
Resiliency and Holistic Inhalant Abuse Treatment

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Abstract

In Canada, a major and innovative national response to inhalant abuse among First Nations youth has been the establishment of residential treatment centres through the federally funded National Native Youth Solvent Addiction program (NNYSA). This paper focuses on the role of a holistic conception of resiliency in inhalant abuse treatment in the NNYSA program. A blending of policy and practice issues and their contribution to the health status of First Nations youth inhalant abusers guide the paper's discussion of resiliency and its fundamental role in NNYSA's traditional Native teachings program. A holistic conception of resiliency is viewed as a key contributor to the program's achievements to date. The focus on resiliency has been identified in assisting youth in uncovering their inner spirit and strengthening their spirit by drawing on available community resources. Data and case illustrations from two NNYSA treatment centres—White Buffalo Youth Inhalant Treatment Centre (Prince Albert, Sask.) and Nimkee NupiGawagan Healing Centre (Muncey, Ont.)—are presented. The paper also offers NNYSA policy solutions that have been guided by a holistic concept of resiliency and account for the intersecting roles of culture, spirituality, and community in creating and maintaining the health of First Nations youth solvent abusers. The paper concludes with suggestions for future research.

Key Words

Resiliency, inhalant abuse, treatment, National Native Youth Solvent Addiction Committee

INTRODUCTION

The use and abuse of inhalants among youth is an international concern with serious health, social, economic, and spiritual consequences. Among 40 countries reporting lifetime use prevalence during the 1990s, 16 reported rates of less than five per cent, 15 reported rates of between five and 10 per cent, and 10 reported rates between 10 and 20 per cent. Rates in poorer communities and among Aboriginal Peoples were reported to be much higher. For example, in Sao Paul, Brazil, nearly 24 per cent of nine to 18 year olds living in poverty had tried inhalants. Studies of First Nations communities in Canada and the United States have shown that, in some communities, up to 60 per cent of youth report use of inhalants.¹

National and local responses to inhalant abuse are wide ranging, but in general focus on community in-

terventions, youth and retailer education, and treatment for chronic users. In Canada, one major national response to inhalant abuse among First Nations youth has been the establishment of residential treatment centres through the federally funded National Native Youth Solvent Addiction (NNYSA) program. Residential treatment for inhalant abuse is a relatively new concept, so there has been little research to inform policy and practice.

This paper focuses on the role of resiliency in holistic inhalant abuse treatment in the NNYSA program. A blending of policy and practice issues and their contribution to the health status of First Nations youth inhalant abusers guide the discussion. A holistic definition of resiliency is provided before the NNYSA program is outlined. This is followed with an examination of the underlying element of the traditional Na-

tive teachings program that is identified as the fundamental contributor to its achievements to date. Its foundation within a holistic conception of resiliency assists youth in uncovering their inner spirit and strengthens their spirit by drawing on available community resources. Data and case illustrations from two NNYSA treatment centres—White Buffalo Youth Inhalant Treatment Centre (WBYITC) and Nimkee NupiGawagan Healing Centre (NNHC)—are presented. (See Photographs 1 and 2.) Next, NNYSA policy solutions are offered. They have been guided by the holistic concept of resiliency, accounting for and intersecting the roles of culture, spirituality and community in creating and maintaining the health of First Nations youth solvent abusers. The paper concludes with suggestions for future research.

RESILIENCY DEFINED

The concept of resiliency is based in psychological and human development theory.² A common definition is the extent to which someone can recover from adversity.³ A resilient person is often compared to a rubber band. They have the ability to bounce back in spite of significant stress. More recently, the term has been used to describe an individual's ability to manage or cope with significant adversity or stress in effective ways. The individual's coping strategies are potential contributors to an increased ability to respond positively to future adversity. Resiliency is viewed here in a holistic way, consisting of a balance between the ability to cope with stress and adversity (recognizing the consequent creation of a skill set of positive coping strategies) and the availability of community support. (See Figure 1.)

Two dynamics are associated with the concept of resiliency: risk and shield.⁴ Risk dynamics pertain to an individual living in a context of stressful events. To illustrate, documented risk dynamics for clients at the WBYITC and NNHC include parental alcoholism, a range of forms of abuse, multiple losses, and lack of connection to schools or other support networks. Shield dynamics, commonly referred to in the literature as strengths or protectors, are individuals' personal skills, traits, spiritual connections and practices, and community supports. Shield dynamics are formed in two ways—inherent internal spirit of the individual and external community support and their development as a consequence of adversity. Shield dynamics provide a buffer as well as a pool of resources to effectively deal with strain. Note that both risk and shield dynamics are comprised of individual and community components. Also, both risk and shield factors

Photograph 1



White Buffalo Youth Inhalant Treatment Centre

Photograph 2



Nimkee NupiGawagan Healing Centre

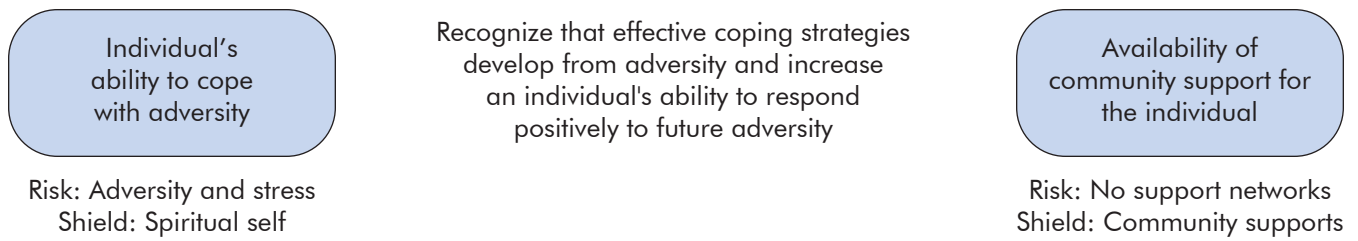
are genuinely dynamic in nature. They can change over time.

Key to this holistic definition of resiliency is the concept of spirit. Traditional Native world view highlights one's spirit as the core of one's self—the motivator and animator of one's life. The spirit is what gives one the ability to bounce back. The conception of resiliency discussed here blends both Native and western philosophies. It is put forth as a set of Native identity based characteristics that have transcended historical oppression and current-day adversity. The spirit is not a material form, so it is indestructible.

The NNYSA program, in its practices and guiding policies, is grounded in the holistic concept of resiliency as defined. It emphasizes the inner spirit through traditional Native teachings and holistic healing.

The literature identifies a number of risk and shield resiliency dynamics in populations defined to be under stress.⁵ Drawing on the work of Steven Wolin and Sybil Wolin⁶ and supported in the work of others,⁷

Figure 1: Holistic Definition of Resiliency



there are seven personal resiliency dynamics: morality, humour, creativity, initiative, relationships, independence, and insight. The components of this perception of resiliency parallel conceptions of traditional teachings and holistic healing within First Nations culture. (See Table 1.) This lends support to the holistic definition of resiliency offered, in which individual spirit is highlighted.

The NNYSAs adherence to the holistic definition of resiliency presented is seen as key to its success. It is of course necessary to develop a scientific review of the program to conclude this. In the absence of this at present, it is possible to use existing treatment centre data and case illustrations to put it into context and support the discussion. Before reviewing the NNYSAs treatment program's grounding within the concept of resiliency, the program is briefly described.

NATIONAL NATIVE YOUTH SOLVENT ADDICTION PROGRAM

The NNYSAs program was established in 1996 through a partnership between First Nations people and Health Canada (First Nations and Inuit Health Branch). It is a solvent addiction residential treatment

program with nine sites across the country. All programs are culturally based and governed by First Nations people. There are currently 112 residential treatment beds for First Nations youth ranging in age from 12 to 26. Programs vary by structure, from co-ed to gender based, and from continuous to block intake. The nine centres are linked through the Youth Solvent Abuse Committee (YSAC) network, which involves program directors, NNYSAs representatives and various field experts. YSAC's mission is to provide culturally-appropriate, therapeutic, inhalant treatment and community intervention programming for First Nations youth and their families.

There is a fair amount of literature on the epidemiology, causes and prevention of inhalant abuse among youth, including First Nations youth.⁸ However, there is little information on treatment and even less on residential treatment. This is similarly true of the youth addictions treatment literature in general.⁹ However, there is some consensus among researchers and clinicians that residential treatment can be helpful for individuals who have special needs or require intensive programming, such as chronic solvent abusers.¹⁰ Pamela Jumper-Thurman and Fred Beauvais suggest that treatment for solvent abusers should be long-term

Table 1: Wolins' Resiliency Traits

<i>Wolins' Resiliencies</i>	<i>Traditional Teachings</i>
<i>Morality</i>	Interconnectedness; respect; humility; faith
<i>Humour</i>	Teasing as acceptance and welcome; balances the seriousness of life; facilitates learning
<i>Creativity</i>	Survival; tool making; continuance of life
<i>Initiative</i>	Personal courage; integrity; freedom; autonomy; promotes wholeness and quality of life for all
<i>Relationships</i>	Kinship; sharing; unconditional love; generosity; community
<i>Independence</i>	Mastery; taking on of adult roles; courage; non-interference; reciprocity
<i>Insight</i>	Vision quest/fast; strength; knowing self in relation to all else; identify development in relation to gender, spirit name and clan

because “. . . solvent abusers . . . have a greater breadth and depth of problems.”¹¹ Conversely, some research claims residential treatment programs for inhalant abuse rarely survive for a multitude of reasons including the degree of difficulty that treating solvent users entails.¹² The NNYSYA program has proven otherwise and demonstrated innumerable successes in its seven years of operation. As proposed, one recognized reason for the NNYSYA’s success is its adherence to a holistic conception of resiliency through its policy and practice.

In the past decade, Canadian health care in general has experienced a paradigm shift to a more holistic way of viewing health issues. The population health or determinants of health approach has been given significant weight in health policy papers and health service accreditation programs.¹³ A definition of health from a Canadian health promotion perspective refers to the “bodily, mental and social quality of life of people, as determined in particular by psychological, societal, cultural and policy dimensions.”¹⁴ The concept of health has grown to be inclusive, accounting for more than merely the absence of illness. In principle, this paradigm shift supports holistic resiliency as a means of solvent abuse treatment because it accounts for much more than the eradication of the inhalant abuse behaviour.

RESILIENCY IN THE CONTEXT OF INHALANT ABUSE TREATMENT

Assisting Youth With Uncovering Their Inner Spirit

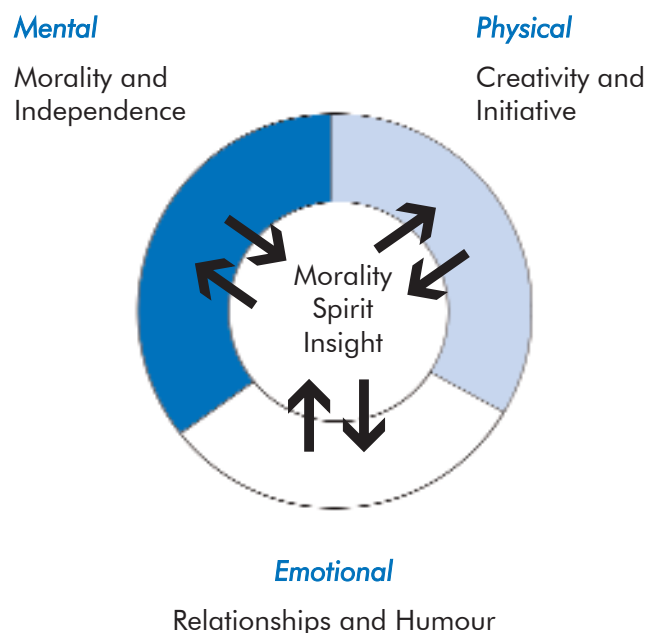
As discussed, the concept of resiliency adopted by the NNYSYA program is holistic in nature. It accounts for the balance between one’s ability to cope and the availability of community support. It acknowledges the influence of risk and protective dynamics. Further, an individual’s spirit is seen as central to his/her ability to bounce back. The NNYSYA treatment centres promote this holistic concept of resiliency through cultural teachings and programming as well as policy development. Cultural programming begins with a belief in a world view that promotes a holistic perspective of life, placing traditional healing practices and cultural values in the forefront.¹⁵ As such, programming reflects the four components of reality: spiritual, emotional, physical, and mental. Spirituality is believed to be the core or the foundation for the other three dimensions. (See Figure 2.) This belief comes from the Anishinabe or Original

People Creation Story. Every culture has a Creation Story that informs the people of their origins. The Anishinabe Creation Story talks about all colours of people and how each was given their own instructions by the Creator, their own values, purpose, and gifts to carry in life. It is said that it is one’s spirit that carries this bundle from the spirit world to the physical world.

In the First Nations perspective, the attachment to a Creator and ways of accessing the Creator through spiritual ceremonies and practices are important factors in building resilience. The alliance between strong spirituality and resilience may arise from the increase in confidence, optimism, and belief in the meaning of life. Time after time, clients of the WBY-ITC and NNHC rate spiritual and traditional program components as the most influential factors in their recovery.¹⁶ Similarly, studies have concluded that clergy or church attendance are important sources of support and role models for resilient children and adults.¹⁷ A 2000 study supports that individuals successfully recovering from substance abuse

. . . tend to report high levels of religious faith and religious affiliation . . . Results also indicate that among recovering individuals, higher levels of religious faith and spirituality were associated with a more optimistic life orientation, greater perceived social support, higher resilience to stress, and lower levels of anxiety.¹⁸

Figure 2: Holistic Resilience



The inherent values of the original people of North America are kindness, caring/sharing, honesty, and strength. The family, extended family and community are charged with parenting a child in a way that reflects and strengthens the expression of these values. These values are said to be ever present despite the level of nurturing and support that a child receives. The NNHC nurtures these values in its programming by including natural medicines for detoxification (burdock, valerian and dandelion root); sweat lodge, fasting, naming, and spirit feast ceremonies; drumming and socials; and traditional assessments by Elders to determine client specific spiritual needs. (See Photograph 3.)

There is a connection made between the cultural activity and the individual's spirit. This connection is fostered in innumerable ways including sharing traditional teachings about each activity before an individual chooses to participate. Gender-based teachings that facilitate an understanding of male and female roles and responsibilities are important for youth. For example, male youth are taught about their relationship and responsibility to the fire and female youth are taught about their relationship and responsibility to the water. This activity

. . . generates a sense of the interconnectedness and interrelatedness of all-that-is a spiritual cent[re] that imbues all life with a quality that is not only deserving of respect but itself motivates a respectful relationship with oneself and others.¹⁹

Strengthening Youth Spirit by Drawing on Available Community Resources

It is well documented in the literature that adversity coupled with the absence of community support are direct contributors to youth inhalant abuse.²⁰ The healing path supported by the NNYSYA program is about making connections to one's self as well as the universal family of Creation. Youth drawing on community supports to strengthen their resilience is central to the Creation story.

NNYSYA's recognition of the importance and integration of an individual's community (social and family support) into the treatment process addresses in part a key criticism of residential programs in general: recovery cannot occur in environments and with people other than where and with whom they live and work daily. Some argue that if the community is not fully engaged in the recovery process and the individual does not recover directly in the home community,

Photograph 3



A traditional sweat lodge

the individual is destined to fail. This is because s/he will not have acquired or had the opportunity to practice the new skills in the home environment while environmental factors will not likely have changed.²¹ For example, reports from Davis Inlet, Labrador, support that many of the children who were sent to residential treatment for solvent abuse relapsed when they returned home.²² In part, this may reflect the chronic problems that plagued their community.

A key assumption leading to the establishment the YSAC programs was that young solvent abusers needed a safe place for detoxification separate from their home communities. This was because it was evident in many cases that families were not always supportive and were often highly dysfunctional. The support of a family network cannot be assumed to exist for some young solvent abusers. This needs to be addressed as a part of the inhalant abuse problem.²³ To illustrate this, the work of Matthew Owen Howard and Jeffery Jenson found that inhalant users were more likely to have low family support and cohesiveness, low self-esteem and substance abusing parents and peers.²⁴ Similar findings were uncovered in a recent Canadian study.²⁵ As discussed, the holistic definition of resiliency supported here encourages accessing available community supports. This is evident in the policies and ensuing practices of the WBYITC and NNHC programs.

Also fitting with NNYSYA's perspective, the literature supports the importance and effectiveness of after-care and follow-up to residential treatment.²⁶ It is suggested that after-care and follow-up often need to be long-term, involve multiple community resources and include community re-integration. It must consider a multitude of intervening factors including ease of access to inhalants, detrimental effects on mental

functioning, social factors, environment, and peer pressure. Such considerations are also evident in the policies and practices of the NNYSAs treatment centres.

The WBYITC and NNHC residential services for First Nations youth are complemented by services designed to build capacity and promote resiliency in youth by drawing upon resources in their communities. In addition to assisting the youth in understanding their inner resilience, the youth are taught how to seek external protective factors in their communities such as through the school system, community support groups, and Elders.

One of the unique practices of the White Buffalo treatment program is that it requests community after-care plans for the client before the client is accepted into treatment. The after-care plan is reviewed midway through treatment to ensure continued relevance and community commitment. The emphasis of the plan is documentation of all available community supports for the youth and to clearly identify who is responsible for helping the youth make the transition back into the community.

To further illustrate, the outreach policy of the WBYITC ensures activities and interventions are conducted at the community level. For example, incidents of cluster sniffing are addressed in a way that involves the whole community. It is the policy of the WBYITC to not intervene in an identified sniffing crisis unless four to five community volunteers are available to be part of the planned intervention. Community members (parents, aunts/uncles, cousins, counsellors) fully participate in the intervention, from identifying the perceived symptoms or risk factors to being trained by WBYITC staff to deliver healing sessions in a week-long condensed form of the residential treatment program. This method of capacity building leaves the tools for effective early intervention within the com-

munity and adds to a community's resilience and ability to deal with early stage sniffing. (See Photograph 4.)

The NNHC program includes the regular participation of family workers through monthly reviews of the treatment plan of care and regular communication. All the way through this process, community referral workers become educated about the skills the youth learn in treatment and how they could support and facilitate the continuance of these skills in the community. Referral workers are also encouraged to refer more than one youth from the community as a way of building a natural support network for both the youth and the family.

In 2000, the NNYSAs program negotiated a national policy change with Health Canada, First Nations and Inuit Health Branch, to allow its treatment centres to include family participation in the calculation of performance criteria for occupancy. This national policy change allowed the NNHC to restructure its own policy on how families participated in the treatment program. Because of that, youth acceptance into the program became conditional upon confirmation from their family that at least two significant caregivers would participate in the family portion of the program at the treatment centre for a minimum of five days. The results have been astounding. Family participation rates prior to the policy change were at an annual average of 73 per cent of families participating in two days of face-to-face interaction and conference calls. That increased to an annual average of 97 per cent of families (at least two family members per youth) participating in 10 days of face-to-face interaction and monthly conference calls. In the 2002 NNHC Client Satisfaction Survey, 99 per cent of parents rated their satisfaction with the treatment program and staff assistance skills as very good or excellent.²⁷ Client completion rates have also improved by seven per cent, from a 73 per cent average prior to implementation of the new policy to an 80 per cent average over the three years following the policy change.

Photograph 4



White Buffalo Mobil Treatment Centre 1999,
Thunderchild First Nation

NATIONAL NATIVE YOUTH SOLVENT ABUSE PROGRAM POLICY SOLUTIONS

In addition to practice, the NNYSAs program has placed extensive attention on generating and implementing policy solutions regarding residential treatment for youth inhalant abusers and their health within their communities. NNYSAs developed three key policy solutions for creating and maintaining the health of First Nations youth inhalant abusers: expanded community involvement, re-examination of

the definition of those returning to inhalant use as failure, and addressing the link between solvent and other drug use. These policies are guided by the holistic definition of resiliency including the roles of culture, spirituality, and community to create and maintain the health of First Nations youth.

As the NNYSA program has progressed over time, its policies have also evolved. One area of policy growth has been enabling treatment centres to increasingly include outreach and community-based activities as a part of their mandates. This has allowed treatment centres to plan more proactive, resiliency-focused intervention methods and to more suitably address community needs. This includes early stage prevention, cluster sniffing at its onset, and community teaching. In turn, this has increased the treatment centres' understanding of available community resources. This has translated into greater capacity to build effective follow-up plans. With this new policy in place, one NNYSA centre was able to visit every First Nations community in its province within a two-week span to provide preliminary outreach services.

At the outset of the NNYSA program, client tracking practices defined individual re-entry into treatment as recidivism, that is, returning to using inhalants. The original governmental philosophy was that clients would only be eligible for a one-month to six-month treatment episode during a two-year period. In this sense, re-entry into treatment was viewed negatively. Over time, the NNYSA centres identified a distinctive pattern among its clients who were considered recidivists. Clients' motivation levels for treatment increased upon second entry. They were more ready for change and were generally making the referral themselves. The clients also appeared to be more open to participating in spiritual portions of the programs. It was as if their spirit was awakened during the first treatment episode and their second entry gave them a clearer avenue to explore their spiritual self. Further, it was witnessed that female clients who entered treatment a second time frequently did so by indicating their readiness to explore deeper core issues (i.e., sexual or physical abuse). With all this in mind, the NNYSA changed its recidivism policy. The word recidivism and its negative connotations were removed from the NNYSA vocabulary and replaced with an understanding that treatment re-entry is a necessary part of the treatment process for some.

NNYSA treatment centres recognize the impact of early stage inhalant use and its predictive value for

later drug use. Research has found that abuse of inhalants during childhood and early teens is related to later use of illicit drugs and other drug involvement.²⁸ It is not clear that inhalants are a gateway drug. Rather, inhalant abuse may be a marker for risk of other drug use.²⁹ For this reason, NNYSA policy directs treatment approaches to not centre exclusively on inhalants as the drug of choice. Clients receive education on all substances. The resiliency model is used to emphasize the position that by building a strong shield during early teen inhalant treatment, a youth is developing and enhancing the skills necessary to resist other drug use at later life stages.

FUTURE DIRECTIONS FOR HOLISTIC RESILIENCE RESEARCH

The integration of holistic resiliency practices and policies into residential services at two First Nations NNYSA treatment centres in Canada has been the focus here. To date, treatment centre data, case illustrations and client feedback have favourably supported the effectiveness of the centres. For example, follow-up data for the NNHC showed that 82 per cent of past clients in 2000 and 95 per cent in 2001 reported abstinence from inhalants in the six months following treatment. While 82 per cent of youth were not in school at the time of admission in 2001, 67 per cent of these youth returned to school after treatment.³⁰

For these successes to be evaluated, the authors suggest four initial research areas. The first is the development of an inventory of what holistic resiliency is comprised of to provide qualitative and quantitative measures of pre- and post-residential treatment outcomes. The follow-up with clients should move beyond the documentation of relapse and toward measuring resiliency traits and positive life changes that are maintained after treatment, even if relapse to the drug of choice has occurred. Secondly, it is suggested that a structured review of inhalant abuse treatment best practices be conducted, highlighting the role of resiliency. Thirdly, there is a need to evaluate community prevention and intervention attempts and their focus on resiliency, in particular where peer cluster sniffing is out of control.³¹ Finally, it is important to account for the role of gender in these suggested areas. Research has shown that females and males display different resiliency dynamics that are often dependent upon their age.³²

CONCLUSIONS

The need for inner resiliency is paramount in the economic, social, psychological, and spiritual stresses faced by youth today. They are no less challenging than the physical adversity of yesterday. The recent expansion of the view of health beyond the individual to the family and community and the recognition of social, psychological, and spiritual environments as influencing health are consistent with the broadened and holistic interpretation of resiliency. The challenge will be to explain the conceptual links between health promotion and resilience and to test mechanisms that foster resilience in treatment, in particular for First Nations youth inhalant abusers. Strategies within the First Nations community may include creating supportive environments as well as promoting self-esteem, effectiveness and empowerment. Participatory, applied and evaluative research is therefore timely. Resiliency theory has considerable promise for application for First Nations and non-First Nations health promotion programs and policies in Canada if it is based on sound theory and research.

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HANDBOOK OF EARLY CHILDHOOD INTERVENTION

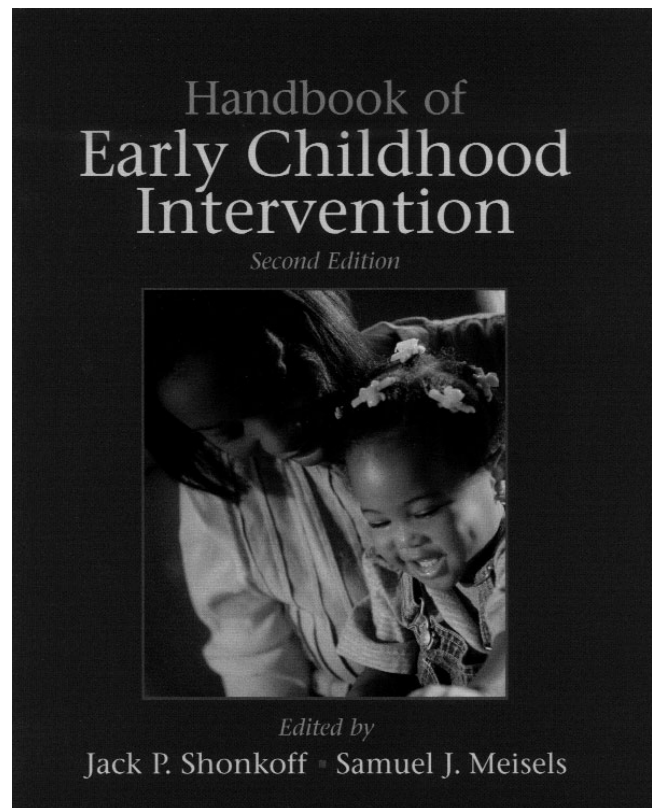
Second Edition

Edited by Jack P. Shonkoff and Samuel J. Meisels
Cambridge University Press, 2000
ISBN 0-52158-573-2
756 pages

The second edition of the much-heralded *Handbook of Early Childhood Intervention* is a core text for students and experienced professionals who are interested in the health, development, and well-being of young children and their families. This book will be of interest to professionals in a broad range of disciplines including psychology, child development, early childhood education, social work, pediatrics, nursing, child psychiatry, physical and occupational therapy, speech and language pathology, and social policy. Its main purpose is to provide a comprehensive overview of the knowledge base and critical implementation strategies of early childhood intervention. With 15 new chapters and 13 extensively revised chapters, it is unique in its balance between breadth and depth and its integration of the multiple dimensions of the field.

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