The Nechi Institute on Alcohol and Drug Education

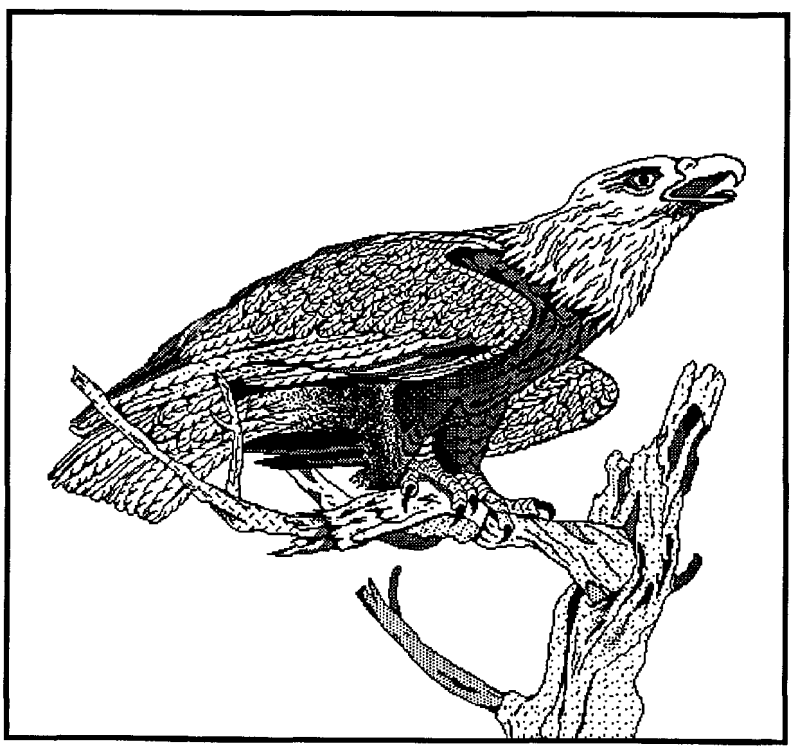
The Eagle Has Landed

BY MAGGIE HODGSON

In the mid-1800s there was an Hopi prophecy which said:

"Our Indian people are in midnight and we will come out of our midnight into our day to be world leaders. This change will start when the eagle lands on the moon."

No one understood this business of an eagle landing on the moon. In the 1960s when the first space ship landed on the moon, they sent word back to the world, "THE EAGLE HAS LANDED." That week the first Indian Alcohol and Drug Program was set up. The Native Alcohol Programs in North America have been the primary instruments in dealing with addiction prevention and treatment from the holistic way. They have been catalysts in the renewal of the Indian Culture. For good social change to happen, it has to have a "spirit" of healing to it, an energy, a vision, and movement. The Native Alcohol Programs have been the rebirth of our culture. *See the Spark!*



This prophecy has evolved in the Canadian Indian population. I will take you on our Indian Communities' journey into drug addiction to where we are today. This journey has been one which has involved our people, our government, and our partnership in building one of the leading programs to effectively deal with alcohol and drug abuse within our indigenous population of Canada.

HISTORY

In the 1800s, the Canadian Government entered into a number of treaties

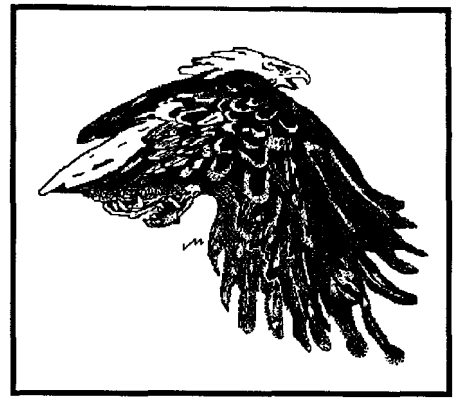
with our people. These treaties laid the foundation for Government's responsibility in the areas of health and education of our population. Education was offered through the development of an institution called a residential school. Canadian Indian children were forced to leave their homes to attend these schools away from their region from age 5 and often remained in these facilities until age 20. They returned home once a year, if they were lucky. When they entered these schools, they spoke their own dialect of Indian and followed Indian customs and religion.

The intention of the government was to provide them with education and opportunity to learn English and a Caucasian religion to enable them to fit into mainstream society. The results were there was a period of 100 years when our population was removed from our language, our parents and our Elders, which are all the integral elements of our culture and values. Emile Durkheim described the effect on cultures when this phenomena happens: a state of anomie sets in, a valueless society in which there is a loss of the original culture and an inability to adapt to the new culture. The results of the anomie within our Indian population manifested itself in the form of alcohol and drug addiction in pandemic proportions. By 1970, 50% of the Canadian Indian population was 20 years old or younger because we had such a high death rate from drug addiction. One hundred percent of our population was affected by alcoholism directly or indirectly.

The Province of Alberta responded with programs designed to deal with mainstream societal drug abuse in the early 1960s with little success in attracting into treatment indigenous peoples who were addicted.

In the early 1970s three Alberta Indigenous programs were developed, administrated and staffed by our people. These programs were funded by AADAC. Alberta is one of the first provinces in Canada to be willing to listen to our population's requests to develop or unfold our own vision of dealing with our addiction and the state of anomie within our population.

There were many barriers to this happening. The primary barrier was the lack of academically qualified Indigenous people to staff these programs. Our position to Government was that our people share the same experience and will be able to effectively deal with substance abuse from a cultural perspective. AADAC had the wisdom to listen.



We did not only lack the academics to deliver treatment programs, we also lacked academics to deliver training programs. AADAC trusted us to develop ourselves in this arena, with the benefit of limited funding in 1972.

The treatment programs were set up in old buildings (usually old houses) and operated on a minimal budget with limited staff. These programs were administrated by Indian controlled Community Boards, administrative staff and counsellors. AADAC did assist when requested and largely maintained a "hands off position." Funders operated on faith because all our people involved at that time had no previous experience in this industry and our programs were operated by recovering alcoholics or recovering drug addicts. Newly recovered to boot! Contemporary research says that it is not the way to go if you want success, but when you have nothing, the only place you go is up.

The treatment centre staff required training; a former director of one of the treatment programs developed our organization. He was a very young newly recovering alcoholic. While the Nechi Institute in Edmonton is now the largest in Canada, at that time we were the only training centre which operated from a store-front facility. The first graduating class held their training sessions in a teepee on the grounds of the University. They had all of 10 days of training to equip them to deal with this pandemic in our community. Brave eh?

VISION

Our culture operates within a symbol called the Medicine Wheel. The Medicine Wheel teaches many cultural beliefs which manifested themselves through the years. One such form is as follows:

The four peoples of the earth are equal. White people bring movement; the Yellow people bring vision; the Brown people bring relationship or feelings; the Black people bring patience. Each race contributes our own gifts to development. The Medicine Wheel symbolizes the four seasons of spring, summer, fall and winter. Morning, noon, dusk and dark and all of these phases continue into infinity.

The beginning to the wheel is Vision. The vision of the originators of Nechi was one of identifying the need to have many Indigenous programs to deal with drug abuse.

The initial training program was set up in an experiential model of training. The average grade level of counsellors employed in the field was grade seven or basic elementary. This model enabled the trainers to transfer skills without worrying too much about reading levels and testing. The focus of the training from 1973 to 1980 was largely directed at community development skills. The content was divided with a 30% focus on alcohol and drugs and 70% on personal and community development. The average counsellor in training had a history of personal deprivation in their cultural, emotional, physical and spiritual lives.

Our model developed differently from the mainstream model in which the counselling relationship is between the client and the agency. The social change and counselling relationship is one which starts with how the counsellor relates to himself, his children, his family, friends, his community and finally how that affects how he will relate in his agency. His clients see him in the first four roles and build their trust level based on what they saw in how that counsellor was able to be within his or her extended family system. Our culture is based on relationships, formal or informal extended family systems. Social change within our community is founded on that principle.

The community development training modules focus on the mobilization of those social structures. We focused on the development of informal leaders to formal leaders and proposals to government for new treatment facilities. The average grade level was grade seven and from 1974 to 1982, there were 13 treatment facilities,

detoxification facilities and half-way houses started and 26 urban and rural community based programs opened and funded by both AADAC and National Native Alcohol and Drug Abuse Program of Health and Welfare Canada.

FEELING

Community Development utilizing DeBono's model of stretching our ability to analyze a situation was encouraged. One Indian community developed a model of "the community is a treatment centre," as the philosophical base for their program. This community had 100% alcoholism in 1972.

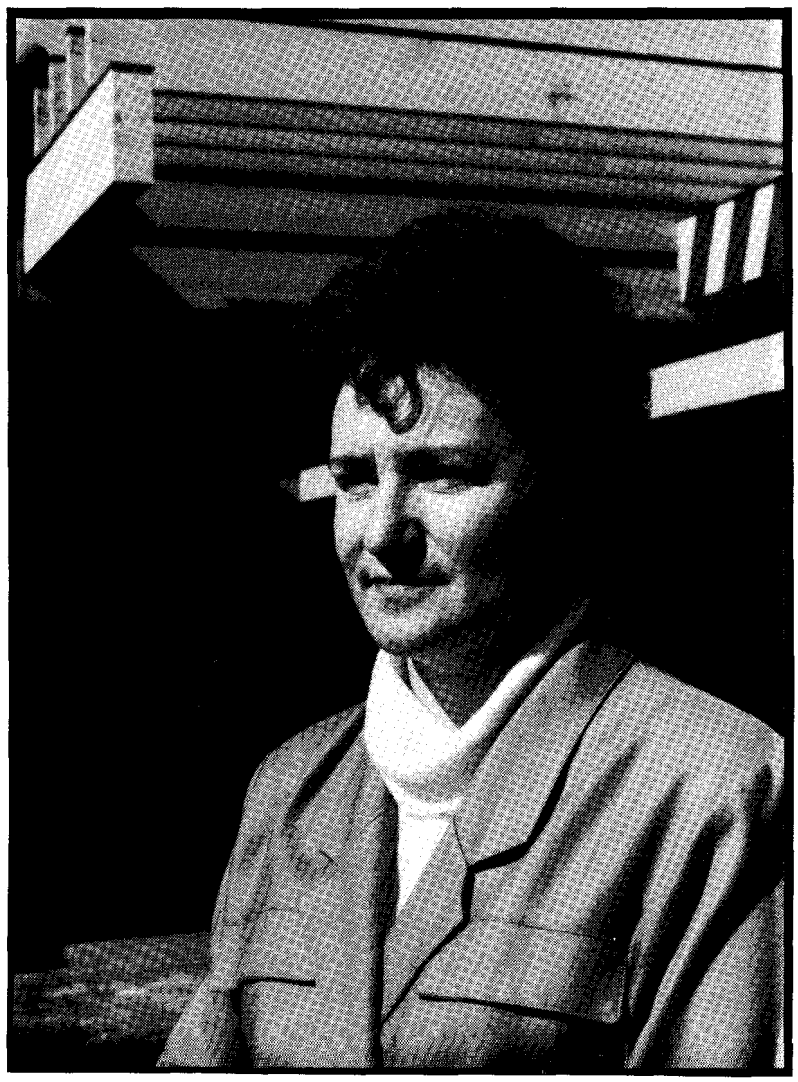
A member of their community was motivated to seek treatment because his daughter wanted to live with her grandmother because of the drug abuse in their home. He sobered up and systematically approached people and referred him or her into treatment until he had a whole council sober. They attended our training and broadened their strategies. They charged all people illegally selling alcohol in the community, including the Chief's mother. They fixed up people's houses when they went for treatment. They commenced training of all who sobered up in a counsellor training program, building on a peer counselling model and social norms of community responsibility.

They set up small businesses which served the communities' basic needs, which employed the peoples returning from treatment. They cut off social benefits to all drug impaired residents and only gave them the necessities. They rewarded success and supported each other in a nurturing manner. They reintroduced traditional Indian religion and cultural dancing. They commenced sober dances. They actively directed all their energies at the development of sobriety as the new social norm. Within ten years, they moved from 100% alcoholism to 95% sobriety. They moved from a death a week to one death per year; from 75% of the children in the care of the government to 100% of the children returned to their homes; from thirty convictions of impaired driving per year to one conviction in the last three years; from two suicides per year to two in the last five years. They moved from people dying of alcoholism to people dying of old age.

THINKING

Training has moved from 30% on alcoholism and 70% personal and community development to 30% on personal and community development and 70% on alcohol and drug addiction. We address primary prevention, secondary and tertiary skills development. The academic level of entrance to the program has moved from Grade 7 to Grades 11 and 12; from no exams and ten days of training to two years of training and exams; from no reading to regular curriculum with extensive reading requirements; from no planning to extensive Planning in Level of Prevention. Counsellors stay in the field for an average of 21/2 years. Studies of a random sample of 300 participants of the 2000 people we have trained reflect that 36% have gone on to further education, 49% moved into leadership positions and 65% sit on community boards and associations. The key issue is that we only train non-drinkers, whether they be recovering addicted people or co-dependents.

The model which was set out in 1974 is bearing fruit. We are moving from anomie to a societal norm where an Indian leader who is a social drinker said, "You know it is quite trendy to be a sober Indian; I feel like apologizing for having a social drink. I sure know how you smokers feel: you are the minority and I am quickly becoming the minority." The training is effectively developing new norms for every sector of our society. It's like a germ which is spreading into every facet of our society — except this germ carries health.



DOING

One community has expanded on a mobile treatment model. They chose to refer a minimum of 5 to 10 people to treatment together at a time to ensure there would be a peer support system built in. They had all members of their Council go for treatment within six months of being elected. They then referred all service givers, whether they were addicted or co-dependents. Their purpose was to build on role modelling and the relationship model. They set up a special program for their inhalant abusers. They referred a total of 50 of their community of 400 to a residential centre within a year. They utilized the cluster referral processes. They then brought out a mobile treatment team to work with their counsellors

in the delivery of a day treatment program. Community members celebrated the opening day with an attendance of 250 people: imagine 2/3rds of your population out to celebrate sobriety!

The community development model and clustering resulted in community members cooking for the clients. They babysat for them and donated food for those in the treatment program, which was operated in the school gym. The cost per client day of this futuristic treatment model is $30. The costs of residential treatment within the NNADAP funding structure is $50 to $70 per day per treatment bed. The community which followed this model has moved from 100% alcoholism to 85% sobriety within 2 1/2 years. One Elder said, "Our extended family system is our greatest strength. If we ignore addictions and enable the people we love to drink, it becomes our greatest weakness." This model erodes enabling and ensures our greatest strength does not become our greatest weakness.

SOBRIETY AND BEYOND ISSUES

The two communities I referred to have had to deal with the aftercare issues of maintaining the sobriety for the adult population and developing programs for the children raised in addicted homes. Once sobriety was a reality, the violence which existed in these homes became uncovered. They have identified community safety as their primary concern to address the primary prevention with the youth. They are facing 50 charges of child sexual abuse in one community because they are changing the "don't talk, don't trust and don't feel rules" to "talk about dysfunction." They are now trusting and allowing the rage out about the massive parental neglect, child abuse and the cultural abuse perpetrated by the residential school supervisors. It will take a minimum of two more generations to develop people who are reared in violence-free and substance abuse-free homes. They are developing and delivering programs which first deal with substance abuse and secondly treat the violence to ensure our children do not have to drink to cover up their pain and sadness.

EVALUATION

Our program requested and underwent a formative evaluation process in 1984 with a review of the implementation of those recommendations in 1986. We implemented 56% of the recommendations and partially implemented 36% for a total of 92% of the recommendations. We increased our program by 100% with a 21% cut in our budget. Our purpose is program quality improvement and role modelling the importance of evaluation to the 45 programs we serve. We, too, role model change.

We have a research department which has developed a new model of management, from a management by objectives to a management by values of relationships model. We have researched a new employee assistance program to address the increase in Indian self government programs. We are presently researching the relationship between the decrease in family violence and the decrease in addictions in those two communities. We are presently working with the Solicitor General's department in tracking the reduction of impaired drivers in communities which have elected to develop a community as a treatment centre model versus other communities which continue to deal with substance abuse from an individual client model. We have implemented a treatment program for our Board of Directors and our staff in Co-Dependency and Children of Alcoholics because our research identified Adult Children of Alcoholics (A.C.O.A.) and Co-Dependency as major stumbling blocks in problem solving in sobriety and beyond communities. As a result of our leadership, three other communities have implemented an A.C.O.A. treatment program for their leaders and staff. The key here is this A.C.O.A. treatment is 100% organization funded. It has evolved from 100% government funding alcohol treatment to 100% of the A.C.O.A. of sobriety and beyond being funded by Indian organizations. That is the proof in the pudding of how our model works and how the faith of the government was the right strategy for them.

We have moved from 100 people attending a sober Pow Wow (a Native traditional dance), which was 100% government funded, to 3000 people attending, which was 100% government funded, to 5000 sober Indians with prize money of $25,000, which is 100% funded by volunteer hours raising funds for this cultural activity. We have moved from a 100% dependency relationship to one of greater autonomy in social service, education and policing.

We have Nechi graduates who have continued on into and are completing their education in the faculties of psychology, nursing, social work, education and into the Royal Canadian Mounted Police.

Our facility is a 6 1/2 million dollar facility funded by our Provincial Government. Our total training and research budget from foundations and different levels of government is one million dollars per year. We have fifteen computers and a trainee data analysis system which is funded 100% by non-government funds. Our organization is now staffed by Indian academics and paraprofessionals. These are the results of the Alberta Government's faith in Indian people's ability to deal with Drug Addiction. We have trained and hosted indigenous students from Australia, New Zealand, Thailand, Malaysia and Nicaragua to enable them to see how they might harness the energy of their paraprofessionals in the delivery of treatment, training and prevention programming for their Indigenous people.

We are networking with Indigenous groups to lobby the United Nations to declare one year World Drug Prevention Year of the Community because drugs effect the child, the woman, the homeless. It is possible!

Can you see that prophecy come true? "Nechi" means "my spirit touches yours." I hope in some small way my spirit and the spirit of our Indian people has touched yours.