OTHER POTENTIAL OPTION 2

TYPE OF TREATMENT	LOCATION/REQUIREMENTS	NUMBER OF CLIENTS	TIME FRAME
Maintenance program In Davis Inlet?	- Goose Bay or Davis - requirement: 3 houses/homes	[redacted]	April 9 Start the Process
Native Solvent Abuse Treatment (with Innu workers and family support) White Swan.	Native Solvent Abuse Treatment Centre (same location boys in one facility girls in another)		April 2 Children + Parents
Country Treatment	Labrador		April 6
Youth Care Agreement	St. John's NF		First week of April
Specialized sexual behavior treatment	Out of province		First Week of April
Supervised boarding home (adult client)	Goose Bay Labrador		first week of April

are we do - country programs? 5/5

TREATMENT FOR THE PARENTS OF THE YOUTH

Adult country mobile treatment	Labrador	To be determined	April, 2001
Innu treatment centre for alcohol and other drug abuse	Kauauitshi Akanit Innu Treatment Centre (Moisie)	To be determined	April, 2001
Community treatment	Davis Inlet	Target the community	April, 2001

Con to the Centre. Out of Province
Concerns: Therapeutic Relship - built - then Broken again.
Robert. These are accredited facilities - not foreign to the Children.

Maintenance Program: / Option 1

TYPE OF TREATMENT	LOCATION/REQUIREMENT	NUMBER OF CLIENTS	TIME FRAME
Maintenance program	Goose Bay, Labrador Requirements: 9 houses/homes	[redacted]	May or June 2001 Does this mean we keep 27 kids at Grace Centre then?
Native Solvent Abuse Treatment (with Innu workers and family support)	Charles J. Andrew Treatment Centre or other out of province center	[redacted]	Week of March 26
Country Treatment	Labrador	[redacted]	April 2 – will this be ready?
Youth Care Agreement	St. John's	[redacted]	March 30
Specialized sexual behavior treatment	Out of province	[redacted]	April 2
Supervised boarding home (adult client)	Goose Bay, Labrador	[redacted]	April 2

9 kids to go 1st week 2 April

B. Long Term Treatment Plan

It is anticipated that the following residential settings will take approximately four to six months to reach full operational therapeutic levels.

Contingency Plans looks the same as LT Tx Plan

[redacted] youth go to 7 therapeutic caregiver/group homes
youth go to 2 alternate living arrangements
youth goes to an addictions treatment facility, must include component for inappropriate sexual behaviours
youth will participate in independent living program in St. John's
youth goes to an addictions treatment facility and/or to a supervised board and odging residence (should he/she choose to do so)
youth goes to an addictions treatment facility, followed by the cultural program
youth go to the cultural program, followed by return to a therapeutic setting

Therapeutic caregiver/group homes - homes staffed with live-in house parents (have special skills and training) or live-in management staff, supplemented with support staff as required based on the assessed need.

Alternative living arrangement - home staffed with live-in management staff or staffed with shift workers - setting intended for extremely challenging youth who are at high risk and need strict supervision and monitoring.

Difference – Draft Plan - had 14 children going to Charles J. Andrew or out of province tx. facility (option 2) – and 10 children GB (by April 9).

Carmel 685-4624

VERSION 2.

CLINICAL RECOMMENDATIONS BASED ON A SUBSTANCE/CLINICAL RISK ASSESSMENT OF INNU YOUTH

(Final Draft Copy)

Introduction:

On March 20 – 21, 2001, a substance/clinical risk assessment was completed on each of the 32 Innu youth (18 males and 14 females) who were referred to the Grace Facility in St. John's, Newfoundland in response to their high risk and solvent abusing behaviours. Since the solvent (as well as other substances in certain cases) abusing behaviours of the Innu youth are the result of many negative biopsychosocial factors, the assessment protocol was completed by a multidisciplinary team (i.e., medicine, psychology, education, social work, addictions) in order to provide a wholistic and comprehensive evaluation. The goal of the assessment process was to determine the unique treatment needs of each Innu youth and to develop a sound therapeutic intervention that would appropriately accommodate the short and long term treatment needs of the Innu youth. It was agreed upon by the assessment team that without appropriate treatment and therapeutic supports, all of the youth would be at high risk for reappearance or exacerbated development of chemical dependency behaviours and associated problems. Also, the assessment team agreed that any treatment recommendations made for the Innu youth would need to be culturally sensitive and done in concert with the healing to be undertaken by the families and the community as a whole.

It should be noted that eight older youth admitted earlier to the Grace Facility chose to return home before a complete assessment could be completed. These youths, should they chose to return to the program, will be accommodated as much as possible within the established services at that point in time.

Results of the Multidisciplinary Assessment:

The multidisciplinary assessment involved consolidating the information (e.g., psychological, medical, family systems and cultural evaluations; observations made by social workers and teachers, etc.) gathered on the 32 Innu youth over the last 2 months. This information was used to determine a clinical profile of each Innu youth based on relevant information pertaining to their presenting referral concern (i.e., solvent abuse and high-risk behaviours). The next step was to outline the treatment needs (the multiple risk factors that will need to be treated), prognosis (the degree to which the youth has the capacity and responsiveness to be engaged in treatment - e.g. workable, very challenging, etc.) and degree of risk (the perceived potential of continuation or escalation of aberrant behaviours without appropriate interventions and recommended support systems - e.g. low, moderate or high) for each of the Innu youth.

Results of the multidisciplinary assessment indicated that the degree of risk for the 32 youth was as follow: low (1) moderate (11) and high (20). With regards to prognosis, most of the youth (except for 5 who were perceived as extremely challenging) were seen as workable if the proper programming, support of specialists and training of staff was put in place in order to effectively engage and treat the youth with a developmental, culturally sensitive, family/community systemic

and "asset capacity building" approach.

It was also determined that most of the youth presented with a complex clinical picture resulting in numerous treatment needs that would require a sophisticated and wholistic therapeutic intervention. Although not final, the potential list of therapeutic services likely required are listed below and indicate the breadth and depth of services needed as well as the required skill sets and spectrum of professional disciplines considered to be necessary to address the treatment concerns of these young people.

- social skills training
- educational programming
- counselling (grieving processes, post traumatic stress disorder concerns, past abuse, etc.)
- high ratio of staffing due to high risk acting out behaviours – significant developmental deficits and poor impulse control
- caregiver and group home placements – depending on need for structure and age appropriate supervision and nurturing
- sophisticated treatment program – needs to be able to address multiple therapeutic needs
- behaviour modification
- sexual education
- therapeutic intervention (ongoing clinical assessment, ability to adapt treatment plan to evolving needs of youth, etc.)
- medical support and pharmacological consultation, e.g. use of antidepressants ?
- mentoring program – significant needs for appropriate role modeling
- life skills program (education)
- individual and/or family therapy
- solvent, alcohol and other drug counselling
- cultural (e.g., "going into the country") and spiritual (e.g., elders teaching) programming to address significant cultural deficits
- recreation interventions – develop proactive recreational skills

Taking the degree of risk, treatment needs and prognosis in mind, a contingency and long-term treatment plan has been outlined.

The admission of the youth to the Grace Facility represented the Phase 1 component of their recovery processes, i.e. detoxification and assessment for continuing services. Phase 2 should continue the healing processes for these youth by their participation in therapeutic regimens offered in caregiver residential settings, cultural interventions and in the home community as well as specialized treatment settings for certain youth (4).

Recommendations For Treatment Of The Innu Youth:

It is agreed by all the members of the multidisciplinary team that the movement of the Innu youth from the Grace Facility needs to be therapeutically sound. It would not make sense to place the Innu youth in a different setting that could not maintain their safety and would not lead to preparing to engage them for long-term treatment. Even if safety and proper supervision could be provided, the new placement would only be a maintenance program without the proper treatment programming (clinical and cultural), training of staff and involvement of family/community. If a contingency plan is acted upon, there needs to be a commitment to putting the appropriate resources in place to address the long-term treatment needs of the Innu youth (clinically and culturally as well as in the home community to support the healing process for the youth and his/her family). It is also important to note the clinical team's concern around the need for appropriate programming with an effective treatment model and adequate training of staff. Research indicates that solvent abusers are the most difficult and unmanageable individuals to treat (Beauvais & Trimple, 1997; Jumper-Thurman & Beauvais, 1992). The research on background and psychosocial characteristics show solvent abusers to be characterized by serious, multiple problems that lead to dysfunction in a wide range of social and personal domains. Research also indicates that solvent abusers present with a unique clinical profile that does not fit well within existing treatment programs based upon traditional drug and alcohol techniques (Dinwiddie, Zorumski & Rubin, 1987; Groves, 1990).

A. Contingency Plan

If the Innu youth are to be moved from the Grace Facility in the near future, the multidisciplinary team recommends a variety of options that will have to be employed that would initially be only a maintenance program basis (i.e. no programming developed, only essential supervision and therapeutic services initiated). It should be noted that long-term plans would need to be started immediately so as to minimize the time period of the maintenance program. Also, if the youth are transferred to therapeutic caregiver homes in Goose Bay, the physical homes used and the staff hired could be used for the long-term plan with the transition starting as quickly as possible. This scenario makes strong clinical sense since the maintenance staff would be starting to engage the youth and could continue this therapeutic relationship if they were to be trained for the long-term treatment program. Also, one more home may be needed for the 5 youth selected to go into the country (6-week program) if the community supports are not in place when they complete the 6-week cultural program.