. Children and youth with substance abuse problems receiving services must have their rights, preferences, values, strengths, cultural, and racial backgrounds respected by any human services personnel providing interventions.

4. Beyond a period of protective intervention, children and youth should receive necessary supports to remain with their families or caring, custodial adults. Out-of-home placements should only be considered as a last resort for the long term.

5. In providing crisis intervention services and long-term harm reduction and support services, intervention programs for children or youth at risk of — or demonstrably engaged in — self-destructive substance abuse or anti-social behaviours associated with substance abuse should utilize the strengths of families by:

   ! ensuring that they are full partners in the planning, implementation and evaluation of services;

   ! viewing the child or youth as a whole person in the family unit, rather than emphasizing the substance abuse problem or other behavioural problems;

   ! empowering families and children to make decisions about their lives rather than being dependent on professionals or public agencies;

6. Children or youth at high risk as a result of substance abuse should receive services that are integrated, with linkages between child-care agencies and programs and mechanisms in place for planning, developing, and coordinating services.

7. Multiple interventions for children and/or youth experiencing a substance abuse crisis should be carefully coordinated. This coordination should take place through a case management process. In this fashion, the multiple services required would be delivered in a synchronized and therapeutically sound manner, with different interventions complementing rather than contradicting each other. This would optimize the likelihood that the children/youth can move through the system of services in accordance with their actual needs, which can be expected to change over the course of service provision.

8. In some small, remote communities, it is possible that all sources of local support are incapable of providing the necessary, long-term support for a crisis intervention strategy targeted on children and youth engaged in high-risk substance abuse, even with the aid of short-term, crisis management intervention. In such cases, it may be necessary to supplement local service capacities with additional staff, family support services and/or residential care facilities.

9. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

6.7 CULTURAL ASSUMPTIONS ABOUT THE CLIENT'S HELPING CIRCLE

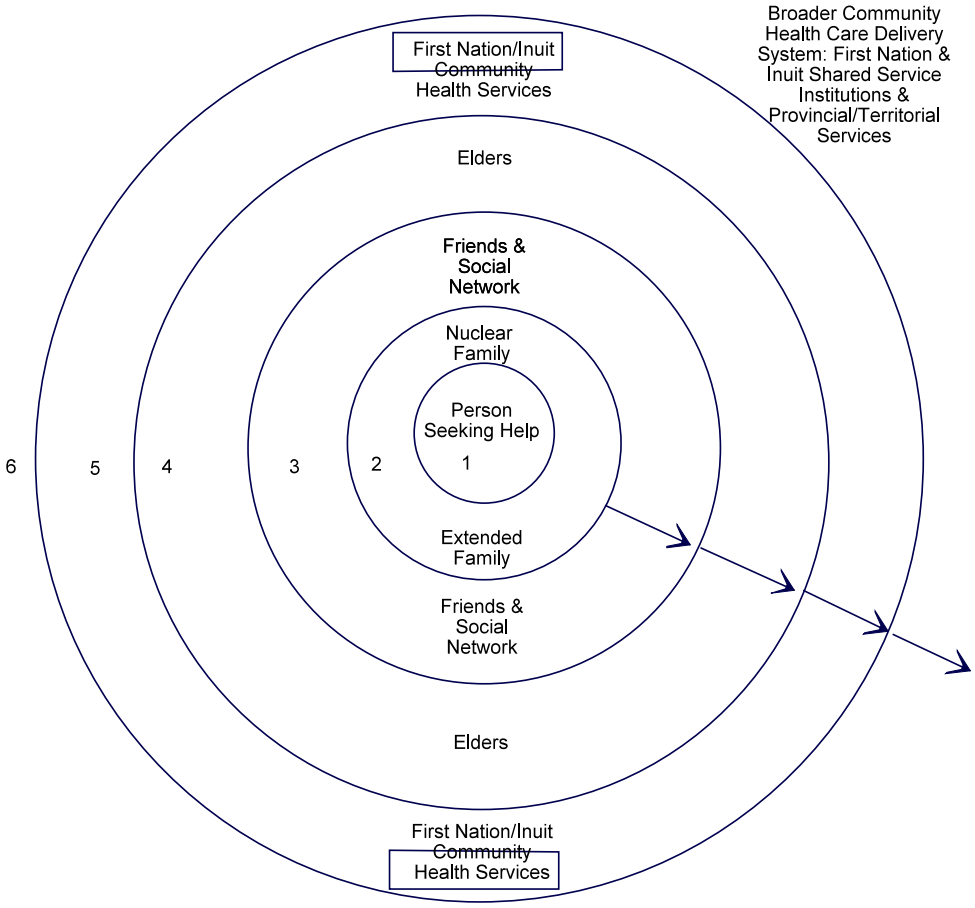
While it is true that a significant set of health services and social services have grown up around First Nations and Inuit communities, members of indigenous settlements tend to first seek help for emotional, and behavioural and addictions problems from family, friends and informal community contacts before turning to professionals. A schematic diagram of the typical pattern of individual help-seeking circles is presented in Figure 2 below; it presents the order in which an individual is likely to seek the assistance of others in solving personal problems.

The FNI-CERP approach to intervention would respect the distinctive preferences of children and youth and their families regarding community healing circles. A strong effort would be made to place the greatest emphasis on primary social ties rather than secondary relations with professionals, then working outward through extended family, social network, and more distant, informal and formal community supports.

Respect would be shown for whatever spiritual, religious and social beliefs are held by the implicated youth and their families. Local Elders would be consulted and, if requested, clergy from Christian or other religious faiths would be invited to participate in the healing process.

A knowledgeable, Traditional Healer, would be a core member of CERT and that individual would provide an added dimension of sensitivity to significant cultural considerations. The Traditional Healer would work with local Elders for the purposes or discovering and advising the CERT members about local cultural customs and sensitivities. The Healer would also engage the local Elders in a consultation process that would, subject to the agreement of the local Elders, lead to the formal acceptance and blessing of the work of the CERT members in the community.

Figure 2 Schematic Diagram of Helping Circle Normative for First Nations and Inuit People



7.0 PROGRAM ELEMENTS

The core elements of the program are the services it would provide and its essential supports. Supports of this kind include human resources, information management and financial resources. These elements are described below.

7.1 PROBLEM MONITORING AND NOTIFICATION SYSTEM

In keeping with the principle that the program must be integrated into the existing First Nations and Inuit health care service network, the notification process would draw upon local resources already in place in communities, Tribal Councils and other shared service organizations delivering community health care, and FNIHB's Zone and Regional offices.

In consultation with its Regional First Nations and Inuit partners and Health Canada, a ***Monitoring and Notification Protocol*** would be prepared by FNI-CERP staff and circulated to all of these parties. The protocol would describe a monitoring procedure, assisted by a risk-assessment check-off form, and a notification sequence with local, area and national program contacts.

FNIHB staff would provide to all potential risk monitors an outline of how these protocols would work. The protocol would identify ***Monitoring and Notification Agents (MNAs)*** responsible for initiating a ***Notice of Concern*** report by one of the following local or area health service personnel:

- the NNADAP Coordinator on-reserve
- the NNADAP Advisor (with FNIHB or an First Nation or Inuit shared service organization)
- Child welfare/family support workers
- the Community Health Nurse (CHN)
- a Mental Health Counsellor
- a Recognized Elder from a community-in-crisis or an Elder from a nearby community who is acceptable to the membership of a community-in-crisis (with community-designated names on a list maintained by NNAPF Inc.).

The Preliminary Notice of Concern report would be simultaneously forwarded to the leadership of a community and to the FNI-CERP ***Emergency Response Specialist*** (*and FNI/CERP Program Coordinator*).

The Specialist/Coordinator would be a full-time employee of NNAPF Inc., reporting administratively to the Executive-Director. S/he would be a clinician with a balance of experience working with First Nations and/or Inuit peoples and senior credentials as a clinician and supervisory social worker, psychologist, addictions specialist, or psychiatrist The individual would be a seasoned administrator, a skilled human relations trainer, and have

extensive background in crisis intervention and substance abuse and addictions counselling.

As currently conceived, the E.R. Specialist would immediately make telephone contact with the individuals submitting the Notice of Concern, as well as with three other responsible parties, including the Chief of the community-in-crisis. If the verbal responses to the telephone queries are consistent with the Notice, then a preliminary risk assessment procedure would be triggered.

7.2 CERP 'BRIDGING' INTO THE COMMUNITY, PRELIMINARY RISK ASSESSMENT, HARM REDUCTION PROCEDURES, AND INTENSIVE INTERVENTION REQUESTS

Subsequent to the validation of the Notice of Concern, the E.R. Specialist would dispense an ***Emergency Response Assessor*** (ERA), designated by a Regional Addictions Working Group or responsible Regional First Nations/Inuit Substance Abuse Prevention Coordinating Body to visit the community and meet with the community leaders and local officials. A Regional Youth Solvent Abuse Centre may be identified by a Regional Coordinating body to select the Assessor for the Region.

7.2.1 - ESTABLISHING A COMMUNITY ADVISORY COMMITTEE

The Assessor would typically encourage the community to establish a ***Community Advisory Committee***. The need for a local contact group includes the following:

- to establish a working relationship between the Assessor and, potentially, other interveners, and community spokespersons;
- to creating a social and informational bridge for the interveners into the community-in-crisis;
- to help focus a mandated group of local leaders on a solution-oriented strategy.

Such a committee would (a) have the support of recognized local leadership and (b) include a selection of people who are acceptable to local health workers and parents/care-givers of children and youth at risk.

A *Community Advisory Committee* would function to advise external interveners and local leadership and would act as the overseer of the project. The Committee would also serve as the primary liaison with the local Elders. Depending on local custom, an Elder (or Elders) would participate as committee members.

7.2.2 - IDENTIFYING SUBSTANCE ABUSE VICTIMS

With the assistance of local child welfare workers and police, the E.R. Assessor would identify children and youth at risk and ensure that appropriate legal procedures are in place

to intervene in a child protection capacity.

7.2.3 - PREPARING AND IMPLEMENTING AN IMMEDIATE PROTECTION/DETOXIFICATION PLAN

The E.R. Assessor, under the supervision of the E.R. Specialist/CERP Program Coordinator employed by NNAPF Inc, would work with child welfare workers and families of the children to prepare an immediate protection and detoxification plan. The plan would determine whether there is sufficient local capacity to place the children into protective care until further plans can be made or if other options are more appropriate. Alternatives for immediate protective care and, potentially, detoxification of the children or youth, include:

a. The child(ren) or youth and their parent(s) could be placed under a child welfare agreement that would clearly define the nature of supervision and their associations with peers involved in substance abuse.

b. The children could be temporarily removed from the community to attend a YSAC or NNADAP in-patient program or, depending on bed-space availability and mental health and behavioural needs, another stabilization facility.

c. A request could be made for the FNI-CERP Intervention Team to provide in-community services.

7.2.4 - REQUESTING 'CERT' ASSISTANCE

The Emergency Response Assessor would also carry out an initial assessment of the community's capacity to adequately intervene with its own resources beyond the initial protection period.

If further assistance is likely, the Assessor would identify or work towards the establishment of a local contact group.

If the Community Advisory Committee and the Emergency Response Assessor believe that the intervention of a team of external crisis management facilitators is called for — interveners who are specialists in assisting communities with their efforts to overcome and prevent the relapse of similar crises — then a team of specialists would be invited into the community, whether that be CERT or a Regional team (*Note*: It is anticipated that, eventually, all Regions would have full capacity to provide emergency intervention services from a team specifically serving their own area).

7.3 *CERT*: THE INTERVENTION TEAM LINKING NATIONAL AND REGIONAL PARTNERS IN ACTION

The Community Emergency Response Team (CERT) is the core of the direct service assistance strategy that FNI-CERP can provide.

The program would retain the E.R. Specialist/Program Coordinator, 5 core members of CERT and the back-up group of 10 additional members (1 from each Region who would serve as ERAs) who may or may not be called upon to be core CERT members during the intermediate intervention phase when.

From the community's perspective, the core team would include the Emergency Response Assessors (as indicated, 1 from each Region), as well as 3 mental health facilitators, 1 Traditional Healer, and 1 community organization specialist. Depending on the community's needs, the entire core team of 5 might be sent in or only 1 or 2 of the team members.. Through participation in a special group development and technical training program, the entire team would be skilled in the following processes/techniques:

- ❑ Organizing and indirectly facilitating the organization of community responses that utilize identified, local human and other resources
- ❑ Child and youth risk assessment
- ❑ Family support capacity assessment
- ❑ Community social needs assessment
- ❑ Identifying local human, organizational and physical assets that could be mobilized to develop short- and long-term prevention and intervention strategies
- ❑ Substance abuse and addictions assessment
- ❑ Critical incident debriefing and counselling support
- ❑ Suicide prevention/intervention
- ❑ Individual counselling
- ❑ (multi-systemic) therapy strategies
- ❑ Parental competency training
- ❑ Aboriginal family systems and couples, family and network therapy
- ❑ Healing Circle work
- ❑ Social group work.

The Regional Emergency Response Assessors would serve as back-up members of CERT, becoming trained in the CERT methods and acquiring the capacity to train Area and combined Area and Local Emergency Response Teams (ALERT Teams).

7.4 THE 'CERT' TRAINING INSTITUTE AND SUPPORT GROUP

To prepare for its work, the initial CERT team participates in an intensive training and support group development process. The purpose of the training and group development process that team members go through is not to upgrade team members to a professional level; in fact, all members of the team are highly qualified individuals. The process is in place for team members to learn and give shape to a common body of knowledge and to learn and collectively craft a standardized skill set.

Through lectures and demonstrations provided by leading experts and by having real input and an opportunity to discuss, debate and reach a consensus on effective methods and strategies, CERT members would hopefully acquire a sense of ownership of the strategy, pride, group solidarity, and a passionate commitment to the approach, as it has materialized for the team. As a result of their training, team members can work effectively together and core members can be replaced by back-up members when one or all of the core team members are not available to undertake an intervention.

Having back-up members serve as Emergency Response Assessors in each of the Regions serves not only to ensure the availability of team members at all times but ensures greater sensitivity to Regional realities and greater acceptance of CERT in the Regions.

All members of the team would go through an initial, intensive period of training, methodology design, and a group-building process and they would meet for refresher institutes once every two years. The core team would be its own support group, meeting once a month by teleconference hook-up, with the proceedings taped and shared with the back-up members. If the entire core team had to be replaced, a full-scale CERT Training Institute would have to be facilitated.

Part Two:

SITUATIONAL STABILIZATION

8.0 ASPECTS OF 'CERT' INTERVENTIONS DURING THE STABILIZATION PERIOD

On the direction of the E.R. Specialist, the CERT team would engage with a community at the request of the Community Advisory Committee and on the recommendation of the Emergency Response Assessor. Depending on their assessment of intervention needs, the team would provide one or an appropriate mix of several of the following services:

1. striking a *Community Intervention Agreement*
2 preparation and coordination of an *Intermediate Protective Treatment Plan*
3. providing a *Suicide Risk Assessment and Harm Reduction Plan*
4. preparation and management of a *Communications Strategy*, including communications in the community, confidentiality maintenance, and *media management* techniques;
5. preparation and coordination of a *Community Stabilization Plan and Intervention Process* that may involve *Critical Incident Debriefing and Grief Counselling*;

8.1 STRIKING A 'COMMUNITY INTERVENTION AGREEMENT'

The fact that CERP's most fundamental commitment is to promote a community capacity-building process, the involvement of CERP would involve a formal, 3-part agreement:

Part One

The first part of the Agreement would include the terms of reference under which CERP would engage the community, covering both the initial risk assessment and the stabilization process.

Part Two

The second part of the Agreement would cover the intensive CERT ecological assessment of the many factors contributing to the problems and potential solutions for the child or youth in crisis. The assessment would examine his/her distinctive, individual needs, as well as the social context within which the routines of daily living are played out: It would explore his/her family system, peer relations, and relationships within the school and larger community. The assessment would place primary emphasis on the assets and resiliency factors in each of these aspects of the child/youth's life. Taken together and articulated in a systematic way, these resiliency factors would provide the foundation for an Intermediate Action Plan.

Part Three

The third part of the Agreement would cover the long-term, primarily community action plan, the assignment of new financial resources or employment positions to the community, any institution- or program-building aspects of the plan, and any continued CERP involvement, whether from NNAPF or a Regional, Area or Provincial/Territorial Partner.

8.2 PREPARATION OF A PROTECTIVE TREATMENT PLAN TO REDUCE RISKS DURING THE PERIOD OF INTENSIVE THERAPEUTIC INTERVENTION

If appropriate arrangements are not yet in place, upon entrance into the community, CERT would immediately work with local police and child protection officials to establish a plan and take appropriate actions to ensure the health and safety of children engaged in substance abuse behaviours when they return to the community or when their initial, emergency protection or family support plan is completed. Various options are possible, depending on the nature of the child's needs, the level of risk, the ability and willingness of the family to play an active role, and the local resources available.

The decision to intervene with a protection plan would follow from a preliminary assessment based on observations of responsible parties, including the treatment centre directors or out-patient treatment coordinator(s) working with the child/youth during the preliminary protection/detoxification/treatment period.

Several options are possible:

- ❏ agency-supported, home-based, parental supervision under a special custodial order under court authority;
- ❏ CERT-assisted, home-based, parental supervision under child welfare authority;
- ❏ protection in an appropriate local facility until further arrangements can be made;
- ❏ a furtherance of the stay in a YSAC Centre or NNADAP residential treatment centre in close proximity to the community in crisis.

8.2.1 - INTERVENING TO PREVENT SUICIDES

The fact that suicidal intention and excesses of substance abuse are often related means that emergency interventions into youth substance abuse incidents must take both threats and actual but unsuccessful attempts to commit suicide very seriously. Suicide can be defined as a self-inflicted act, consciously intended and successful as behaviour aimed at ending one's own life and undertaken in the absence of considerations of an opportunity to reverse its self-destructive outcome.

As part of the Intermediate Protective Treatment Strategy, The CERT intervention in suicidal behaviour would include:

- individual risk assessments
- peer group risk assessments
- family support capacity assessments
- organizing medical/psychiatric assessments (with hospitalization included as an option) and medications
- individual and family counselling
- developing behavioural contracts
- organizing suicide watches
- developing service and social network supports

The CERT intervention would also include the training of local, front-line workers in suicide risk monitoring, counselling and facilitating a social support system to support the adherence of the child/youth at risk of suicidal or self-destructive behaviour to his/her intervention goals.

8.2.2 - ADVICE AND ASSISTANCE REGARDING THE PREPARATION AND IMPLEMENTATION OF AN APPROPRIATE COMMUNICATIONS STRATEGY

The nature and quality of the communications surrounding community crises are important elements of a successful crisis intervention process. It is essential that clear, accurate and timely communications occur between those charged with external intervention and the immediate families and relatives of children- and youth-in-crisis. When a child or youth is in grave trouble, his or her intimates tend to agonize over the situation; some experience shock. A steady flow of information can significantly reduce the anxiety of loved ones by relieving them of the added worry resulting from morbid speculation and rumour.

It should also be recognized that the community as a whole receives various benefits from accurate and well-managed information dissemination and suffers from a lack of information, as well as misinformation. However, in the scheme of priorities during an intervention, systematic communications strike most people as having a relatively low status. So it is important that a formal community information dissemination process should be established, with specific individuals designated to provide specific kinds of information to community members.

Another critical aspect of communications in a crisis is the management of the information flow to the press and media. Obviously, it is the role of journalists and the communications media to report on critical incidents such as youth substance abuse crises. Unfortunately, what makes a story newsworthy is often its sensational quality rather than a full public understanding of the reported events or the needs of the people directly involved in the actual events that are the focus of the news. In a crisis, the media itself becomes a factor that impinges significantly on the management of the crisis. If carefully addressed, media

communications can be a minor bother or even of some benefit in overcoming a crisis; if left to chance or badly managed, media attention can frustrate an effective intervention process.

Typically, one or two leaders from the community would be designated as the *only* spokespersons for the community, with other local officials agreeing to refer all media queries to community designates. A governing council or a designated communications task team may determine whether or not to sanction the type of in-depth coverage that would require direct contact with ordinary community members and the parents and children or youth implicated in the crisis.

The job of CERT would be to assist community leaders designated as spokespersons or communications coordinators to respond to the media in a way that supports the intentions of the intervention process they have initiated. It would also be to assist designated communicators in their attempts to prevent and correct any flow of misinformation that might occur and to contain the unnecessary leakage of potentially misinterpreted information that might prove disruptive. It might also be the job of CERT to facilitate local means of deterring the children from using the media as an outlet for expressing high risk behaviours in order to "send a message" and to deter community leaders from "making a political football" out of children's needs by using media coverage as a pressure tactic.

The CERT Community Organization specialist would assist the community by training front-line workers in "media savvy." Topics covered in CERT presentations would include:

- the need to avoid exploiting child and youth crises as a "political football" to secure new resources;
- how to deter children and youth from utilizing the media as a showroom for the expression of high-risk behaviours;
- news releases that reporters appreciate;
- developing rules of communication with reporters;
- rules for writing press releases;
- writing news releases for radio;
- how to stage a press conference;
- making the most of interviews;
- when to exclude the press from meetings and when to withhold information from the press and media.

8.2.3 - INDIVIDUAL, FAMILY AND COMMUNITY STABILIZATION

Beyond the immediate stage of emergency intervention to protect the children and youth whose health is at extreme risk, a process of community stabilization must occur. During this stage, the harm reduction procedures would have to continue, with special attention

given to efforts needed to deter children- or youth-at-risk from suicidal behaviours. Further, the interveners and the local Community Advisory Committee must continue to "calm the waters" in the community by maintaining the flow of necessary, accurate information and by providing support to those closest to the children and/or youth directly implicated in the crisis.

8.2.3.1 - PROVISION OF CRITICAL INCIDENT DE-BRIEFING AND SUPPORTIVE COUNSELLING

Often a tragedy or near-tragedy has triggered the concern of a community that invites the intervening assistance of CERP. A child whose close friend has died from an overdose of a chemical substance or the parents of a group of children who lie comatose and in critical condition in a hospital after a night-long bout of gas-sniffing are themselves likely to be psychologically traumatized from the experience. To respond to the shock, disorientation and grief experienced by intimates of those who have suffered a lethal or near-lethal experience, CERP would provide critical-incident debriefing services and grief counselling services.

Crisis management techniques would be utilized by CERT and taught to front-line workers. The techniques would be intended to foster growth and avoid negative, destructive outcomes of traumatic events. The elements of a crisis intervention strategy would follow from the assessment of the following:

A. Immediate Stabilization

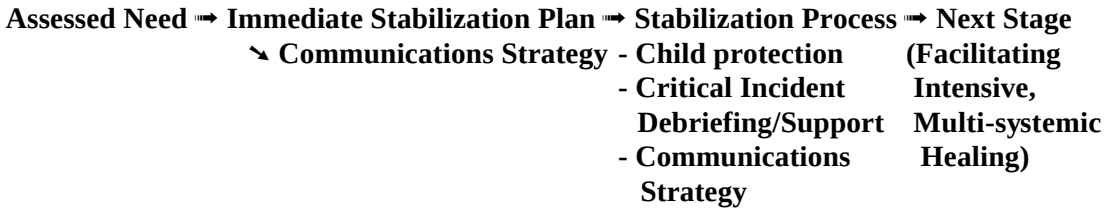
In conjunction with front-line workers and under the advisement of the Community Advisory Committee, CERT would undertake the assessment activities outlined below.

1. An attempt would be made to gain an immediate understanding of how the child or youth and his/her parents and caring relatives and community members are thinking, feeling, and acting.
2. An assessment would be made of the need for emergency protective services related to any perceived suicide risks.
3. An assessment should be made regarding any critical health problems for the child or youth or a family member that might be exacerbated by the crisis (e.g., a parent or grandparent at high heart health risk during times of stress; a parent with a mental health problem that might be compounded by the crisis; spousal conflicts that might be triggered by the crisis).
4. An assessment should be made of potential endangerment to individuals stemming from conflicts between peers involved in the crisis or between families with children involved in the substance abuse episodes.
5. The need for grief counselling and other forms of support and counselling should be assessed and the parties with the needs identified.

6. Information management and communications needs would be identified in relation to (a) the children/youth in crisis (b) the families/care-givers of the children/youth in crisis (c) other mandated agencies with obligations to intervene (d) the general membership of the community-in-crisis and (d) the media.

On the basis of these assessed areas of need, an immediate critical incident intervention plan would be prepared and a process would be activated.

FIGURE 3 STABILIZATION PERIOD: PHASE 1 *CERT* INTERVENTION



Part Three:

THE INTERMEDIATE PHASE: MOBILE, INTENSIVE INTERVENTION & HOLISTIC CAPACITY-BUILDING

9.0 OVERVIEW AND OUTLINE OF HOLISTIC ASSESSMENT

During the intensive intervention stage, CERT would facilitate or, at the wish of the Community Advisory Committee, directly undertake the following:

1. preparation of a comprehensive *Substance Abuse, Life-Situation, and Strengths Assessment* for all *Children- or Youth-in-Crisis* and their *Families*;
2. a *Community Capacity Assessment* aimed at determining what informal social networks and local service providers can contribute to both intermediate interventions and long-term interventions, and what capacity-building assistance they could benefit from to prevent future crises;
3. preparation and coordination of a *Crisis Intervention Plan and Implementation Process* that could last up to 3 months, with subsequent follow-up visits, and with the team members working on this *intermediate intervention process* on site at several intervals;
4. assistance with the preparation of a *Long-term Action Plan* and *proposal to FNI-CERP for financial resources;*
5. assistance with the *mobilization of local assets* to participate in prevention and intervention activities;
6. *Intensive Counselling Services for Substance-abusing Children, Youth and Their Families*;
7. training in the provision of *Family Preservation Services*: *Parenting Skill Development; Disciplinary Methods;* and *Family Councils;*
8. *Group Counselling and Community Healing Circles* (in conjunction with local Elders)
9. *Social Group Work Training* for front-line workers
10. training in *Pro-social Youth Recreation and Personal Development Programming*.

9.1 HOLISTIC ASSESSMENT

To prepare each child or youth for resumption of life in the community and with those adults responsible for his/her care after a period of intensively supervised care at home or in a residential treatment facility CERT would undertake a comprehensive substance abuse and life situation assessment process.

The overall approach is to prepare an intervention plan based on a set of goals developed with the child and his/her custodial care-givers, with significant, supportive assistance provided, when and were possible, by informal and formal social networks, and the school in the community.

The fundamental purpose of the assessment is to describe the child/youth's substance abuse problem and its relationship to the larger, ecological context, in which both the routines and

disruptions of his/her daily life are carried out. As in both traditional, holistic healing philosophies and contemporary ecological and systems approaches to counselling and social work, the goal of the assessment is to explain behavioural health problems such as substance abuse as a response to multiple environmental influences. This means that an assessment becomes the basis for efforts to simultaneously facilitate (a) the transformation of a child or youth's self-destructive or anti-social responses into a personally empowering, pro-social behaviour pattern and (b) the restructuring of the influences of key family, peer and community networks that may be reinforcing substance abuse patterns.

To prepare a community emergency intervention plan aimed at overcoming the crisis by motivating the children and youth in crisis to pursue healthy and safe behaviours and to avoid risky substance abuse behaviours, the following factors must be assessed:

1. the ***strengths of the nuclear and extended family*** or alternative care providers of the child in crisis, and the various ways that they can be mobilized in support of both a holistic healing process and a sustained, healthy lifestyle support system which, by its very nature, prevents relapse;

2. any ***interaction patterns between parents or alternative care providers and the child or youth*** that might contribute to his/her substance abuse, with emphasis given to the effectiveness of supervision and monitoring strategies;

3. the opportunities and constraints for healthy, substance-free lifestyles that are potentially available through ***peer relations*** in the community;

4. supportive coalitions, alliances and service supports with ***local educators and the school system*** that can be enlisted in a cooperative, co-ordinated strategy aimed at reinforcing the pursuit of plans by the children and youth in crisis and their families;

5. direct and indirect ***community services*** provided by community health workers, social development, child welfare/family support workers, justice workers and police personnel that can be integrated into the intervention plan.

Specifically, the plan should be based on an assessment that would generate the following types of information:

1. Background Material on the Children- and Youth-in-Crisis

- # Basic identification/demographics: the child/youth's name, age, gender, grade, quality of school experience, parents names, parents living arrangements/parenting responsibilities; parents education, and occupation; religion; culture; language.
- # A detailed description of the incidents leading to the intervention and the nature of the social group relationships supporting the group substance use.
- # Religion/core beliefs of parents that might influence child's behaviour or intervention.
- # Mental status of child/youth:
    a. appearance, behaviour and attitude

b. characteristics of talk

c. emotional state

d. content of thought: special preoccupations and experiences

e. anxiety

f. orientation

g. memory

h. general intellectual evaluation

i. developmental limiting factors (developmental delay; ADHD, learning disability, FAS/FAE, other conduct disorders, other psychiatric disorders, etc.)

psycho-social assessment

a. abuse in background

b. family history (parents current relationship)

c. relationship with parents and siblings, locus of authority in family/child welfare interventions

d. substance abuse in family

e. relationships with friends

f. school experience

g. academic achievement

h. substance abuse problems at school

i. discipline/conflict issues at school

j leisure interests (sports, hobbies)

k. participation in gangs

l. conflict with the law (history/current)

m. history of past and recent treatment, if any, or involvement with child welfare agencies

n . suicide or self-injury risk

o. anti-social, violence risk

p. personality assessment: distinguishing attitudes and behaviour patterns; personality, attitudinal, and behavioural strengths and behavioural weaknesses

2. Family Assessment

a. parents' visible concern and willingness to assist intervention

b. parents' emotional capacity and motivation to assist

c. parents' financial/economic status

d. grandparents/extended family roles

e. mapping of family relationships: using genogram and eco-map techniques

f. history of interactions with agencies (gained from child welfare workers *and* parents)

g. assessment of parental supervision pattern, disciplinary skills and family needs and behaviours that might contribute to a child or adolescent's substance abuse activities, and the skills and strengths it has the might be used to overcome the abuse

3. Substance Abuse Assessment

a. detailed history of child/youth's substance use/abuse

b. intervention history: detoxification; inpatient treatment; out-patient

c. social circumstances of current use

d. peer group influences

e. detailed description of current use

f. explanation of current use

g. description of behaviour while abusing: self- and others

h. effect of substance abuse on family relations, school, leisure time activities

i. habituation/addiction level

4. Functional Analysis of Problems

a. description of positive and negative consequences of problem

b. identification of conditions and settings that stimulate substance use/abuse

c. identification of people who encourage substance abuse and people who discourage it

d. medical assessment: indicators of medical and surgical limitations to activity

e. socio-cultural analysis: recent changes in milieu, social relationships, other recent

traumas or stresses

5. Developmental and Learning Disability Issues

Children with severe, often irreversible, limitations of cognitive and behavioural capacity pose special problems for not only crisis intervention but also for the organization of long-term prevention and intervention services, especially in small communities. Beyond the typical mandates of front-line health and social development workers, the special needs of these children and youth must be addressed within both the informal and formal social networks that comprise a community. Often those networks neither have the understanding nor resources to satisfactorily cope with the special challenges posed by young people afflicted with these developmental difficulties. School personnel sometimes find that, if large numbers of children with such problems are included in their student populations, excessive amounts of teaching time is spent addressing difficult-to-manage behavioural problems. This time is gained at the expense of nourishing thought and teaching academic skills to the larger student body. NNADAP treatment personnel have frequently complained that differences in the abilities of FAS clients and the majority of clients pose often unsurmountable problems for program management, the unhappy result being that neither population is getting their full due.

Youth with FAS/FAE and other cognitive and behavioural disorders can deviate from the norm in several ways. Some are very easily led, while others can be extremely assertive, aggressive and anti-social in their expression of frustration or anger. Most have significant learning difficulties and needs, including limitations on their capacity to form a clear foundation in morality, to learn new, more acceptable behaviours from past mistakes or to clearly understand consequences of their own actions generally. Given the fact that the goals of most effective therapies require active client motivation for treatment and an understanding and commitment to goals focussed on behavioural change, this population is a real challenge both for mental health facilitators and for other community institutions and services. Despite the challenge, something must be done, especially in community substance abuse crises in which children with such disabilities are active participants.

The ecological approach promoted by CERP would be extended but adapted specifically to learning-disabled and conduct-disordered children and youth and their families. CERT members would attempt to incorporate planning and training in special family and community support strategies to address the needs of children engaging in substance abuse who have FAS/FAE conditions, severe behaviour problems or learning disabilities originating in other causes.

6. Resiliency Factor Assessment of Family and Child/Youth

A *Child/youth and Family Resiliency Assessment* would be conducted to determine the

aptitudes, skills, special qualities, personality factors, motivations, and special interests that the children or youth and their families possess which can be mobilized in support of an intervention and relapse prevention plan.

7. Community Capacity Assessment

A *Community Capacity Assessment* would be undertaken to assess the extent to which local resources and local commitment and responsibility levels are likely to be able to effectively manage a long-term healing strategy. The assessment would produce an *Inventory of Relevant Community Assets* (local agencies, individuals with special skills, visiting mental health facilitators, interested Elders, available recreation programming, school assets/programs that could be utilized; funding sources; volunteers),and *authorities* (e.g., Curfews, Parent Child Care orders) that could be, respectively, pooled or utilized to respond to the problem.

The Asset-based Community Development Institute at Northwestern University in Chicago has consistently argued that "successful community building depends on both (1) building a belief in the capacities of local people, and (2) mobilizing their capacities to produce concrete outcomes." The Institute suggests that the following questions a community should ask in undertaking a community capacity assessment (Kretzmann & McKnight, 1997):

- What are the *skills* they can put to work?
- What are the *abilities* and *talents* they can share?
- What are the *experiences* from which they have learned?
- What are the *interests* and *dreams* they would like to pursue?

The community capacity assessment could be coordinated by CERT or by a local NNADAP, health service or social development worker, under the advisement of the local advisory committee and with the participation of health and social service staff.

These different assessment processes are brought together in a single chart that identifies the systemic strengths, weaknesses and needs of the child or youth and the different primary interaction systems in which s/he is routinely involved.

FIGURE 4 EXAMPLE OF A CERT ASSESSMENT SUMMARY

Systemic Strengths	Systemic Weaknesses/Needs
Individual (Name: *Allen* **Age:** 13*)*	
History of average grades until Grade 7; likes going on to land with uncle; average athletic skills; has shown some talent experimenting with soapstone sculpture (and used to help uncle with small soapstone sculpture)	History of staying out late, especially when parents were away (they were, frequently); often not attending school but doesn't inform parents: In fact, communications with parents is now minimal; submits to group pressure easily and often inhales in greater volume than other peers involved with substance abuse; his father is often away; threatens physical violence against mother when she tries to get him to stop sniffing and drinking.
Family	
Mother still obviously cares and indicates concern about boy; mother protects children from occasional abuse by father; father is moody with Allen but he does want him to get an education and to learn how to do soapstone sculptures.	Mother leans towards permissive parenting, offering little supervision and not setting limits until she becomes afraid of Allen's getting in trouble; father used to lean toward authoritarian parent style, sometimes beating children; Allen is no longer afraid of his father and there is a tension between the two, with the father becoming almost totally non-communicative with Allen.
School	
One teacher is quite supportive of Allen; school provides outlet in gym for some sports that Allen likes; the school is close to family's home on the reserve.	Principal has threatened permanent expulsion; there is a history of conflicts between Allen and several kids at school and negative interaction with several teachers.
Peers	
Some peers are not involved in the substance-abusing group Allen has been spending most time with lately; one friend is athletic and stays away from group called "druggies" locally (Allen's main peer group)—and he wants Allen to take up with another group of kids that he is involved with.	The peer group that Allen hangs out with is increasingly viewing itself as gang with the capacity to steal, sell bootleg alcohol and drugs and, in those several ways, make spending money. Allen is a bit of a follower in the group and has a great deal of difficulty overcoming their pressure to engage in high risk and delinquent behaviours.
Community (Informal and Formal Social Networks)	

Systemic Strengths	Systemic Weaknesses/Needs
Informal Social Networks: There is a kindly Elder who takes a special interest in Allen; a local man who has been involved in coaching thinks that Allen is a good skater and might enjoy playing hockey: He would be willing to teach him some skills and coach him on a team that plays other communities. A hunter would be willing to spend some time with Allen on the land. The local NNADAP worker has a good relationship with Allen and he wants him to help him run a youth camp next summer.	Several anti-social kids who are very persuasive and heavily into substance abuse live in a nearby house. A home is nearby with one teen and one adult who regularly bootlegs and establishes wild parties with the kids to raise a bit of money.

10.0 THE INTERVENTION PROCESS

Based on the detailed assessment described above and working directly with the child and his/her family, CERT would facilitate the establishment of an intervention plan based on a set of realistic cognitive and behavioural goals (structured efforts to decrease negative thoughts and behaviours and increase positive thoughts and behaviours), beginning with a short-term orientation and, gradually, establishing longer-term goals.

The team would work with the parents of the child (or youth) and other family members to develop a strategy of care and discipline that rewards sobriety in the family and adherence to the behavioural plan. This work would be undertaken jointly with local child welfare authorities.

The families would be supported through counselling, through assistance with decision-making, through the provision of respite child care, and through training in psycho-educational, structured enrichment. Depending upon the needs of the families, intervention can be focussed on parenting practices, marital relations, family communications patterns, clarification of adult and child roles, and child/adolescent development needs.

CERT would also work with local Elders, child welfare workers, school officials and teachers, the police and other relevant community service workers to mobilize support and reinforcement for the attempts of the child and the efforts fo the child's family to follow the intervention plan.

10.1 INTENSIVE ECOLOGICAL INTERVENTION: WORKING WITH THE CHILD, THE FAMILY, PEERS, THE SCHOOL, AND THE COMMUNITY

As indicated, CERT members would work not only with the child but with the child in relation to and with his biological or surrogate family, his peer network, his school and with key influences in the wider community in which the child lives. Intervention approaches can be briefly described as follows:

10.1.1 - INDIVIDUAL INTERVENTIONS

Individual counselling interventions with *both* children/youth and parents would be based on sound, empirically supported general counselling techniques and, more specifically, on cognitive-behavioural interventions that respond well to the individual needs of a child or adolescent. Cognitive-behavioural techniques have demonstrated their effectiveness with not only substance abuse and addictions problems but also depressive and anxiety disorders. They have also shown considerable promise in work with aggressive behavioural and social skills problems in youth, especially when augmented with interventions engaging parents and teachers.

Interventions with parents would be primarily focussed on encouraging active engagement

in a productive therapeutic alliance to help the child/youth experiencing the substance abuse problem.

10.1.2 - FAMILY INTERVENTIONS

The family is really the core of CERT interventions. General categories of family phenomenon that tend to be implicated as causes of serious self-destructive and anti-social behaviour patterns among adolescents include (1) parenting styles and the knowledge, skills, and beliefs that support those styles (2) personality and lifestyle choices (e.g., sobriety or non-sobriety; gambling; excessive aggression, etc.) that impact on the child care practices of the parent(s) (3) the quality and nature of marital or adult partner interactions (4) interactions throughout the family system (4) practical characteristics of the individual parent figure impacting on the family's capacity to intervene: finances; transportation, employment/unemployment, interpersonal conflict, conflict with the law, etc. The family assessment process would focus on examining each of these general categories of family functioning.

In response, interventions would be tailored to assisting the family deal with problems that may have arisen in each of these areas, with priority given to those aspects of family life that are identified as being the greatest obstacles to the healing of children and youth with severe substance abuse problems. Emphasis would be given to:

- Enhancing the parents' warmth and empathy expressed in interactions with the child.
- Working through communications difficulties and conflicted interactions of parents.
- Encouraging enhanced supervision, control and monitoring of the whereabouts of children.
- Encouraging and teaching authoritative parenting and eliminating neglectful and authoritarian styles. Authoritative parenting can be described as a parenting style that is responsive to the reasonable needs and desires of a child that are appropriate to his stage of development. This parenting style requires that parents make demands of a child or youth that are appropriate to his/her specific stage of development. The authoritative style insists that parents should have clear and well-defined expectations and rules regarding the child's peer relations, school performance, whereabouts and supervision, and assistance with household chores.

10.1.3 - INTERVENTIONS IN PEER RELATIONS

Peer interactions are typically critical to pre-teen and adolescent substance abuse problems. It is therefore paramount that therapeutic planning includes specific strategies for (i) reducing the participation of a child/youth in self-destructive and anti-social peer relations that promote substance abuse and (ii) increasing his/her positive peer relations and friendships and (iii) increasing his/her comfort and enjoyment levels when engaged in activities

involving solitude.

A variety of competencies develop in the context of social interaction between age mates that are critical to the process of sustaining positive peer relations. These competencies include perspective-taking collaboration in activities and tasks, empathy, and initiation and precipitation of interactions with others. In general, youth who achieve positive status among their peers display these competencies across multiple social situations. These competencies, however, take different forms at different stages of development and, therefore, in the provision of therapeutic support, age-specific competencies must be emphasized.

10.1.4 - SCHOOL-ORIENTED INTERVENTIONS

Often, troubled children and youth who are engaged in high-risk substance abuse activity attend classes with other children with serious emotional disturbances or behavioural problems. In remote northern communities, southern reserves, and inner-city communities, many children and youth would be sharing the classroom with part or all of the peer group in which the substance abuse has been taking place. As a result, the classroom and its social reality often conflicts with the goals of protective and therapeutic intervention. The fact is that one of the fundamental goals of therapy is to influence the youth's peer relations in such a way that they have limited contact with problem peers, while maximizing associations with pro- social peers. What compounds these difficulties is the fact that the youth and their parents often have negative attitudes towards the school and, in turn, school personnel often have negative attitudes towards the youth and their families. These circumstances themselves further contribute to the tendency for youth to engage in anti-social and substance abuse behaviours, as well as to poor school-related performance for the child or youth in crisis. The goal of CERP would therefore be to help front-line workers and parents develop interventions that empower parents to advocate for and facilitate their children's school-related outcomes.

Often, children in substance abuse situations are not attending school at all. In such circumstances, the role of the school might well be to create after-school programs or modified instructional programs that would re-engage learners. If children are in protective residential care, the schools might play a role in providing group or individual learning assistance during or after regular school hours.

The intention is to encourage and enable parents and their troubled children to take advantage of the opportunities offered by school settings. School does, after all, provide the opportunity for children to secure a formal education that leads to work, as well as a basic education in a variety of pro-social and personal development activities.

10.1.5 - COMMUNITY INTERVENTIONS: LINKING THE CHILD AND THE FAMILY TO COMMUNITY SUPPORTS

Social isolation and social networks are both sources of stress for families. Research suggests that social isolation:

- can adversely affect the emotional bonding of children and parents. For example, mothers living with many stresses are more likely to act coercively towards their children with behavioural problems when they have few contacts with members of a social support network;
- reduces the likelihood that parents, especially single parents, would follow through on therapeutic goals;
- limits the pool of potential human support available to the family.

Obviously the quality of social network exchanges can have adverse affects on parent-child interactions. For example, unpleasant interactions with friends, neighbours, other members of organizations that a parent is involved with or mental health facilitators or social service personnel, can create duress that sullies parent-child relationships. Further, parents can be so consumed by activities outside the home and through their social networks that the work of parenting can be neglected.

The CERT mental health facilitators would assess the impact of existing community linkages to the family with a view to determining its influence on parent-child relations. Assessment of community linkages primarily involves identifying those factors in the family's social network that influence the family system and parenting in a positive way (e.g., grandparents' support of the parents discipline strategies; neighbour's help to monitor a child's after-school activities) and in a negative way (drugs and solvents are readily available in the community; the most popular peer group promotes drug use).

The assessment provides the basis for the community interventions; it does so by asking the following questions:

- Who are the friends, neighbours, co-workers, or extended family members that are most likely to help when needed?
- What types of assistance does each of these people provide: companionship/comfort; a good listener; a role model; a "big brother;" practical advice?
- Who are the individuals in the social network who are most stress-creating?
- What services and what service personnel are regarded as most helpful and why?

Active and positive social support networks (i.e., high quality support from extended family, friends, neighbours, co-workers and community organizations) are strongly associated with favourable family functioning. Families with robust social support networks have more human and material resources to draw from in a time of crisis and more capacity to promote social responsible behaviours.

The types of resources that can be provided by social support networks include:

- *Emotional support*, such as providing encouragement, listening, showing empathy,

concern, love, trust and caring.

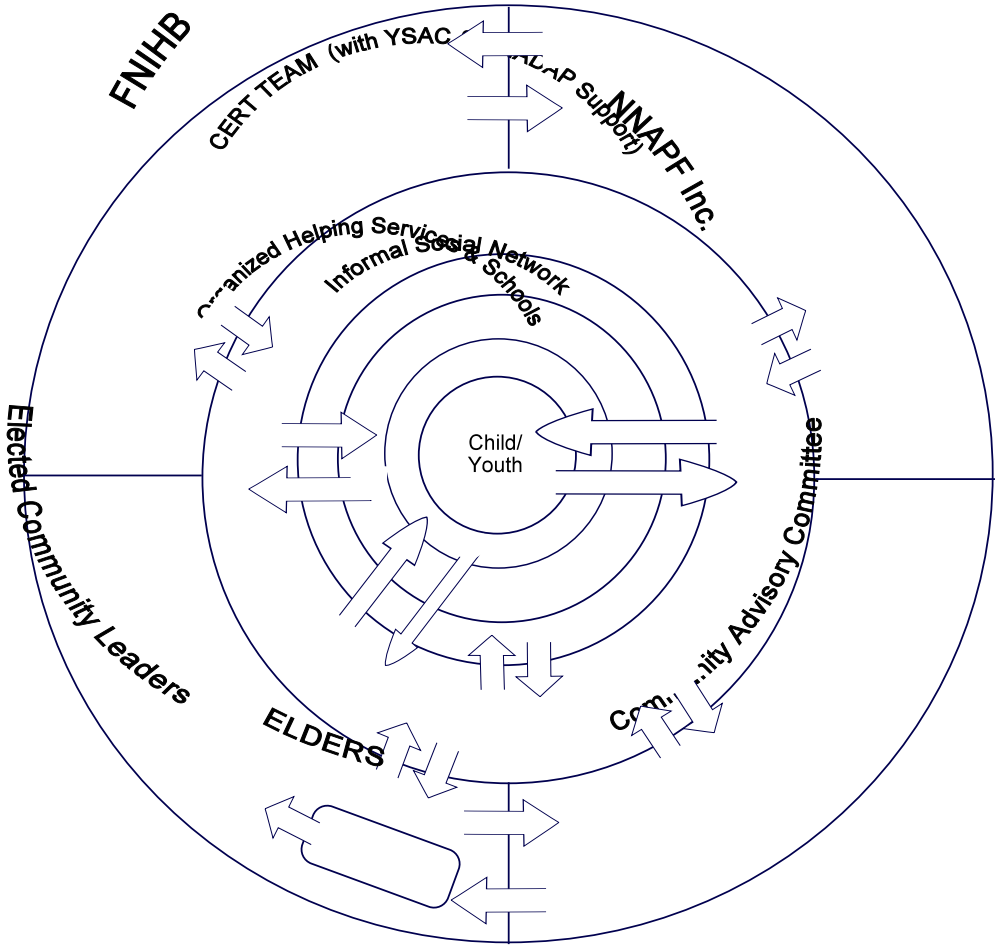
- *Affirmation* or, in other words, providing feedback (e.g., "I think you're going about dealing with this situation in the right way. I know it's tough, but hang in there!").
- *Practical assistance*, such as providing child care or help with housework or house maintenance.
- *Material assistance*, such as lending money, providing food or clothing, or passes for the children to participate in a recreational program.

Referring to the Community Capacity Assessment resource profile, the CERT team members would encourage the family to seek out as much help as they can get from their informal network connections before going to the formal network (i.e., agencies) but both have much to offer. In both case, support should be linked to the goals of the intervention plan.

To get a clear sense of all the mutual influences which together define the intervention process, the schematic diagram is presented below, entitled *The CERT Influence Circle: Facilitating the Flow of Information, Advice and Guidance in Overcoming A Crisis.*

Figure 5 the CERT 'Influence Circle': Facilitating the flow of information, advice and guidance in Overcoming a Crisis

FIGURE 5 THE CERT 'INFLUENCE CIRCLE': FACILITATING THE FLOW OF INFORMATION, ADVICE AND GUIDANCE IN OVERCOMING A CRISIS



10.2 TIME FRAME OF INTERVENTION PROCESS

The actual intervention process, in which the CERT team — whether the full complement or a smaller number — is actually working directly in a community-in-crisis, would be determined by the nature and intensity of the need. The normal time horizon for on-site work is three (3) months, although in most instances this period would not involve a 3-month residency but, rather, a staggered period of on-site visits in which the mental health facilitators are directly and intensively involved with a small caseload of families and their at-risk youth in facilitating substance-free, positive behavioural change through skill transfer, joint problem-solving discussions, and by drawing upon the strengths of the child or youth and his/her family.

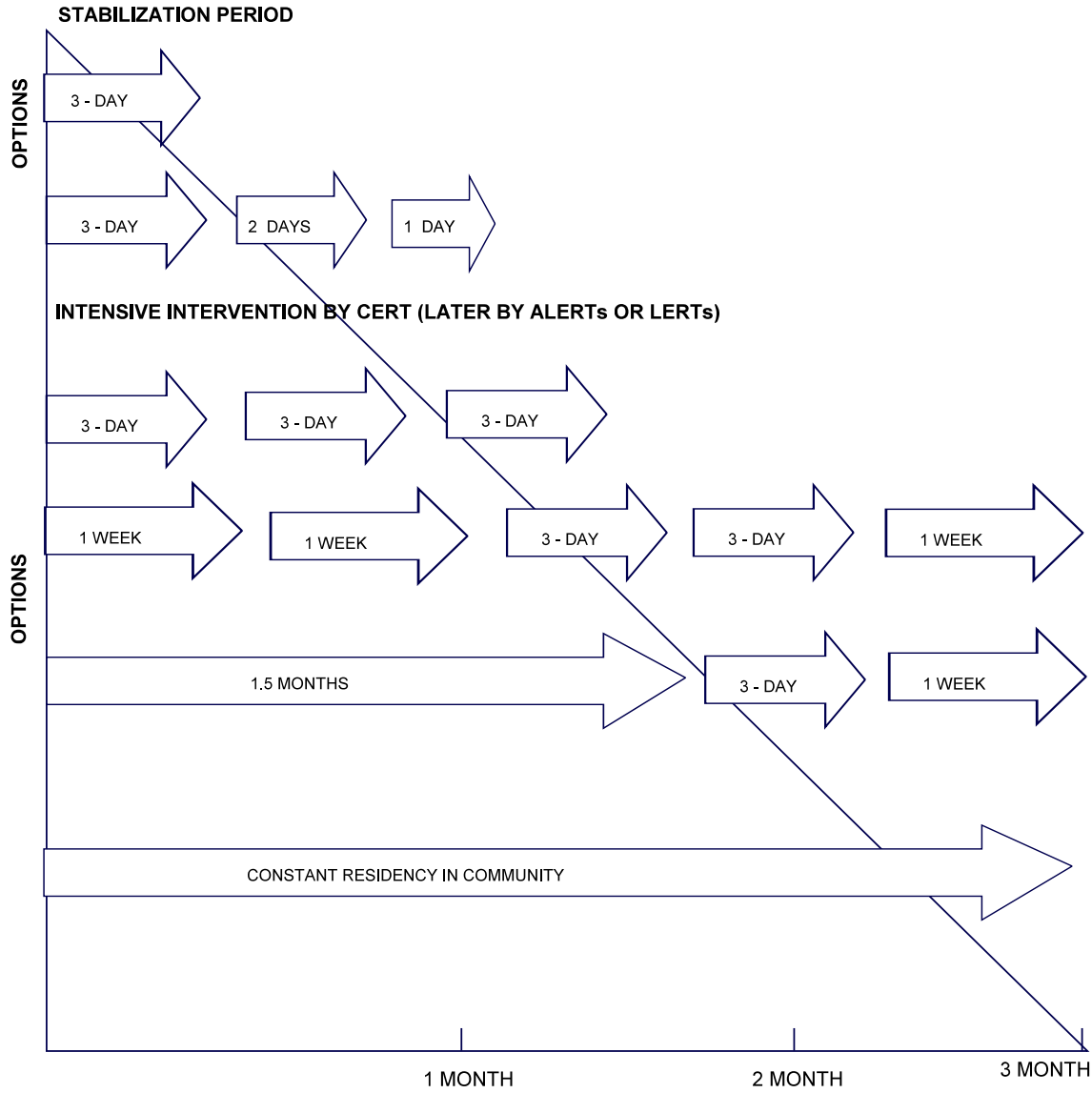
The mental health facilitators would also attempt to facilitate positive relations between the families of the children/youth in crisis and other sectors of the community. The focus would be on informal social networks and front-line services that can be enlisted as supports in reinforcing the intervention plan.

The Community Organizer would work intensively with the Community Advisory Committee to ensure that the mental health facilitators are not violating local conventions and customs. S/he would play an even greater role than the mental health facilitators in facilitating positive change in the informal and formal social networks linked to the youthful substance abusers.

The Skill Transfer Process is Essential: Front-line NNADAP or Mental Health Workers Would Work Directly with CERT Mental Health Facilitators

During this time, specific front-line workers would be working alongside the CERT mental health facilitators in order to complement and later continue the work described in the intervention plan.

Figure 6 Plausible Time Sequences for On-site Work by CERT



LEGEND:

CERT = (NATIONAL) COMMUNITY EMERGENCY RESPONSE TEAM

ALERT = AREA (i.e., Shared Service Area) + LOCAL EMERGENCY RESPONSE TEAM

LERT = LOCAL EMERGENCY RESPONSE TEAM

Part Four:

PASSING THE TORCH: CAPACITY BUILDING FOR THE LONG-TERM

11.0 ASSISTANCE AND SUPPORT WITH LONG-TERM ACTION PLANNING AND RESOURCE ENHANCEMENT

The intervention team (CERT) would also assist the community in designing a long-term action plan to strengthen and in some instances build new prevention and intervention elements into (a) the cognitive and social problem-solving skill sets of children at risk (b) into the family environments of children at risk and (c) into the local health, social service, recreational and educational service system.

A relapse prevention service protocol would typically be a critical element of a long-term action plan, as would pro-social, sobriety-promoting social/recreational programming for children and youth. The plan should be very concrete and goal-oriented. Considerations in the plan would include the following:

the community's continuing capacity to provide the appropriate range of professional services suggested by the plan—and *if* new positions are required (and where funding might be found to support those positions)

the need for an individual, agency or group to play the lead role in coordinating the continuing intervention process—and the capacity and willingness of a local entity to assume that role.

11.1 PROPOSAL DEVELOPMENT AND ADVOCACY SERVICES

The FNI-CERP strategy is not intended to replace local resources but to enhance them by providing "hands on" assistance in the form of short-term (up to one month) and intermediate-term (up to 3 month [although, typically, involving no more than 3-day to 10-day visits], intensive therapeutic interventions, and community organization assistance, planning, proposal development and skills training rolled out over a period of up to 3 months. If the community requires a significant injection of new resources and external management and program personnel assistance or if it is apparent that a community has competent and motivated leadership and human service personnel but that they need additional training, therapeutic or organizational personnel or program resources (e.g., recreational capital, sports equipment, etc.) to support a long-term plan, then CERT would assist, as required, with the following:

1. Preparing a proposal to appropriate funding agencies to access necessary resources.
2. Assisting with the hiring of personnel.
3. Acting in an advocacy capacity to assist the community with its attempts to access necessary human resources or capital.

11.2 ASSISTANCE WITH THE MOBILIZATION OF LOCAL ASSETS TO SUPPORT THE LONG TERM PLAN

It is an unfortunate but recognized fact that many if not all First Nations and Inuit communities have had much of their local problem-solving system replaced by externally imposed alternatives. With medicine provided by professional physicians, education by certified teachers conveying "Euro-Canadian" curricula, and the design and detailed work of infrastructure and housing construction provided by provincially or federally certified trades persons, engineers and architects, traditional roles have been displaced and, in varying degrees, lost in time.

An especially troubling outcome of this role displacement process is a gradual acceptance that external "experts" and sophisticated technicians must be available to solve virtually all complex, local problems. Local people have often come to see themselves as incapable of tackling many of the tougher community problems. Many, perhaps most have the view that the more challenging difficulties facing their communities should be addressed by the government, be it local leadership or the Federal Government. However, in confronting issues such as youth solvent abuse or widespread substance abuse among pre-teens, visiting professionals have not proven themselves capable of finding effective solutions.

Visiting professionals can surely help local people address such problems but they cannot solve them—at least not for the long-term. The community's human service employees can play a very important role in problem-solving but they cannot do it on their own. It is only ordinary, local people — the people who live, permanently, in the community and who collectively define its beliefs, values and norms — who can solve them. Yet it has often been said that "voluntarism is dead" in First Nation and Inuit communities. While this definitive comment is surely overstating the case, voluntary participation is *not* generally an active component of organized community life in contemporary Aboriginal communities. However, voluntary assistance is a critical aspect of in significant youth solvent abuse crises is essential to effective prevention and intervention.

There are essentially three aspects of the CERP assistance that would be provided to assist with the recruitment and mobilization of volunteers:

1. Careful explorations with local people to determine the specific factors that successfully draw people in the community into voluntary roles.

2. Approaches to encouraging voluntary participation, through such efforts as personal appeals, the circulation of posters and invitational letters, public meeting presentations, and the activation of social networks.

3. Ways to establish intangible rewards for volunteers, such as social gatherings and various forms of public recognition.

4. Improving volunteer motivation through job design, by:

    # making the job seem less intimidating and making the potential or actual recruit comfortable with its basic expectations by undertaking and sharing a role

component analysis: breaking down a volunteer task set into its component tasks or activities (e.g., organizing a "pot luck" supper can be broken down into several activities, such as:

- Deciding who's to be invited

- Selecting a date, time or place

- Design invitations

- Take invitations around to people you want to come

- Arrange food and beverages (who brings what)and utensils

- Arrange room

- Plan and get equipment for games

- Etc.;

or by providing *style options* to match individual's interests, aptitudes, "helper comfort zone" and practical circumstances,

e.g., Does the volunteer want to . . .

- work with people (e.g., a mentor) or things (e.g., helping a family with renovations)?

- help on a regular basis or continuously?

- avoid working on certain problems because of personal emotional difficulties (e.g., an individual who has had a family member or friend commit suicide recently may want to deal with the issue by helping someone who is contemplating suicide—or s/he may want to avoid the issue entirely)?

- work only with a specific age group of people?

- work in a direct way in providing a service because of an interest or skill or work in an indirect way, such as being a program advisor or board member?

11.3 FAMILY PRESERVATION TRAINING SERVICES: PARENTING SKILL DEVELOPMENT; DISCIPLINARY METHODS; FAMILY COUNCILS

The orientation of CERT would be to train front line workers to assist families in crisis to establish home environments that support healthy personal development activities which deter rather than promote high-risk substance abuse activity on the part of their children and youth. The goal is to preserve or redevelop parent/child and sibling group relationships that can support the efforts of the child with the identified problem to overcome his or her substance abuse behaviour rather than to separate the child from the home environment.

Typically, the problem in the family is twofold: the child's behaviour is not adequately monitored and supervised and the disciplinary procedures that would deter the youth from substance abuse are not effective. The challenge is to help the family become a good monitor, to function as an adequate supervisor and to know and implement effective supervisory procedures that keep a child from harm's way.

To help a family accomplish these, CERT mental health facilitators would work with parents or custodial care-givers on a daily basis for a period of from one to three months. The workers would assist the child in coping with personal health and hygiene issues, peer group influences, conflicts, academic needs and other basic challenges in his/her life. It would also assist the parents develop an understanding of child/youth development needs, and to provide adequate supervision and alternative activities to those invited by negative peer group influences. Parents would also be coached in disciplinary methods for youth.

The CERT mental health facilitators would also work closely with the CERT community organizer to create positive recreational activities for the family, and to involve grandparents and respected Elders in re-engaging the youth in traditional understandings.

11.4 SOCIAL GROUP WORK TRAINING AND FACILITATING THE DEVELOPMENT OF LOCAL, CULTURALLY APPROPRIATE APPROACHES TO GROUP HEALING AND SELF-HELP

Social group work is one of the core methodologies of social work and its use as an intervention methodology is especially appropriate for dealing with adolescents in substance abuse treatment. For serious, long-term intervention to be absorbed into the community's mutual aid system, front-line workers can benefit from learning social group work methods. A CERT intervention would therefore involve provision of training for front-line workers in social group work processes.

The social group work approach stresses the function of the social group worker as an *enabler* rather than as the expert leader and emphasizes the pivotal importance of the contribution of the group members. The group leader interacts with group members from the very beginning, when the purpose and goals of the group are established.

The dynamic and therapeutic forces of group work include:

- The facilitated social group provides the potential for young people to learn the skills of developing intimacy outside the family, with peers. The group offers adolescents the chance to learn what they have to offer and how to offer it in a cohesive group. This process is a stepping stone on an uphill path to greater intimacy with peers.
- The group offers the adolescent the chance to gain a collective sense of common ground with other youth—a process which can serve as a counter-force to the isolation and frustration of feeling unheard and misunderstood. As adolescents move away from their families and take their first tentative steps towards participation as an accepted member of a peer group, they are susceptible to periods of intense isolation. Often, they perceive

these experiences as being unique, something that they alone are going through. The group experience helps adolescents to understand that these feelings are shared and that they are a normal part of a transitional experience of maturation.

- The group also offers an outlet for expressing the need for altruism, of giving to others without feeling obliged to or without expecting tangible returns. In his/her own family, kindness or sharing may well be perceived as either an expectation or as a demand. The peer group offers the opportunity to freely express a desire to give to others, and receive for others, which is the essence of participating in a mutual aid system that is the core of a healthy community.

- A facilitated peer group can offer hope to a despondent child whose future is perceived as being very bleak. Often, the group that children and youth participate in underscore, reinforce and even intensify the child/youth's sense of despair and hopelessness, presenting high risk behaviours or vengeful, anti-social activities as the only alternatives. The structured, facilitated social group can provide a vision of the way things can be under more desirable circumstances. In a pro-social group, peers and the social group worker are able to passionately communicate positive feelings and expectations about the future to help members gain faith in their own abilities.

- Group work can provide members with extensive information about subjects some may not be familiar with but are interested in, as well as an opportunity to deal with taboo subjects that they may not have another appropriate place to deal with. In the safety of a trusted social group, misinformation and myths can be challenged. Issues of sexuality, substance abuse, cultural diversity and other problems and needs can be countered openly with factual information and advice. Skills for living can be developed by youth through learning from one another, from a group leader and through role playing such things as assertive interactions and conflict resolution and anger management.

- Adolescent group members must follow certain rules, adhering to norms and expectations that help the group as a whole to achieve its goals. Group members must endure frustration, accept fair guidelines and limits, moderate their resistance to authority, and modify or eliminate their inappropriate behaviours.

- A group also offers an adolescent an opportunity for catharsis. The expression of their ideas, feelings, hopes and dreams, as well as their descriptions of personal experiences in an accepting environment, can reduce anxiety and energize youthful group members to work together to reach value goals

- The group can also offer individual opportunity to re-experience some troubling family patterns and interpersonal relationships and to work through their dynamics in a safe and supportive environment.

- Distortions of perception can also be safely presented and challenged through the social group work process. An adolescent group member may find it difficult to hear an adult; however the voice of a peer, and especially a group of them, is hard to escape. A combination of confrontation and support provided by a group of peers " in the same

boat" can serve to challenge and minimize distortions of reality caused by denial or defensiveness.

The social group work model that CERT would train local, front-line workers in using would emphasize the following principles:

- helping the members to develop a mutual aid system.;
- structuring the group to engage the "whole" person;
- encouraging both group and individual autonomy;
- understanding group process itself as an important change dynamic;
- emphasizing the "groupness"of the group throughout its developmental cycle;
- using program activities (verbal and nonverbal) to promote belonging, competence, rationality and spontaneity;
- focusing on the multiple contexts impacting on the members lives;

11.5 HEALING CIRCLES

Healing circles would also be encouraged by CERT team members. Teaching and sharing circles can be powerful vehicles for healing, strengthening and motivating substance-dependents, and for transmitting values. Such groups provide a nurturing environment for learning, altering values, and for modelling behaviours. Traditional teaching and sharing circles link the individual's plight and healing journey to that of the community as a whole; it does so in an indirect, non-judgmental and non-interfering manner. Group members may choose to contain or share information, in degrees of exposure graduated according to one's personal comfort. The process fosters honesty and trust and discourages competition.

In sharing and teaching Circles, the assignment of special status to those who are most knowledgeable or have the most authority is removed and a sense of equality and interpersonal trust is fostered. An underlying principle is that each person travels around the circle of life at his or her own pace and with personal levels of understanding as a result of unique experiences.

11.6 PARTICIPATION IN CEREMONIES

Communities would also be encouraged to draw upon the ceremonies for their own cultural traditions. Not all Aboriginal people participate in or believe in the validity of traditional ceremonies as a component of healing. No one should be forced to participate in ceremonies intended for healing. However, even non-believers, who are willing to respect the beliefs of others, can benefit from the aesthetics and sense of spiritual cleansing that comes from ceremonies that have been passed down in time.

Traditional ceremonies may include attendance or participation in sun dances, medicine lodges, fasts, sweat lodges, and pipe ceremonies. Such ritualized events not only serve to celebrate and develop a sense of shared respect and pride in traditional cultures, they also are the means and method for establishing social networks. Traditional ceremonies also help the individual to reconnect personally, and to developing a sense of spiritual connectedness, story telling and to learn traditional teachings. All of these elements can work together to profoundly influence an individual's recovery from emotional troubles, suicidal inclinations and addictions.

11.7 ASSISTANCE WITH ORGANIZING AND TRAINING IN COMMUNITY-BASED, PREVENTIVE, RISK-REDUCTION PROGRAMMING FOR YOUTHFUL SUBSTANCE ABUSERS

The CERT mental health facilitators and the community organizer would train front-line health and education workers in developing effective, community-based primary and secondary prevention programming—i.e., programs that draw upon various resources in the community to both prevent substance abuse and other anti-social behaviour patterns among youth and to intervene in such behaviour with children and youth in an organized way. The basic approach draws on elements of the Round Lake Treatment Program, the Community Reinforcement Approach (CRA) and the social development approach articulated in both a well-received American youth intervention program published in a book entitled *Communities that Care: Action for Drug Abuse Intervention* (Hawkins *et al,* 1992) and *Vision Seekers* (1998), a program prepared by Socio-Tech Consulting Services specifically for high social-risk First Nations and Inuit youth.

In basic outline form, CERT trainers would advise communities to include the following development processes and elements in their program design:

Initiating the Process: Phase I

1. Consult with and gain support from Elders.
2. Establish a Youth Services Board that contains an Elder, a representative of the elected community leadership, NNADAP, health care and social development workers, police, and school representatives (this may or may not be the CERT local advisory board).
3. Provide community board training.
4. With Board, review *Community Assets Inventory* to determine various outlets for assistance with programming.

Program Planning: Phase II

- Basic goals in workshop format.
- Establish task forces to explore local assets and extra resources needed to respond to each

goal (with CERT member working with each task force)

- Meet to secure concensus on action elements to be mobilized to achieve each goal
- Propose a work and resource assignment schedule for plan implementation.
- Consult with resource people/institutions and funding agencies to determine what resources can be called upon to respond to each action element
- Prepare resource/funding development strategy to fill gaps in desired program profile.

Program Elements

Family and Pre-school Elements

- Utilize existing Community Health Representatives and Community Health Nurses to promote pre- and post-natal self-health care and early parent-child bonding.
- Establish or utilize existing Early Childhood Development (Day) Care or Headstart programming to train parents in early childhood development knowledge and parent effectiveness training.
- Provide educational programs for parents of children aged 2 to 5 through parent training classes or counselling. Parents, child-care workers and teachers can learn ways to promote reading and language skills and to build positive ways to set and enforce clear rules, and learn how to help children manage their own behaviour.
- Parent training to improve family management skills in areas such as communication, problem-solving, creating clear expectations (such as setting limits and establish effective rewards and disciplinary sanctions), and managing children's behaviours in positive ways. This training is not only useful for parents but for all adults with care-giving responsibilities, including foster parents, grandparents and day care workers.

School Elements

This element consists of training in:

- School organization and management techniques are introduced to parents, teachers, mental health staff, and administrators at the school level. This program element includes a method for evaluating changes in school practices.
- Assigning school mentors to children at risk.
- Arranging for tutorial assistance, when needed.
- Pro-social curriculum modifications are recommended, including those that teach young people to resist pro-drug influences from peers and the media. A strong element associating a drug-free lifestyle with positive role models and traditional values would be recommended for the curriculum.

! Instructional improvement training for teachers. With this element, teachers learn ways to improve their instructional practices, including the use of pro-active classroom management, interactive teaching, and cooperative learning methods. Teachers also learn peer coaching techniques to support their colleagues in adopting these new skills.

After-school Elements

! Training and planning assistance would be provided to help local service personnel in their attempts to create pro-social, drug free, after-school and holiday recreational programming. The approach would vary, depending upon local resources and cultural traditions. Not only organized sport but other hobby/leisure activities would be encouraged. A greater frequency of family and traditional community gatherings, such as feasts and indigenous (or contemporary) sporting events or dances in which behaviour- and mood-modifying substances are not allowed would be promoted.

  Cultural camps and children/youth excursions on the land or in the wilderness, learning about nature and traditional hunting and survival skills would also be promoted.

  While cautioned to pay serious attention to safety issues in matching people to roles, communities would be encouraged to identify contributions that all community members can make to child/youth-oriented recreation programs—and to build a volunteer program around the contributions of the wider community.

! Encourage participants to develop education goals, employment goals, and teach them and encourage their participation in hobby/leisure activities matching their interests and aptitudes.

! Programs focussed specifically on troubled children and youth would also be encouraged, with training in program development and implementation provided to teachers, youth workers, mental health workers or social workers who might facilitate them. Such programming would differ from the general recreation program in that it would have a distinctly therapeutic aspect.

11.8 ASSISTANCE WITH ESTABLISHING ALTERNATIVE HOME ENVIRONMENTS FOR CHILDREN SEPARATED FROM PARENTS

There is sometimes a need for innovative, nontraditional programs to meet the needs of children who are homeless, are runaways, or who cannot be adequately supervised or cared for by their own biological or surrogate parents. In such instances, substance abuse intervention efforts do not come to a halt but in fact are probably more necessary than they are for those children who have some support in the home. The CERP approach to providing services for such youth is to work from their strengths in an attempt to achieve three goals: (1) to eliminate a high-risk substance abuse problem (2) develop an alternative family support structure and (3) develop the skills of independent living.

Resources recommended for such a residential garment may include creative, new ways of

using foster care monies and federally funded demonstration grants. Small group homes can be used to implement the approach, although they need to be significantly different from traditional group homes. They could house only five or six youth, an older peer counsellor, and helping professionals acting as coaches rather than as experts. Substance abuse and addictions counselling would be a mandated on-site service.

In addition to the services of coaches and addictions counsellors, other components of the approach would include the following:

- educational and/or vocational services
- workshops focussed on independent living
- self-assessment and self-monitoring of independent living skills
- task groups
- family meetings
- mentoring by positive role models.

12.0 THE FINANCIAL RESOURCE PROGRAM

Another aspect of FNI-CERP is the potential for a community to access financial resources to support the enhancement of local programming in a way that links directly to a long-term CERP action plan. The intention of the program is not to incur exorbitant new program costs outside the community but to "kick-start" local, area and regional efforts to build a community's capacity to prevent and avoid the remission of critical incidents.

Items that can be funded might include:

Staff Expansion

Hiring of new staff with special skills that are not currently available in the community.. The hiring process would have to include selection criteria, actual personnel selection and a plan directed at transferring the skill to the community itself.

- e.g., The hiring of a mental health facilitator(s) or community organizer (or both) for a 3-5 year period.

The CERP financial support program would pay for recruitment and moving expenses and would provide an isolation bonus but the community itself, the Region, FNIHB or another funding source would have to be found to pay actual salaries.

Program Expansion

CERP would pay for the cost of written and audio-visual program curricula, as well as training of front-line workers in primary and secondary prevention programming and practical recreational administration.

1. *Curriculum*

Funding in amounts not to exceed $1500 can be made available to explore and purchase program curriculum materials.

2. *Training*

Actual costs of training of front-line workers in the provision of structured, curriculum-guided programming can be made available, with total amounts not to exceed $8,000 per annum for a maximum of 3 years.

Facilities Expansion

The community that is utterly lacking in physical facilities to support healthy, pro-social recreation or therapeutic activities, might require new recreation equipment, a gymnasium or a recreation centre.

While CERP would not be established as a capital program, it would provide money for the

following:

a. Leveraged, 1-shot funding of (30% cost-shared) of needed moveable capital expenses up to $20,000 (with CERP paying no more than $6,000).

b. Proposal and business plan development for submission under Regional FNIHB capital plans and to other funding sources in an amount not exceeding $25,000.

c. Architectural and engineering costs for a recreation facility.

d. Lobbying support with funding agencies when a recreation facility is needed.

Long-Term Family Support Circle

When a community has been assessed as being incapable of following through with its share of the long-term crisis management implementation plan — even with the addition of other resources provided by CERP partners — special supports would be recommended in the form of a ***Long-term Family Support Circle.*** The circle can be defined as an arrangement by which a selected group of individuals, supported by supplementary personnel working on its behalf, would assume responsibility for overseeing and facilitating the implementation of a long-term plan.

The Family Support Circle would consist of visiting professional mental health facilitators with caseloads of no more than 5 families, front-line NNADAP workers, a Regional Intervention Advisor from FNI-CERP, and an Elder or other respected advisors selected by the community. The Circle would be called upon to support a child or youth and his/her family through a period of 3 months to 5 years beyond an initial crisis intervention period lasting up to 3 months.

This support would take the form of a funding agreement to cover long-term, supplementary support for the community in amounts up to 25% of the actual costs, with the total amount cost-shared with the Non-Insured Health Benefits (NIHB) program of FNIHB.

13.0 THE PROGRAM RESPONSE FLOW: A RECAP

To summarize the flow of possible responses by FNI-CERP to a community crisis, the following steps are taken:

1. Community observations by front-line health service workers (*Monitoring and Notification Agents [MNAs])* undertaken under the guidance of a *Monitoring and Notification Protocol* raise serious concerns that a crisis has arisen that may require expert, external intervention. This concern results in a *Preliminary Notice of Concern* report being submitted to elected community leaders and to FNI-CERP's *E.R. Clinician in Charge.*

2. A Regional *Emergency Response Assessor* is dispersed to the community to undertake a *Preliminary Risk Assessment* to determine if sufficient expertise is available in the community, area, or Region to effectively assist the community or if *CERP* assistance is advisable. The Assessor also: (1) facilitates the immediate establishment of a *Community Advisory Committee* to work with interveners (2) identifies and gathers preliminary background information on the children/youth-in-crisis and (3) works with local child welfare workers (and possible police) to prepare and implement an immediate child protection plan, including detoxification, as a harm reduction/safety measure. That plan would normally involve some form of controlled observation and protection.

3. The Emergency Response Assessor and the Community Advisory Committee either request local or area resources, potentially with some needed, crisis intervention assistance through Health Canada's Non-insured Health Benefits Program (NIHB) or invites the intervention of the national Community Emergency Response Team. CERT is operationalized by a core team, including the Emergency Response Assessor, 3 mental health facilitators, a Traditional Healer, and 1 social worker with special skills as a professional community organizer.

4. CERT negotiates a *Community Intervention Agreement* to cover initial assessment and situational stabilization, which includes critical incident debriefing; it also covers an ecological assessment of the child's problems and the family patterns, peer relations, school participation dynamics, and formal and informal networks that are implicated as sources of support in the community for recovery and personal development or for relapse and unhealthy behaviours and lifestyles. In keeping with Aboriginal traditions, the assessment is "system-focussed," aimed at understanding the whole person and the environmental press which results in high risk substance abusing activity. Suicide risks are also carefully assessed. Two subsequent parts of the Agreement are signed as addendums to cover the intensive intervention and long-term support periods.

5. An *Intermediate Protective Treatment Plan* is established to reduce risks during the intensive intervention that follows the protection period at the outset of the identified emergency situation. This plan focuses on the health and safety of children and includes *Suicide Prevention Assessment, Planning and Implementation* procedures.

6. A *Communications Strategy* is prepared and implemented to address internal, community

needs, and to manage potentially disruptive media coverage of the crisis.

7. A *Situational Stabilization* phase is entered into, in which (a) critical incident debriefing and grief and trauma counselling is provided and (b) a detailed, holistic (ecological) assessment and planning process is undertaken.

8. An *Intermediate Intervention Plan Is Implemented*, either by ALERT or by the national intervention team, CERT. If CERT intervenes, therapeutic work would be undertaken to operationalize a problem-solving and support strategy that links the child/youth to his/her family, peers, school, informal social networks, and community and area helping agencies. Special attention is paid to situations in which children are assessed as having a learning or behavioural disability. The intervention team would help the community to revitalize its internal capacities to help not only with the current crisis but to generate a healthier community with a far more robust mutual aid network. Interventions involve several skill-transfer processes for front-line workers, including family systems development training, social group work methods, and ways to incorporate Healing Circles and Traditional Ceremonies into the healing process.

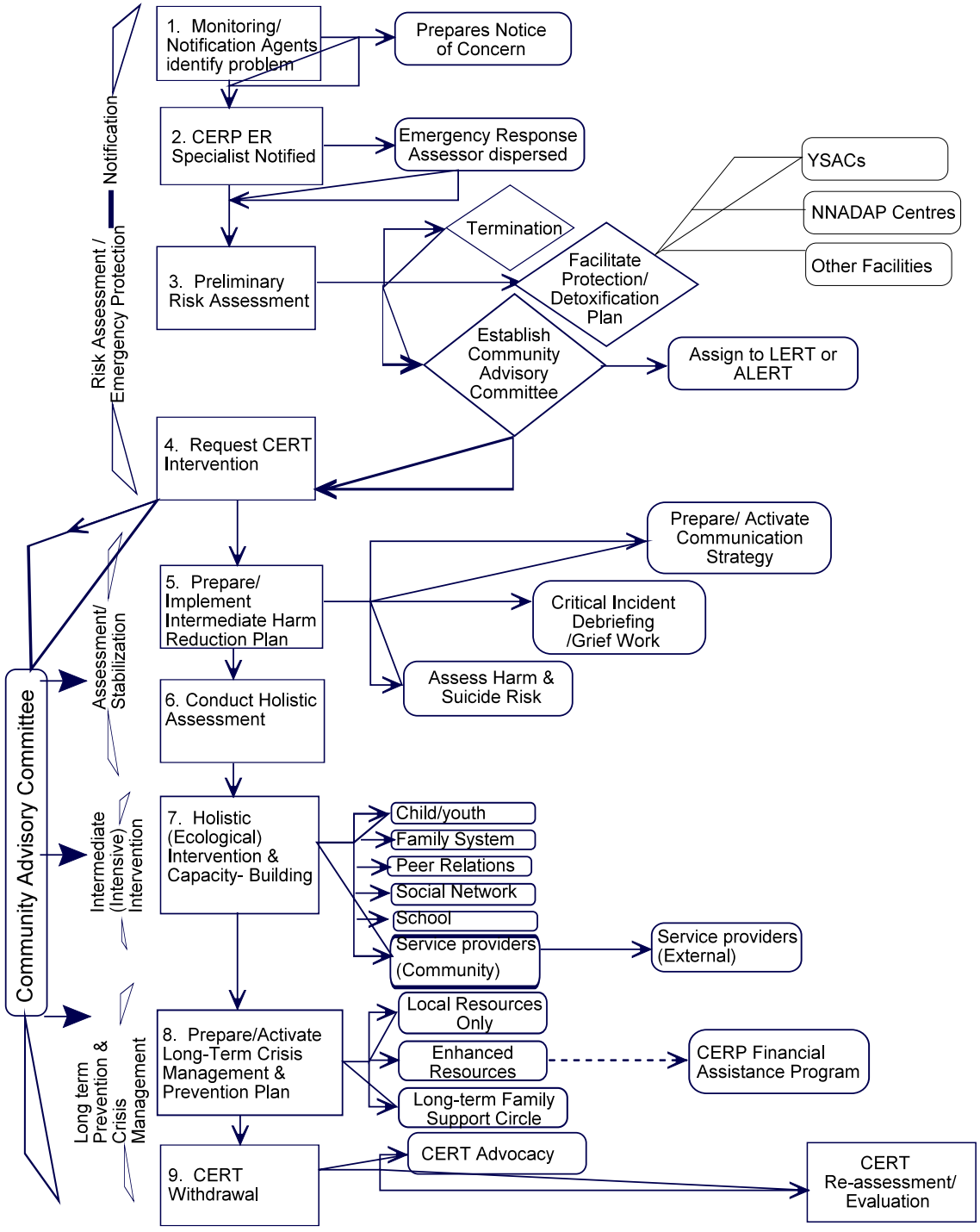
9. Once the healing work set out in the intermediate, intensive intervention plan is completed, the CERT members assist the Community Advisory Committee with the development of a *Long-term Crisis Intervention Plan*. As part of the plan, the intervention team would also train potential program providers in primary and secondary prevention programming. They would also assist with *advice and planning work if special group home arrangements are necessary* to provide proper supervision and support for a child or youth because parents are not able or willing to provide an acceptable standard of care. If necessary, the team also helps with the development of a proposal and funding request and with presentations/advocacy with appropriate funding agencies. The team might also identify the need for and recommend that the community needs to operate its long-term intervention plan with the assistance of a third party organization that would assume responsibility for delivery.

10. When materials or operational program enhancements are necessary to support primary or secondary intervention activities in the community, FNI-CERP can make cost-shared funds available.

11. The FNI-CERP program would also revisit the community at pre-determined intervals and undertake or participate in an evaluation of the outcome of CERT or ALERT interventions.

A schematic diagram charting the flow of a community and its children- or youth-in-crisis through the FNI-CERP response system is presented below (Figure).

Figure 7 The Flow of FNI-CERP Emergency responses to a Child or Youth Substance Abuse Crisis



14.0 THE REGIONAL, LOCAL AND SHARED SERVICE AREA DEVELOPMENT PROCESS

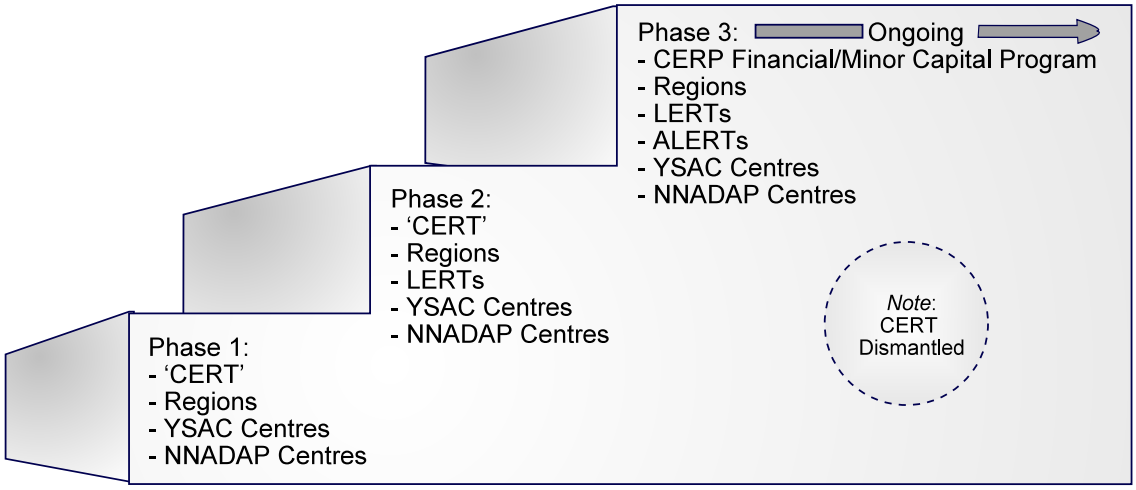
It may be important to sustain FNI-CERP on a permanent basis as a national coordinating and small-scale, leverage funding program. However, the program's active function as a delivery agent directly providing emergency response services, would be gradually phased out over time. It is anticipated that, at the end of ten years, CERT would no longer be in place. In effect, the system development process that is part of FNI-CERP would facilitate the enhancement of local, area and regional capacities to fully assume responsibilities for emergency substance abuse intervention. Further, consideration should eventually be given to the consolidation of emergency response services that embrace a full range of substance abuse age groups and a full spectrum of crises centred on mental health problems, suicide or intense, interpersonal and inter-group conflict and violence.

The program would work with all the Regional partners and the Emergency Response Assessors (ERAs) — who serve as back-up team members selected by each region — to prepare a training and development plan, initially focussed on developing a regional response capacity, then a combined area (e.g., a tribal council or addictions centre area)/community capacity (ALERT).

The ERAs would be trained as members of CERT and they would have ongoing contact with the CERP Coordinator and the CERT Support Group. With the coordination support of the ERAs and the assistance of the core CERT team and the program Coordinator, each regional First Nation and Inuit addictions coordinating body would establish a training and development plan. The plan would initially target each area and, in turn, each area would attempt to create crisis management and emergency response teams in all communities.

The schematic diagram (Figure 8) displays the anticipated developmental process through which the regional, area and local capacity-building process would be staged and CERT would dissolve.

Figure 8 The Evolution of Regional, Area and Local Crisis Management and Emergency Response Capacities



15.0 BUDGET REQUEST

The budget below presents the revenue requirements for mounting the FNI-CERP initiative. The estimates include both start-up costs and year one operational expenses.

PHASE I - TRAINING	
Consultant/Retainer fees/Salaries	
Project Coordinator/Emergency Response Specialist (annual)	$120,000
Team (Core) - retainer fees (5 x $5,000/yr)	25,000
Training Institute	
Team Salary	112,500
Team Travel (accommodations, meals, air/land)	67,600
Specialist Travel (accommodations, meals, air/land)	22,920
Backfill assistance cost (to home organizations)	45,000
Trainer Fees	100,000
Trainer Travel	33,000
Materials/manual development/distribution	
Development & Distribution	60,000
Translation	20,000
Sub-total	**$606,020**

PHASE II - IMPLEMENTATION - estimated cost of implementation of Phase II depending on number of Team members dispatched.		
Activity	**Partial - Three individuals**	**Full Team - 5 individuals**
1. Assessor	$2,500	$2,500
Travel	4,000	4,000
2. CISD Fees	15,000	15,000
Travel	12,000	12,000
3. CERT - Estimated at 3 months of intervention activity		
Team members	135,000	225,000
Travel	104,000	140,400
Backfill	27,000	45,000
4. Program Funding (Set aside annually - amount spent will depend on ability to leverage/cost share	500,000	500,000
5. Evaluation/Monitoring	9,000	9,000
6. Travel	18,000	18,000
Sub-total	**$826,500**	**$970,900**
7. GRAND TOTAL	**$1,432,520**	**$1,576,920**

Note: Budget does not include admin fees.

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Glossary of Key Program Terms

Substance Abuse Problem: An individual is experiencing a behavioural problem related to substance abuse if the frequent use of alcohol or another mood- or behaviour-modifying drug (or drugs) is affecting his or her physical, emotional, social, intellectual, educational or occupational functioning. Substance abuse is associated with the following self-destructive behaviour patterns:

- *recurrent substance use resulting in a failure to fulfill major role obligations associated with one's central life activity, such as parenting, work or schooling*;
- *recurrent substance use in situations in which it is physically hazardous;*
- *recurrent substance-related legal problems;*
- *continued substance use despite having recurrent social, interpersonal or physical health problems associated with substance use episodes.*

A ***Child- or Youth-in-Crisis*** would be defined as any First Nations or Inuit child who is identified according to a common set of standards to be abusing beverage alcohol, inhalants, or other drugs in a fashion that places the child or youth or those in contact with the child or youth below acceptable levels of health and safety.

A ***Child- or Youth Group-in-Crisis*** is any group of children or youth with three or more members who are known to engage in substance abuse behaviour in a fashion that poses extreme health and safety risks to the members of the group and other members of the community.

A ***Family-in-Crisis*** is described in the program as any unit of socially bonded, adult care-givers and their dependent children and youth in which the adults are unwilling to provide or incapable of providing sufficient motivational, supervisory or disciplinary care to protect the child from the risks of substance abuse.

A ***Community-in-Crisis*** would be defined as any community in which the dangerous use of beverage alcohol, solvent or drug is believed to be a sufficiently frequent and growing practice among children and adolescents that their children that a concerted intervention initiative is required.

A ***Monitoring and Notification Protocol*** is a protocol established by NNAPF and FNIHB as part of the FNI-CERP program that would describe a monitoring procedure, assisted by a risk-assessment check-off form, and a notification sequence replete with local, area and national program contacts.

Monitoring and Notification Agents (MNAs) would be front-line NNADAP or other community health workers who would assume responsibility for implementing the Monitoring and Notification Protocol.

Preliminary Notice of Concern A report by an MNA intended to officially alert the FNI-CERP system that an emergency risk assessment should be undertaken because a local youth substance abuse crisis may have become and emergency that may reach beyond the intervention skills and resources of a community.

Emergency Response Specialist/Program Coordinator: The individual holding this position would likely be the Coordinator of FNI-CERP. S/he would be the official recipient of the Preliminary Notice of Concern and would be responsible for a quick assessment and the decision to conduct a formal risk assessment to determine if the NNAPF mobile team (CERT) should be deployed to assist the community. The person with this title would also be expected to act as major program developer and to ensure that appropriate professional supervision is in place to assist the CERT team during an intervention.

Emergency Response Assessor. The ERA is an individual chosen by First Nations in an FNIHB service region to serve on the CERT team and to be assigned by the FNI-CERP program to visit a community that has submitted a Notice of Concern regarding a perceived child or youth substance abuse emergency. The ERA is also expected to ensure that a Community Advisory Committee is in place to work with and to steer the overall crisis management process. Upon entry into a community, the ERA's first task is to work with local officials, child welfare workers and police to ensure that the health and safety of the children/youth at risk is assured through a harm containment strategy.

***Community Advisory Committee*:** To advise and guide the CERT team and to promote local acceptance of the team, as well as to guide the intervention follow-up, CERT members would encourage a community-in-crisis to form a local advisory committee.

(FNI) CERT or CERT, an acronym which stands for "Community Emergency Response Team " is the core of the mobile, direct service assistance strategy offered by FNI-CERP. The team would retain 5 core members and 10 additional members who would only be called upon when needed. From the community's perspective, the core team would include the Emergency Response Assessor (the team's first contact person), as well as 3 Mental Health Facilitators/Therapists, 1 Traditional Healer, and 1 community organization specialist.

***The CERT Institute and Support Group*:** To prepare for its work, the initial CERT team participates in an intensive training and support group development process. The purpose of the training and group development process that team members go through is not to upgrade team members to a professional level; in fact, all members of the team are highly qualified individuals. The process is in place for team members to learn and give shape to a common body of knowledge and to learn and collectively craft a standardized skill set.

A ***Pre-emergency Community*** would be defined as any First Nation or Inuit community in Canada that is in a state of crisis but does not qualify for FNI-CERP assistance because program consultants have determined that local, area or regional resources are available to respond adequately to the crisis,

An ***(Emergency) Red Alert Community*** would be defined as any community that is eligible for FNI-CERP assistance because of the high risk levels facing children and youth in the community, formally qualifies for that assistance, and is agreeable to the terms of intervention under which NNAPF Inc. is willing and able to provide such assistance.

A ***CERT Stabilization Initiative*** is a visit by the FNI-CERP mobile crisis team to a community-in-crisis during which CERT members assist parents, relatives and others affected by the crisis in managing the turbulent circumstances and emotions that are the byproducts of the crisis itself. Preparing a longer-term harm reduction plan for the children/youth after they have completed an initial protection period, communications management and critical incident debriefing and trauma counselling are key aspects of stabilization. Striking an effective working relationship between the Community Advisory Committee and CERT are also important to this phase of intervention.

A ***CERT Intermediate Intervention*** involves a multi-systemic intervention based on an in-depth psycho-social assessment that examines the different social systems in which the child(ren) are engaged. The intervention is one in which therapist(s) and, potentially, a Healer, assist a child or youth and his/her family in developing and following through with the routines of everyday decision-making in a way that reinforces positive, substance-free living. Extended family, peers, school officials and teachers, the police and health workers are all engaged as supports or challenged as obstacles if they fail to cooperate. From the outset, skill development processes are utilized to build the child/youth's sobriety management skills, as well as the skills of his family in supporting his/her efforts, and the skills of the informal and

formal network habituated by children and youth engaged in substance abuse.

Long-term Family Support Circle. An arrangement struck as part of a long-term crisis management plan by which a selected group of individuals, supported by supplementary personnel working on its behalf, would assume responsibility for overseeing and facilitating the implementation of a long-term plan. The Family Support Circle might consist of 1 or more visiting professional mental health facilitators with caseloads of no more than 5 families, front-line NNADAP workers, a Regional Intervention Advisor from FNI-CERP, and an Elder or other respected advisors selected by the community. The Circle would be called upon to support a child or youth and his/her family through a period of 3 months to 5 years beyond an initial crisis intervention period lasting up to 3 months.