



KEYS TO HEALING

Providing News, Education and a Voice in the Continuum of Care for First Nations Addictions Specialists in BC

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Our Purpose:

Keys to Healing is published by the Association of BC First Nations Treatment Programs and is distributed free of charge. Our goal is to provide news, education, support and out reach to Community-based Addictions Specialists. The NNADAP Continuum of Care is a vital part of First Nations Wellness initiatives in BC and Community-based Addictions Specialists are at the forefront of any developments in the Addictions/Mental Health field in BC. Our objective to ensure there is a forum where Addictions Specialists can address issues.

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Association of BC First Nations Treatment Programs hopes to strengthen the continuum of care with the creation of the First Nations Wellness/Addictions Certification Board

I am honoured and proud to have been actively involved in the process of incorporation for the FNWACCB which was achieved in November 2005; this has been an ongoing dream for the treatment directors of BC for several years, states Candace Dion, Executive Director of the Association of BC First Nations Treatment Programs. We are now vigorously following through with our grandfathering stage and are confident that our board will have international recognition within the next 5 years.

The First Nations Wellness/Addictions Counsellor Certifications Board (FNWACCB) was created at the direction of the Association of B.C. First Nations Treatment Programs in recognition of the need for competitive standards with other credentialing bodies, as well as the increasing accountability required by the federal government. Certification is a process by which a non-government agency grants recognition to an individual who has met certain predetermined qualifications specified by that agency, and generally agreed upon by other agencies to be of value. Such qualification might include graduation from an approved training program; completion of a given amount and kind of work experience; acceptance performance on a qualifying examination.

The Association of B.C. First Nations Treatment Programs, which represents all the First Nations Treatment Programs in British Columbia, elected nine delegates to sit on a Certification Board. Composition of the Board includes one Elder delegate, four treatment program representatives, one counsellor from another agency, one

delegate, Community Health Associates of BC, one delegate from Aboriginal Mental Health, and one associate member.

In developing the certification standards for First Nations Wellness/Addiction Counsellors, certain principles have been recognized:

1. Certification is based largely on competence and knowledge about alcoholism/drug addiction and First Nations people rather than on emphasis on academic achievement.
2. Authority for this certification comes from the coalition of First Nations Addiction Program/Agencies, working in British Columbia, and is supported by professionals working in First Nations Addiction who share the concern of the First Nations programs for a standard of excellence and competence.
3. Eventually, standards will be developed for other staff and personnel working within the Addiction field. Persons having counselling skills and utilizing them in positions other than those clearly labeled as "Counsellor" may be certified such as program administrators, and prevention counsellors.
4. Certification will be offered to Wellness/Addiction Counsellors working with First Nations people.

The procedure for certification was outlined in 2005, and the Certification Board is to begin awarding certificates in 2006. A one-year open application period was set aside to permit applications from individuals who were eligible under the grandfathering guidelines (prior experience), closing on December 31, 2006.



Counsellors always should ask if the client has been thinking of suicide, whether or not the client mentions depression.

Stanley Sacks, Ph D., Richard K Ries, MD

Suicidality is not a mental disorder in and of itself, but rather a high-risk behaviour associated with Co-Occurring Disorder (COD), especially (though not limited to) serious mood disorders. Research shows that most people who kill themselves have a diagnosable mental or substance use disorder or both, and that the majority of them have depressive illness. Studies indicate that the most promising way to prevent suicide and suicidal behaviour is through the early

recognition and treatment of substance abuse and mental illnesses. This is especially true of clients who have serious depression (US Public Health Service 1999). Substance-induced or exacerbated suicidal ideations, intentions, and behaviours are an ever-present possible complication of substance use disorders, especially for clients with co-occurring mental disorders.

The topic of suicidality is critical for substance abuse treatment counsellors working with clients with COD. Substance

use disorders alone increase suicidality, while the added presence of some mental disorders doubles an already heightened risk. Counsellors should be aware that the risk of suicide is greatest when relapse occurs after a substantial period of abstinence—especially if there is concurrent financial or psychosocial loss. Every agency that offers counselling for substance abuse also must have a clear protocol in place that addresses the recognition and treatment (or referral) of persons who may be suicidal.

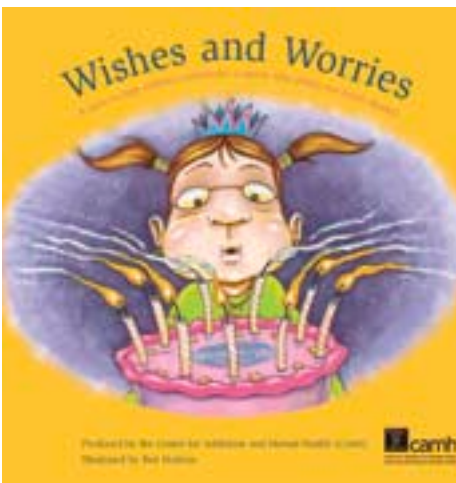
What counsellors should know about suicide and substance abuse

Counsellors should be aware of the following facts about the association between suicide and substance abuse.

- Abuse of alcohol or drugs is a major risk factor in suicide, both for people with COD and for the general population.
- Alcohol abuse is associated with 25 to 50 percent of suicides. Between 5 and 27 percent of all deaths of people who abuse alcohol are caused by suicide, with the lifetime risk for suicide among people who abuse alcohol estimated to be 15 percent.
- There is a particularly strong relationship between substance abuse and suicide

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Book helps children whose parents drink too much



Astrid Van Den Broek

Little Maggie has heaps of wishes and worries. She wishes her father wouldn't drink so much. She worries about her father drinking too much. She wishes her family wasn't so different from other families. She worries about her family being so different from other families. She wishes her friends would come over to play, and worries about



them doing exactly that.

For children such as Maggie, namely kids of parents with substance use problems, it's all too appropriate that a new book aimed at helping them cope with their feelings is titled [HYPERLINK "http://www.camh.net/News_events/News_releases_and_media_advisories_and_backgrounders/wishes_worries_pr0405](http://www.camh.net/News_events/News_releases_and_media_advisories_and_backgrounders/wishes_worries_pr0405).

html" \o "" Wishes and Worries. Maggie may be a fictional character in the story published by the Toronto-based Centre for Addiction and Mental Health, but the book reflects the fear and uncertainty that is the reality of many children with a parent who has an alcohol problem.

Helping children deal with the problem is important because it is well established that children of parents with substance use issues have a higher likelihood of developing mental health and substance use problems themselves. Children may also lose their childhood sense of whimsy. "They become in a sense 'parentified,'" says Lyn Westwood, an art psychotherapist in the Adolescent Medicine Division of Toronto's Hospital for Sick Children. "They often take on the responsibilities of parenting younger siblings, as well as looking after the addicted parent when they are no longer able to look after themselves."

So given the questions and fears children may have, books like Wishes and Worries,

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- among young people.
- Co morbidity of alcoholism and depression increases suicide risk.
- The association between alcohol use and suicide also may relate to the capacity of alcohol to remove inhibitions, leading to poor judgment, mood instability, and impulsiveness.
- Substance intoxication is associated with increased violence, both toward others and self.

Case Study: Counselling a substance abuse treatment client who is suicidal

Beth M., an American-Indian woman, comes to the substance abuse treatment centre complaining that drinking too much causes problems for her. She has tried to stop drinking before but always relapses. The counsellor finds that she is not sleeping, has been eating poorly, and has been calling in sick to work. She spends much of the day crying and thinking of how alcohol, which has cost her latest relationship, has ruined her life. She also has been taking painkillers for a recurring back problem, which has added to her problems. The counsellor tells her about a group therapy opportunity at the centre that seems right for her, tells her how to register, and makes arrangements for some individual counselling to set her

on the right path. The counsellor tells her she has done the right thing by coming in for help and gives her encouragement about her ability to stop drinking.

Beth M. does not arrive for her next appointment, and when the counsellor calls home, he learns from her roommate that Beth made an attempt on her life after leaving the substance abuse treatment centre. She took an overdose of opioids (painkillers) and is recovering in the hospital. The emergency room staff found that Beth M. was under the influence of alcohol when she took the opioids.

Discussion: Although Beth M. provided information that showed she was depressed, the counsellor did not explore the possibility of suicidal thinking. Counsellors always should ask if the client has been thinking of suicide, whether or not the client mentions depression. An American-Indian client, in particular, may not answer a very direct question, or may hint at something darker without mentioning it directly. Interpreting the client's response requires sensitivity on the part of the counsellor. It is important to realize that such questions do not increase the likelihood of suicide. Clients who, in fact, are contemplating suicide are more likely to feel relieved that the subject has now been brought into the light and can be addressed

with help from someone who cares.

It is important to note that the client reports taking alcohol and pain medications. Alcohol impairs judgment and, like pain medications, depresses brain and body functions. The combination of substances increases the risk of suicide or accidental overdose. Readers are encouraged to think through this case and apply the assessment strategy included in the discussion of suicidality in appendix D, imagining what kind of answers the counsellor might have received. Then, readers could consider interventions and referrals that would have been possible in their treatment settings.

Appendix D

Suicidality

Description

Though not a DSM-IV diagnosed mental disorder, per se, suicidality is a high-risk behavior associated with COD, especially serious mood disorders. Suicide is a complex behavior usually caused by a combination of factors. Research shows that most people who kill themselves have a diagnosable mental or substance use disorder, or both, and that the majority of them have depressive illness. Studies indicate that the

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Book helps children whose parents drink too much

which is targeted toward five- to 10-year-olds, are invaluable. "There's not a lot of children's literature that talks about alcohol or other substance use," says Diana Dickey, a child development consultant at the Jean Tweed Centre, a substance use treatment facility for women in Toronto. "Whether it's a parent or someone else who's aware of the problem, they can use books to begin to open up discussion of the problem." Books can also help eliminate the feelings of isolation that swirl around these children. "The book provides a safe framework for the child to realize that he or she isn't necessarily the only one," says Dickey.

Diane Buhler, executive director of Toronto-based Parent Action on Drugs, agrees. She says books like *Wishes and Worries* offer one consistent message to children: You are not alone. "No matter what the issue is, children measure themselves and their situations against the existing stereotype of relationships of family dynamics," says Buhler. "When they do that, they think, 'If I'm different, something must be wrong with

me.'" In children's own language and graphically, a book can say, 'You are not alone; this is not a unique situation for you; and there is help and hope.' It's a very simple message but one that needs to get to children in these situations."

Of course a book is only one component of helping children through a parent's problem. The HYPERLINK "<http://www.jeantweed.com/Pathways%20Project.htm>" Jean Tweed Centre's Pathways to Healthy Families program observes the child's and family's needs. "These children get individual play therapy," explains Dickey. "We do a lot of work around exploring feelings, talking, a lot of games. It's very hands-on and very child-centred."

Individual therapy also gives the child an ally. "It offers an external support system where children know there's at least one person to whom they can go when things seem too out of control or frightening or confusing," says Westwood. "That person becomes an ally when trying to negotiate change in the family." Such supports are invaluable, but Buhler thinks much more programming is needed for children with

parents who have a substance use problem. "Most help is directed to the person who's using [the substance]."

"There isn't much for kids in households where a family member is or has used substantially," says Buhler. "I'd like to see programs that would help reconfigure the parent-child dynamic." Key to that dynamic and to improving children's resiliency is open and honest communication that can begin with a simple but poignant story.

For information about *Wishes and Worries* or to place an order, please contact HYPERLINK "<http://www.camh.net/Publications/index.html>" \o "" Marketing and Sales Services at the Centre for Addiction and Mental Health at toll-free 1 800 661-1111 or 416 595-6059 in Toronto, or send an e-mail to marketing@camh.net.

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Advice to the Counsellor: Counselling a Client Who is Suicidal

- Screen for suicidal thoughts or plans with anyone who makes suicidal references, appear seriously depressed, or who has a history of suicide attempts. Treat all suicide attempts with seriousness.
- Assess the client's risk of self-harm by asking about what is wrong, why now, whether specific plans have been made to commit suicide, past attempts, current feelings, and protective factors. (See the discussion of suicidality in appendix D for a model of risk assessment protocol).
- Develop a safety and risk management process with the client that involves a commitment on the client's part to follow advice, remove the means to commit suicide (e.g. a gun), and agree to seek help and treatment. Avoid sole reliance on "no suicide contracts."
- Assess the client's risk of harm to others.
- Provide availability of contact 24 hours a day until psychiatric referral can be realized. Refer those clients with a serious plan, previous attempt, or serious mental illness for psychiatric intervention or obtain the assistance of a psychiatric consultant for the management of these clients.
- Monitor and develop strategies to ensure medication adherence.
- Develop the long-term recovery plans to treat substance abuse.
- Review all such situations with the supervisor and/or treatment team members.
- Document thoroughly all client reports and counsellor suggestions.

most promising way to prevent suicide and suicidal behavior is through the early recognition and treatment of substance abuse and mental illnesses, especially depression (U.S. Public Health Service 1999). A wide range of self-harm and severely negative feelings and beliefs about the self can be induced or exacerbated by substance use. As a result, suicidal ideations, intentions, and behaviors can be potentially lethal complications of substance use disorders, especially for clients with co-occurring mental disorders.

Self-harm, often called parasuicide, can be expressed in a less extreme form than suicide, such as self-cutting, self-burning, and other self-mutilation behaviors. Poussaint and Alexander (2000) include "victim-precipitated homicide" as a form of

suicidal behavior and recognize that drug and alcohol abuse often play a part in such tragic events. Researchers von der Stein and Podoll (1999) found that self-cutting acts were not accompanied by frank suicidal ideation in 18 percent of 100 male clients with alcoholism hospitalized for detoxification.

Differential Diagnosis

Suicide or suicide attempts can be the result of any substance use or mental disorder; however, suicide is more common in some disorders and more likely to be lethal with particular disorders. Acute suicidal planning or behavior requires immediate intervention; sorting out the differential diagnosis can occur later, once the client is safe. Note that being suicidal does not, in itself, mean that the person has an independent mental disorder.

Risk factors

It has been estimated that "25 to 30 percent of ambulatory clients in general medical practices have a diagnosable psychiatric condition, and a further 10 to 15 percent of people suffering from major psychiatric illnesses such as affective disorder, schizophrenia, and alcoholism will end their lives by suicide" (Blumenthal 1988, p. 937). Suicide rates are particularly high among persons with the following mental disorders (Blumenthal 1988, pp. 944–946):

- Bipolar disorder, particularly at the time of the switch from depression to mania or vice versa (as high as 20 percent)
- Schizophrenia—15 percent end life by suicide
- Antisocial personality disorder—5 percent die by suicide and as many as 46 percent attempt it
- Borderline personality disorder—5 to 10 percent eventually commit suicide, though they may also engage in self-destructive behavior without lethal intent
- Major depression—6 percent
- Substance-induced depression—7 percent

Suicide is also more likely among those with the personality traits of impulsivity, hopelessness, or cognitive rigidity (Blumenthal 1988).

Substance use disorders alone increase suicidality (Inskip et al. 1998), and rates of suicide among persons with the above mental disorders are even higher (roughly doubled) if co-occurring substance use disorders are present. In particular, there is a heightened risk of suicide when relapse

occurs after a substantial period of abstinence—especially if there is concurrent financial or psychosocial loss.

Suicidality and chronic medical illness

The presence of a chronic medical illness also is a major risk factor, possibly by causing depression or by producing an organic disorder. Individuals at particular risk include people with epilepsy (who have a suicide rate of four times that of the population as a whole), people with cancer, people with peptic ulcers (probably because of the association of alcoholism with the formation of these ulcers), clients undergoing renal dialysis, people with Huntington's chorea (their suicide rate is six times greater), and people with AIDS. It appears that "severe or incapacitating medical status when associated with depression, alcoholism, organicity, and neurological impairment are important contributing factors leading to diminished judgment and increased impulsivity in medically ill clients" (Blumenthal 1988, p. 951).

Suicidality and family history

A family history of suicide is a significant risk factor, and there is some evidence that biological factors, such as reduced serotonergic function, contribute to a likelihood of violence against oneself or others (Blumenthal 1988).

Substance Use Among Suicidal Persons

Alcohol and other drug abuse is a major risk factor in suicide, both for those with co-occurring mental disorders and for the general population. Alcohol abuse is associated with 25 to 50 percent of suicides; between 5 and 27 percent of all deaths of people with substance use disorders are caused by suicide, with the lifetime risk for suicide estimated to be 15 percent (Blumenthal 1988). There is a particularly strong relationship between substance abuse and suicide among young people. One study found that as many as 70 percent of adolescent suicide victims had alcohol or substance abuse problems. For people with substance use disorders, the incidence of suicide is 20 times greater than the general population (Blumenthal 1988).

Comorbidity of alcoholism and depression increases suicide risk (Clark and Fawcett 1992), perhaps because these agents exacerbate personality and cognitive problems, and add to environmental stressors. Alcohol also can impair cognitive

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Association of BC First Nations Treatment Programs provides ASIST Suicide Training to Front-line Workers in First Nations Communities.

ASIST is a two-day intensive, interactive and practice-dominated course designed to help caregivers recognize and estimate risk, and intervene to prevent the immediate risk of suicide. It is by far the most widely used, acclaimed and researched suicide intervention training workshop in the world.

The following is an overview of some of the things you might want to know. The workshop is for all caregivers (any person in a position of trust). This includes professionals, paraprofessionals and lay people. It is suitable for mental health professionals, nurses, physicians, teachers, counselors, youth workers, police and correctional staff, school support staff, clergy, and community volunteers. Mixed groups are strongly recommended since the workshop also facilitates collaboration among participants.

ASIST has been refined over 21 years with feedback from over 400,000 par-

ticipants and over 2,000 active trainers. Certain specifications have proven to be essential. The workshop must be conducted in two consecutive days (7 working hours per day). It must be conducted by at least two certified trainers. Each workshop can accommodate from 7 to 15 participants per trainer, although 10 to 12 participants per trainer is a better range. More than 45 participants are best split into separate workshops. Smaller workshops (7 to 15 participants) are possible but represent a less economical use of resources since two trainers must still be present.

Organizers play a big part in the overall success of each ASIST. There are fairly strict room and equipment requirements. One large group room and at least one small group room are needed for an ASIST workshop of 14-30 participants. It is almost essential that the noon meal be provided on site. Refreshments and other "creature comfort" considerations can add

that final touch of excellence. Organizers typically introduce trainers and provide information on local resources should there be participants who are at risk. Organizers often collect participant fees and oversee financial matters.

Participants receive a workshop workbook, a 110-page Suicide Intervention Handbook, a full color, laminated pocket card on intervention and risk estimation principles, and a certificate of participation. Their value is obvious to most participants. Organizers will need to consult with trainers regarding their fees and expenses.

If suicide intervention skills are needed in your community, contact Candace Dion at the Association of BC First Nations Treatment Programs.

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functioning (Rogers 1992). Using alcohol in attempts to relieve depression, anxiety, and fear often creates more depression and psychological distress, an effect labeled alcohol myopia (Steele and Josephs 1990). Alcohol myopia involves narrowing or impaired perception that interferes with inferential thought and makes one "the captive of an impoverished version of reality in which the breadth, depth, and time line of our understanding is constrained" (Steele and Josephs 1990, p. 923).

Thus, the link between alcohol use and suicide goes beyond the pharmacological and interpersonal effects. The association also may be a function of the capacity of alcohol to restrict attention to immediate situations, inhibit the ability to solve current problems, and limit hope for the future (Rogers 1992). "Alcohol and substance use and abuse exacerbate other environmental problems and lessen the ability to cope" (Westefeld et al. 2000, p. 453).

Key Issues and Concerns

The following are key elements of effective suicide prevention.

- All substance abuse treatment clients should receive at least a basic screening for suicidality. All substance abuse treatment professionals should know how to

conduct at least basic screening and triage.

- The counsellor should know his or her own skills and limitations in engaging, screening, assessing, and intervening with suicidal clients. Work out these issues before an emergency.
- Providers are advised to develop clear answers to the following questions: Do you or your agency have the knowledge, tools, skills, and personnel for crisis stabilization and/or ongoing work with suicidal clients? How suicidal can clients be and still be retained in your practice or agency? What about suicidality that emerges later in treatment or in conjunction with relapse?
- The counsellor should know what immediate onsite and offsite resources are available to help with someone identified as suicidal.
- Establish standardized protocols and staff training around suicide screening, assessment, intervention and/or triage: (1) Who asks? (2) What is asked? (3) When is this done? (4) Where does this take place? (5) How are findings documented? (6) What is done with the results?
- Suicide "contracts" are written statements in which the person who is suicidal states that he will not kill himself, but rather

call for help, go to an emergency room (ER), etc., if he becomes suicidal. These contracts are not effective as the sole intervention for a client who is suicidal. While such contracts often help to make the client and therapist less anxious about a suicidal condition, studies have never shown these contracts to be effective at preventing suicide. What good contracts really do is help to focus on the key elements that are most likely to keep clients safe, such as agreeing to remove the means a client is most likely to use to commit suicide.

Strategies, Tools and Techniques Engagement

It is possible, though uncommon, for people with suicidality as their primary complaint to present to substance abuse treatment professionals; it is more likely for them to go to mental health agencies or ERs. Nonetheless, substance abuse treatment counsellors should be prepared to detect suicidality. During the course of substance abuse assessment, the suicidal client may appear withdrawn, depressed, or even angry or agitated. It is important to inquire about these symptoms as they appear. For example:

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- You know, you seem to be pretty down. How depressed are you?
- The issue may arise in response to general questions: “Crack? No, I don’t use that much any more. I get really down when I’m coming off it.” The counsellor might then ask, “How down have you ever gotten? “Were you ever suicidal? How are you doing now?”

At issue is the principle that the suicidal client is more likely to engage with the counsellor and reveal his or her suicidality if the counsellor responds to clues given by the client and inquires sensitively about them. To say to an agitated client, “You seem pretty nervous and uncomfortable—is there something I can do to help?” opens a door to further assessment.

Screening and Assessment

Screening

All substance abuse treatment clients should receive at least a brief screening for suicide, such as: “In the past, have you ever been suicidal or made a suicidal attempt? Do you have any of those feelings now?” All substance abuse treatment staff should be able to screen for suicidality and basic mental disorders. It is expected that those at the intermediate or advanced levels of COD competence will have additional knowledge and skills.

Risk Assessment

No generally accepted and standardized suicide assessment has shown to be reliable and valid, but most established suicide assessments contain similar elements. A particularly easy-to-use method has been developed by the QPR Institute for Suicide Prevention. Further information and

training is available at their Website (www.qprinstitute.com/).

The QPR Institute’s risk assessment interview is designed to elicit information about the individual’s current risk of suicide, which then can be used to match the level of care with the level of risk (Quinnett and Bratcher 1996). The authors note that “client answers to an initial seven questions provide the database for clinical decision making, while the client’s level of commitment to safety/treatment management plan determines the level of care, e.g., outpatient, inpatient, evaluation for involuntary admission. See Figure D-1.

While the entire protocol includes 13 questions, the seven questions in Figure D-1 provide rich data that provide a basis for making clinical decisions. Instead of the common “no-suicide” contracts (e.g., “I will go to the ER before taking an overdose”), this protocol recommends a more complete informed consent, safety, and risk management process that requires the client’s consent to six key elements. These are

- To remain clean and sober.
- To follow medical advice.
- To see the removal of means of suicide.
- To commit to personal safety.
- To seek help in case of an emergency.
- To follow through on referral and/or treatment (Quinnett and Bratcher 1996).

By using this evaluation format or other suicide evaluation tools, the clinician needs to determine whether the risk of imminent suicide is mild, moderate, or high. The clinician must also determine to what degree the client is willing and able to follow through with a set of interventions to keep safe.

Using many of the same indicators, counsellors should also be prepared to probe the client’s likelihood of inflicting harm on another person. Specifically

- On a scale of 0 to 10, with 0 meaning “not likely at all,” how likely are you to harm this person next week?
- Do you have a plan for how you would do this?
- Would you be willing to agree not to harm this person during the next week?
- Would you be willing to agree to tell someone before you do this?
- How confident are you that you can remain sober over the next week? What can you do to increase the chances you will remain sober? (e.g. use of 12-Step meetings, supports or treatment).

Screening personnel should also assess whether suicidal feelings are transitory or reflect a chronic condition. Factors that may predispose a client toward suicide and should be considered in client evaluation can be seen in “Risk Factors” above.

Documentation

In today’s managed care environment, intakes are often preprinted with yes/no or other checkoff items. For example, some State versions of the Addiction Severity Index (ASI) may include only whether the client has ever had psychiatric care (yes/no) and whether the client is on psychiatric medications (yes/no) or some other abbreviated psychiatric inventory. As noted, it is the view of the consensus panel that because suicidality is common in the substance abuse treatment population, all substance abuse treatment clients should receive at

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Figure D-1

Key Questions: Suicide Risk Review

What is wrong?

- Personal narrative about how bad things are and the nature of the problem/s.
- Personal construction of reasons for suicide.
- Personal measure of psychological pain and suffering.

Why now?

- Elements of the current crisis.
- History of real or imagined losses or rejections.
- Sudden and unacceptable changes in life circumstances; for example, the client just received a serious or terminal diagnosis, relapse, onset of possible symptoms (e.g., sleeplessness)

With what?

- The means of suicide under consideration
- Access to the means selected

Where and when?

- Possible location and timing of a suicide attempt
- Degree of planning
- Possible anniversary phenomena

When and with what in the past?

- Past history of suicidal behaviour
- Past history of intense suicidal ideation and/or planning

Whether rescue was avoided

- Timing of past attempts
- Social response to past attempts
- Potential protective factors (reasons for living)
- Comparison of current method versus old method

- Timing of past attempts.

Who’s involved?

- Others who may know or be involved
- Person who may or may not be helpful in managing the client
- Names of potentially helpful third parties
- Possible presence of suicide pact or murder-suicide plan

Why not now?

- One or more protective factors (reason for living)
- Spiritual or religious prohibitions
- Duties to others or pets
- Residential tasks to be completed before the attempt; for example, making out a will

Source: Quinnett and Bratcher 1996

least a brief screening for suicide. If the screen is positive, the client should receive a more thorough assessment as discussed previously. Further screening/assessment should be documented to protect both the client and the counselor. This means writing information on evaluation forms or making additional notes, even if suicide-related items are not included on the form used.

Crisis Stabilization

The first steps in suicide intervention, and thus crisis stabilization, are contained in the process of a good engagement and evaluation. Asking suicide-related questions, exploring the context of those impulses, evaluating support systems, considering the lethality of means, and assessing the client's motivation to seek help are in themselves an intervention. Such an interview will often elicit the client's own insight and problem solving and may result in a decrease in suicidal impulses.

If, however, the client experiences little or no relief after this process, then it is clear that psychiatric intervention is required. This is especially true if it emerges that the client has a co-occurring mental disorder or medical disorder in which the risk of suicide is elevated (see "Risk Factors" above) or if the client has a history of suicide attempts. If either or both is true, arrangements should be made for transfer to a facility that is capable of more intensive psychiatric evaluation and treatment. Emergency procedures should be in place so the counselor can accomplish this transfer even when a psychiatrist or clinical supervisor/director are not available. Once the client is stabilized and is safe to return to a less restrictive setting, he or she should return to the program.

Short-term Care and Treatment

Treatment for the client who is suicidal should include supportive care aimed at helping the client vent feelings, discover alternatives, improve relationships, change negative thinking, and focus on the future (Blumenthal 1988). The clinician should be caring and supportive. The seriously suicidal client should have someone to contact 24 hours a day, and frequent telephone contact between the client and the contact person usually is indicated.

Management of a client who is suicidal "usually requires the assistance of a psychiatric consultant and is clearly indicated for all clients who have a serious plan for suicide or who have made an attempt"

(Blumenthal 1988, p. 958). At a minimum, "consultation with a psychiatric colleague who has specialty training in the diagnosis of mental illness is often indicated and may be particularly helpful in the assessment and management of acutely suicidal persons" (Blumenthal 1988, p. 959). The client should be evaluated by a psychiatrist onsite immediately, or a case manager or counselor should escort the client to emergency psychiatric services. Where available, mobile crisis service, which includes a psychiatrist, is another quick response resource for the management of the client who is suicidal.

Case management

Interventions should seek to increase support available to the client from the family and community, and should provide immediate interventions, including medication to stabilize the client's mental state, if needed.

Psychoeducation

Families and individuals often benefit from education about depression and suicidality, including warning signs, resources for help, and the importance of addressing this problem. Education often provides individuals with a sense of hope and realistic expectations. Many individuals will have passive suicidal ideation at one point in their lives. Some individuals will feel reassured to know their feelings are not uncommon and be more willing to share their feelings about their thoughts.

Adapting mental health/substance abuse treatment approaches to specific disorder subtypes

The co-occurrence of substance abuse and suicidal thoughts increases the risk of suicide and requires clinicians to be more active in their management of the problem. People with chronic substance use disorders may need to undergo detoxification and may have cognitive limitations secondary to chronic usage.

Longer Term Care

Suicidality is not in itself a disease; rather, it is a short-term, acute, and potentially lethal behavior or set of behaviors. Longer term treatment issues for a client who has been suicidal focus on long-term treatment strategies for COD or on other risk factors that have culminated in a suicidal event. In this case, treatment becomes long-term prevention. Some persons who are chronically suicidal need special programs that can handle this chronic behavior (American Society of Addiction Medicine 2001).

Among clients with dependence on alcohol, "suicide frequently occurs late in the disease, often in relation to rejection or some interpersonal loss as well as to the onset of medical complications of the illness" (Blumenthal 1988, p. 945). Particular attention should be given to people with long-term dependence on alcohol who are developing medical symptoms, who are experiencing a personal loss or crisis, or who have had a relapse. It is wise to check for suicidal ideation regularly as it can recur. Since relapse is far and away the most dangerous suicide risk in long-term substance abuse treatment clients, the consensus panel recommends a solid long-term recovery plan as the best approach to suicide prevention. In persons with serious and persistent mental disorders, such as bipolar disorder, long-term medication compliance is a key element in preventing suicide. Just as essential as medication and medication compliance, however, is the need to rebuild a sense of hope in the future and engender the belief that recovery from cooccurring disorders is possible and that one has a sense of purpose, value, empowerment, and role in one's own recovery.

Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005. Note: The guidelines in this document should not be considered substitutes for individualized client care and treatment decisions.



HIV/AIDS Providers: Is your adult client at risk? A Tool for Substance Abuse Treatment Providers

Because substance abuse is associated with the risk of HIV infection, it is recommended that clients receiving substance abuse treatment be screened for HIV/AIDS. The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) has published this pocket tool to assist substance abuse treatment providers in this process. The enclosed card contains two sets of questions that can be used with your clients. Part One, "Identifying Risky Behavior," is used to identify what types of risky behavior, if any, a client may be engaging in. Part Two, "Talking Points for Reducing Risk," contains questions to engage the client in a discussion about changing or avoiding such behaviors.

KEY POINTS for Providers:

Clients need to feel comfortable talking about risky behaviors, especially sexual activities. If there is no one on the clinical staff with whom the client feels comfortable, you should make a direct referral to a listed HIV Counseling and Testing location.

You should be comfortable—and prepared for—discussing any barriers a client might be facing in attempting to change his or her behavior, even if you must do background reading or obtain supervision to achieve that comfort or knowledge level. For clients who are willing, it can be helpful to discuss these issues in a group therapy setting. A culturally sensitive and non-judgmental tone is essential, and motivational interviewing techniques can be helpful to expand the conversation.

KEY POINTS for Your Client:

- ANY risky behaviors at ANY time can result in HIV infection.
- Early identification of HIV/AIDS is critical to improve treatment outcomes.
- Clinics that offer HIV counseling and testing have standard procedures to ensure that those who receive testing also receive counseling about what the results mean and what to do.
- Even if testing yields a positive diagnosis, many people are living successfully with HIV.
- To protect a client's identity, both substance abuse treatment programs and local HIV counseling and testing sites are required by law to abide by confidentiality policies.

- Because there are many strains of HIV, a positive diagnosis does not mean that the client no longer has to worry about HIV infection or reinfection.
- Clients who are or may become pregnant should be assured that medication can now almost entirely eliminate the risk of the baby becoming infected with HIV.

IDENTIFYING Risky Behavior

Ask your client the following questions: Since 1990 have you

- Had unprotected vaginal, oral, or anal sexual activity or intercourse?
- Had unprotected sex with a man who has had sex with another man or other men?
- Had unprotected sex with someone who has HIV or AIDS, or who you think might have been infected?
- Had unprotected sex with someone you believe has injected drugs (someone who "shoots up")?
- Not properly and carefully used latex condoms with people who might have had HIV?

Did you ever

- Inject drugs, steroids, or vitamins, or have a sexual partner who did or does so?
- Share needles and/or the same cooker, cotton, rinse water, or other possibly contaminated materials?
- Have multiple sexual partners?
- Give or get money or drugs in exchange for sex?
- Have a sexually transmitted disease (STD), such as gonorrhea, syphilis, chlamydia, genital herpes or warts, or have a sexual partner with an STD?
- Receive transfusions of blood or blood components between early 1978 and mid-1985, or have a sexual partner who did?
- Have sexual partners who have had other sexual partners who did any of the above?

TALKING POINTS for reducing risk

Ask your client the following questions:

1. How comfortable are you talking about safe sex with a sexual partner (or a potential sexual partner)?
2. Do you know how and when to use a latex condom?
3. Are you able to talk about correct use before you have sex?
4. Do you have any trouble going into a drug store and buying condoms or getting them in some other way?

5. Can you refuse to "shoot up," "skin pop," or come into contact with contaminated materials, even if people around you are doing it?
6. How would you go about convincing a partner of the need for a condom?
7. Is it hard for you to avoid having unprotected anal intercourse?
8. Do you know when to use two condoms for protection?
9. How hard is it for you to ask a partner about his or her previous sexual partners, or other partners they might have now?
10. Do you have any trouble refusing to use a needle that has already been used?
11. How hard is it for you to avoid sex with someone you do not know very well if they want to have sex?
12. How hard is it for you to avoid people who might put you at risk for HIV infection, or to avoid risky situations in general?

If clients identify any of the points covered here as barriers, they may be putting themselves at risk. Let them know that being uncomfortable talking about these subjects is understandable. Also note that even people who recognize that their behaviors put them at risk may still engage in such behaviors because they haven't thought ahead of time about how to change the situation. Clients should know that you can role-play with them possible ways to behave differently and that you can discuss strategies with them for managing risky situations.

A helpful strategy

If a client finds it awkward to talk about HIV with a sexual partner or potential sexual partner, you can suggest that it might be easier to "break the ice" by beginning the conversation with a question, such as, "Are you ever afraid of getting HIV or of giving it to someone else?" Some people find it even easier to begin the conversation with a less direct question, such as, "Do you ever think about having a child (or another child)?" This may lead more naturally to a discussion about fears of getting HIV and its impact on being a parent.

Source: SAMHSA's National Clearinghouse for Alcohol and Drug. DHHS Publication No. [SMA] 05-4003. Printed 2005.

Note: If your client needs assistance in locating an HIV/AIDS testing facility, he or she can call Healing Our Spirit at 1-800-336-9726 or Red Road HIV/AIDS Network at 1-866-913-3332.



TESTIMONIALS

The following are testimonials for treatment within the Association of BC First Nations Treatment Programs. Treatment works!

Antoine D. Archie

My parents both died alcohol related deaths. I was barely out of my teens when my mother died and my father died 10 years later. My parents never went to residential school, as a matter of fact they had no schooling at all.

I attended residential school from 1951 to 1959. I was abused physically, mentally and spiritually. I drifted for years doing meaningless jobs leading nowhere, no benefits or security. On self examination I saw a complete state of hopelessness. This went on for 20 years until some of our people started to go to treatment for alcohol abuse. During this time I had been doing some upgrading taking courses here and there.

As a result of seeing some of my people becoming sober it occurred to me it would be nice if I could do that for myself as I had been on the wagon a few times in my life but always struggled maintaining sobriety. I had a band worker arrange treatment for me at Round Lake in the late summer of 1981.

I completed the program and went on to work for my band in various jobs, always moving up. Finally in 1986 I had the confidence, thanks to my sobriety to move on in life. I enrolled at Gonzaga University in Spokane Washington. I graduated with a Degree in Bachelor of Education in Native Leadership. I went on to become Chief of my band for 8 years. At the expiry of my last term I came to work for Nengayni Wellness Center, started as program manager and was promoted to Executive Director up to the present. All together I have been sober for 23 years. I am now sharing my life experiences and sobriety with all people.

Julie Fontaine

I came to Tsow-Tun Le Lum in September 1989. It was the caring, safe environment

I needed to heal myself and to make changes in my life. The tools I received there carry me through to this day.

I have been clean and sober for over 14 years, gone back to school with goals of completing my Master's degree. I've worked in the helping field for over 11 years in the areas of drug and alcohol addiction, work with sexual offenders, in Residential School healing and currently work as a Family Service Worker with high risk youth in foster care.

I believe in the work that Tsow-Tun Le Lum does. The principles and caring along with the spiritual healing that occurs has helped many people over the years. I received a lot of love and support in my early sobriety, a gift that I have never forgotten.

The gift of healing in such places does not impact only one individual. Thanks to the center, the support and the opportunity for me to address the past and arrest my addiction, my children, grandchildren and generations to come have been affected. Breaking the patterns and understanding dysfunction has broken a cycle within my family. Thank you for the gift of life!

Raymond E. Harris

I am of Gitksan ancestry; my roots are steeped in Wilps Tsibasaa, an ancient and honourable extended family in Gitksan territory. A sub-chief, the most fundamental entity in Gitksan domain I am known as "Niiyeeshiwaas", my second Gitksan name. Right after graduating and surviving the Edmonton Indian Residential School, 37 years ago and after some "20 years of drinking, being sick and sick of being sick," I admitted myself to the Round Lake Treatment Centre and I have not looked back since. I have been clean and sober for 14 years now and been working at Wilp Si' Satxw for 10 years.

After dabbling in business administration related courses at the Northwest Community College, I engaged in serious study of the alcohol and drug counter-culture and secured certificates in counselling theory and techniques from the renowned Nechi Institute. Working as a counsellor for Wilp Si' Satxw, I began a serious study of the many teachings, ceremonies and traditional medicines of the Sacred Pipe pathway. After three, three-day fasts led by Joe and Jenny Cardinal of Saddle Lake, I received the honour and responsibility of holding a Sacred Pipe for the people. I am now the resident Sacred Pipe Carrier, counsellor and workshop facilitator for Wilp Si' Satxw. Recently

I have received a Chartered Herbalists' diploma in herbal medicine.

Angie Louie

I was dying through my addiction, and I knew it but I didn't care. I believed the world would be a better place without me. I had done so much wrong in my life (up to that point) that I didn't think I would ever live long enough to make amends to them all. I honestly didn't believe I was worth the time or the effort it would take to try for a first chance at a better life.

I witnessed sobriety in my Community, but those people were so untouchable. They were like gods to me...someone to Fear and never look in the eye—for fear that they would discover what a mistake I was. Or worse yet, tell me what a mistake I was. I couldn't risk the chance that I would be hurt by them, so I did what I could to hurt myself more than they ever could. They had close families, good jobs, vehicles, and most of them worked at the Treatment Centre on the Rez. "They" were my perceived enemy... because they appeared happy.

Then one day I woke up after another Blackout Drunk and didn't know where I was. I was just thankful that it wasn't the Slammer. AGAIN! I immediately felt the pain of another injury. AGAIN! But there was something different about this injury. I wasn't going to be able to hide this one because I had broken my hand. I couldn't bare the thought of facing people with a broken hand so I made plans to run. AGAIN!

Well, it turns out that I wasn't able to run very far. I didn't have any money to go anywhere or really anywhere to go. So, I sat there and I cried. I cried harder than I had ever cried in my life...for myself! I was sitting at the bottom of my addiction and I knew that someone was going to end up dead and I was hoping it was going to be ME.

I know now that it was in that moment that my tears were my prayers and they were answered. My last drink was March 26, 1992 and since that time, I have changed my life to reflect what a gift I am from the Creator. I sobered up, I found out that I was pregnant shortly after and finally carried a child free from Alcohol & Drugs. (She is a healthy 11 year old girl today.) I wish I could say the same for my oldest daughter. I know that I damaged her and she was where I began my amends. I took her back and raised her in sobriety.

That first year of sobriety was a complete

Continued page 12

NATIVE CUSTOMS

Wilp Si' Satxw House of Purification on their cultural program approach.

Many people of Native descent know relatively little about their culture, as much knowledge was lost because of former provincial laws. However, there is a lot of effort being made to relearn native dances, ceremonies, languages, etc. Because of the loss of some West Coast traditions and because of the variety of Indian groups represented in Vancouver, some plains ways have been adopted here, but there still exist very distinctive traits of each tribe and area, particularly noticeable in their art and handicrafts.

Source: www.wilpchc.ca/nc.html

NATIVE SPIRITUALITY

Donald Prince

Talking Circles

Native people regard the circle as the principal symbol for understanding life's mysteries, for they observed that it was impressed everywhere in nature. People looked out on the physical world through the eye, which is circular. The earth was round, so were the sun, moon and planets. The rising and setting of the sun followed a circular motion. The seasons formed a circle. Birds build their nests in circles. Animals marked their territories in circles. In the old days, houses or shelters were built in circles, like the teepee. To Native people, the whole of life seemed to operate in circular patterns.

Suggested Guidelines For Talking Circles

Welcome everyone and ask them all to sit in the circle.

- Sit in the circle.
- Leader will talk on guidelines and will smudge the circle and the area.
- Leader shares first - using the sacred element he/she desires.
- Sharing goes clockwise, giving each person an opportunity to share from the heart.
- When someone is sharing, no one is to interrupt. The leader is the only one who can.
- If a female is on her moon cycle, she can ask the person next to her to hold the sacred element and continue to share.
- If someone does not wish to share, he/she can pass.

- The Talking Circle has no time limit. Sharing continues until everyone in the circle has an opportunity to speak. There are exceptions to that in we can set a limit but with the understanding that it might go over the time limit.

SAFETY FOR GROUP MEMBERS

Sometimes in the safety of circle, people will find themselves bringing up sensitive issues, and for that reason, it is important that they can let the subject matter drop when they are done talking.

During the break (if you have one) or after the circle, one should not go up to another person and start discussing about what that person said in their talk without asking their permission to do so. Nothing can make person distrust or close up than having to answer for something they said during the circle. Nor should anyone talk about anything personal that others have brought up in the circle.

Remember that the circle is a place of safety and a tool to help people to speak about what they are feeling and thinking. It is not a place where we are trying to solve someone's problems.

EAGLE FEATHER.

- 1 Holding the eagle feather in a talking circle indicates a hunger and thirst to be truthful and alive—together in spirit with all our relations.
- 2 The eagle feather connects strength, wisdom, grace and truth throughout the circle.
- 3 The eagle feather carries our exact words and thoughts to the Creator
- 4 The eagle feather grieves when given a message of foul language to carry.
- 5 The eagle feather connects to our ancestors and they join us in the circle.
- 6 The eagle feather, when passed around the circle, conveys positive or negative energy to the Caretaker of the feather.
- 7 The eagle feather carries on the Native way of life for present and future generations.
- 8 A woman should not touch the eagle feather during her moon cycle.
- 9 The eagle feather is to be respected and handled with reverence and gently like a new born baby.

THE TALKING STICK

The talking stick has been used for centuries by many Native peoples as a means of a just and impartial hearing. The talking stick was commonly used in council circles

to designate who had the right to speak. When matters of great concern came before the council, the leading elder would hold the talking stick and begin the discussion. When he finished what he had to say, he would hold on to the stick and whoever wished to speak after him would take it. In this manner the stick was passed from one individual to another until all who wished to speak had done so. The stick was then passed on to the elder for safekeeping.

Some tribes used a talking feather instead of a talking stick. Other tribes might have a peace pipe, a wampum belt, a sacred shell, or some other object by which they designate the right to speak. Whatever the object, it carries respect for free speech and assures the speaker he has the freedom and power to say what is in his heart without fear of reprisal or humiliation.

SMUDGING

The burning of sage, sweet grass, fungus is called smudging. It is traditionally used to prepare and purify a person, place or thing for a time of openness and truth in the presence of the Creator. Prior to a room being smudged, the eagle feather is smudged. Then you can go around and smudge everyone. If people do not want to partake, they can pass. Sage and matches can be made available for people who are late.

When we smudge, we do it for these reasons:

- | | |
|-------|--|
| Mouth | - so that anything we say will be positive and helpful to others who hear us. |
| Ears | - that what we hear and listen to will be positive and help us to learn. |
| Eyes | - that what we see is positive and we can see that in others, not to look at the outside. |
| Mind | - that what we think or how we react will be positive, with only the well being of others in mind. Not to be clouded by anger, lust, greed, etc. |
| Heart | - that our hearts will feel our pain and joy, to be able to heal and use that to help others. |
| Body | - that we will use our bodies in positive ways and take care of our physical |

Each day I wake up; I pray to my Creator
For good things

I thank him for the four-legged,
The two-legged, the things that fly,
And the things that swim.

I thank those that gave up their lives, so
That I could eat today

I thank Mother Earth for growing the
Vegetable, fruits, and medicines
These things I use everyday.

I thank the Creator for my Family,
for without them I would not be here

I thank him for my Sisters, otherwise
I would be lonely.

I thank him for the positive and the negative
things that happen during the day, for
these are not to hurt me, but to help me learn

I thank the Creator for all the good things
in the world.

For the world is my teacher and my playground

Everything here is for my pleasure

If I do not see the beauty in this, then the
fault is me.

At the end of my prayers, I am pleased with
myself.

For I am ready for this day.

ALL MY RELATIONS

Call for Article Submissions

The Association of BC First Nations Treatment Programs encourages Community Addictions Specialist to complete and report research on emerging issues in the Wellness/Addictions field. The NNADAP Continuum of Care is a vital part of First Nation Wellness initiatives in BC. Community-based Addictions Specialists are at the forefront of any developments in the Addiction/Mental Health field in BC. It is in your power to enrich resources and programs at the grassroots level. Working on the front-line allows you primary and direct sources for information and research on emerging issues, patterns of use, changing attitudes and drugs of choice in your region. Vigilance in reporting new trends in the addictions field ensures up-to-date and proactive addiction/mental health services. The link between ecstasy use at raves and possession of pacifiers (used to stop jaw clenching) would have been first identified by a front-line worker in the law-enforcement or addictions field who work directly with substance users. Also important to report are trends in poly-

drug use, e.g., heroin and powder cocaine in combination with Rohypnol where the speedball effect (in this case, Rohypnol, a depressant, and cocaine, a stimulant) is reported to “soften the fall when users are coming down from the high.” Other areas of interest would be regional slang for drugs/use, e.g. “instant zen”—LSD, holy water, G juice, scoop— GHB, “snackies”— Ecstasy/mescaline, “cat food, kitty, vitamin K”— ketamine.

Research can help improve the planning and delivery of relevant treatment services. For guidance in research, the First Nations Centre of the National Aboriginal Health Organization has a research tool kit available at <http://www.naho.ca/firstnations/english/toolkits.php> or call (613) 233-1543.

Article submissions must be related to ABCFNTF's areas of interest such as, addictions, recovery, prevention, programming, resources, etc. Keys of Healing is published quarterly. Articles lengths can be 400 to 1,500 words.

We'd also like to recognize Com-

munity Wellness/Addictions Specialists who are outstanding in their work. Many of our peers have made extraordinary contributions to our children, families, communities and workplaces. We'll publicize any awards of achievement earned; forward the name of the recipient and award, description of the achievement accomplished, comments from the recipient and photo—electronic copies must be at least 300 dpi. for publication in the newsletter.

For any constructive or positive feedback on this newsletter in relation to addictions, emerging issues, the continuum of care, resources and programs, usefulness of information, please forward your comments and all other submissions to:

Candace L. Dion at the Association of BC First Nations Treatment Programs
#2, 3003 29th Avenue
Vernon, BC V1T 1Y9
Fax : (250) 503-2473 or email:
abcfntf@shawcable.com

miracle of good fortune. I got married, had a baby, got my oldest daughter back, and actually felt Happiness! At the completion of my first year of sobriety, I was eligible to work at the local Residential Treatment Centre on the Reserve. And, so I did as a part-time Secretary.

I watched so many people walk through the doors of the Treatment Centre who had the “look” of defeat and then leave (after 6 weeks) with a glow about them that I cannot describe with mere words. I can only say that I relate it to my own “happiness” and how I somehow found a reason to live. And better yet, a reason to live Alcohol & Drug Free. And...it was ME. I began a personal relationship with myself and my Creator to be a better person in mind, body, and spirit. And, it was through the Treatment Program that I learned how to do any of this work.

Today, I have 12 years of sobriety! And, I am still working at that Residential Treatment Centre on the Rez. I am committed to helping other people who are reaching out. I want to be there for them just as someone was there for me when I needed the help. I don't want to be one of the perceived “enemy” just because I have worked to have the

good things that my family needs. I would never ever judge another addict because I remember how it felt to feel judged. I am now working on my Counseling Certificate so that I can better help. I am now doing Community Workshops to help reach our Aboriginal Communities in our efforts to bring awareness and understanding of how and why we might be “stuck” in addiction as whole Communities and Nations. I will do what I can to help my fellow addicts, because I truly believe that is one of the reasons I was spared by the Creator. The other, number one, reason for my life is to build a happy family with my 3 beautiful daughters and my husband of nearly 12 years.

In retrospect, I know that Treatment isn't for everyone. I am just so blessed that it was available for me when I needed it. I hate to think what might have been if I was no longer in the world. Or, if I was to end up in Prison, or worse yet, living on welfare still drinking and drugging while I damaged another generation of Aboriginal people (my children).



Coming Events

Healing Our Spirit Worldwide Gathering

Edmonton, Alberta

August 6th to 11th, 2006

(1-866-999-4679)

<http://www.hosw.com/index.htm>

Adults with FASD 2006 Conference

Navigating the Rapids: Doing
What Works in Practice

University of British Columbia
Coast Plaza Hotel, Vancouver, BC

May 4-6, 2006

1-877-328-7744

www.interprofessional.ubc.ca

2-day Referral Worker's Workshop

Round Lake Treatment Centre

April 27 - 28, 2006

A great time to learn new
skills and network!

Contact Person: Mary Louis

Phone: (250) 546-8848

intake@roundlake.bc.ca